The modified Brunelli procedure: a simple passage for the flexor carpi radialis tendon graft

V Sharma¹, Z Haider², A Hunter²

¹University College London, UK

²University College London Hospitals NHS Foundation Trust, UK

CORRESPONDENCE TO

Vivek Sharma, E: vivsharma@hotmail.com
doi 10.1308/rcsann.2018.0082

The modified Brunelli procedure is used for the treatment of non-repairable complete scapholunate ligament rupture in the wrist.¹ It aims to restore normal carpal biomechanics, preventing secondary osteoarthritis. A technically challenging portion of the operation involves threading the flexor carpi radialis (FCR) tendon through the scaphoid tunnel. As the tunnel is narrow, using a standard tendon forceps can be difficult because of the size of the forceps head and body. We have found that crocodile microforceps (Fig 1), from a myringotomy set, mitigates this difficulty, allowing easy passage of the FCR tendon through the narrow scaphoid tunnel.

Figure 1 Standard tendon braiding forceps (top) and crocodile microforceps from a myringotomy set (bottom)

Reference

1. Garcia-Elias M, Lluch AL, Stanley JK. Three-ligament tenodesis for the treatment of scapholunate dissociation: indications and surgical technique. *J Hand Surg Am* 2006; **31**: 25–34.

An innovative bespoke technique for the retrieval of broken distal locking bolts

MA Imam, Z Harb, D Elliott

Ashford and Saint Peter's Hospitals NHS Trust, UK

CORRESPONDENCE TO

Mohamed Imam, E: mohamed.imam@aol.com
doi 10.1308/rcsann.2018.0080

BACKGROUND

Broken distal locking bolts after intramedullary nailing of long bones are seen frequently in trauma practice. The retrieval of these bolts is technically demanding, especially the distal part, which is often held within the bone (Fig 1). In our tertiary fracture non-union unit, we have developed a technique for an easy, reproducible and quick removal of the broken parts. The following tips simplify the process and reduce operating time.

TECHNIQUE

The patient is placed supine without traction on a radiolucent table. Guided by an image intensifier, the nail and locking screws are removed. From the proximal entry point, the rod pusher is passed through the power drill into the nail track to act as a nail punch over the remaining screw part, if needed (Fig 2). The punch can be used to dislodge the broken part of the screw in the far cortex. A bariatric laparoscopic grasping forceps (Fig 3), which measures 45cm in length, is used to grasp the broken screw and the broken part is subsequently retrieved (Fig 4).

Figure 1 Broken distal locking bolts held within the medial femoral cortex

Figure 2 Rod pusher, which is passed (whenever needed) through the drill to act as a nail punch

DISCUSSION

Different techniques have been used to retrieve broken distal locking bolts.^{1,2} None of them have demonstrated superior efficiency. To our

Figure 3 Bariatric laparoscopic grasping forceps

Figure 4 The grasping forceps is manipulated towards the broken screw (A). Using the image intensifier, the claws are closed around the broken part (B). Finally, the broken screw is retrieved from the medulla (C)

knowledge, our technique has not been described elsewhere. We report a cost effective, reproducible, bespoke and safe technique that is effective in our hands.

References

1. Erturan G, Handley R. Removing broken locking bolts. *Ann R Coll Surg Engl* 2012; **94**: 448.
2. Matthews SJ, Landsmeer RE, Thomas TL. Removal of broken drill bits and locking screws from an intramedullary nail. *Ann R Coll Surg Engl* 2006; **88**: 316.

Correcting varus malreduction in extracapsular fractures of the neck of the femur using a temporary external fixator

R Dimock, D Elliott

Ashford and St Peters Hospitals NHS Foundation Trust, UK

CORRESPONDENCE TO

Richard Dimock, E: richard.dimock@nhs.net

doi 10.1308/rcsann.2018.0093

BACKGROUND

Extracapsular fractures of the femoral neck are increasingly being managed with cephalomedullary nails (CMNs).¹ Varus malreduction is a recognised complication of such devices, leading to reduced offset and defunctioning of the abductors, and increasing of the moment arm across the fracture, risking gait disturbance, non-union and metalwork failure. We describe a simple and efficient method for both correcting and maintaining the varus deformity while the surgeon and assistant prepare the femur and position the CMN, using two Schanz pins and a single external fixator bar.

TECHNIQUE

After routine setup and preparation of the patient on the traction table, place a 4.5mm Schanz pin through the greater trochanter into the anterior femoral head (Fig 1). Applying a force in the caudal direction allows correction of the varus deformity (Fig 2). A second Schanz pin is subsequently placed from lateral to medial in the distal femur, slightly anterior or posterior to the medullary canal. With the reduction initially obtained and held by hand, these pins can then be linked with a single external fixator bar, thereby maintaining the deformity correction (Fig 3). Following this, the CMN can be inserted in the standard technique and

Figure 1 Insertion of proximal Schanz pin