reduction attempts may lead to exacerbation of an already difficult situation (Figs 2 and 3).

TECHNIQUE

In order to improve the likelihood of success and minimise complications, the patient’s leg should be positioned with 90° of hip and knee flexion, the hip adducted and internally rotated. This leg position disengages the DM shell from the soft tissue or acetabulum and gentle traction can be applied. The leg should not be pulled in extension. The additional use of gentle force on the medial proximal thigh in the lateral direction will assist the reduction.

DISCUSSION

If a DM bearing is present, reduction should only be performed in theatre, under general anaesthesia and image intensifier guidance.

Figure 1 Radiography showing halo around the large poly head, from the dual mobility bearing

Figure 2 Dual mobility bearing components, where intraprosthetic dislocation occurs

Figure 3 Radiography following attempted closed reduction in theatre with femoral stem pull-out and rotation

This will help to prevent forcing the reduction when the large poly head is caught on the acetabulum or ilium and reduce the incidence of intraprosthetic dislocation, stem pull-out or other complications such as periprosthetic fracture.

A tip to prevent total hip arthroplasty femoral stem pull-out

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Figure 1 The first postoperative film of a patient who has undergone total hip arthroplasty and acetabular fixation ('fix and replace' procedure)

Figure 2 Radiography after an initial attempt at closed reduction in the emergency department, causing partial femoral stem pull-out

Figure 3 Radiography showing almost complete femoral stem pull-out and rotation after further attempts at closed reduction in theatre

Cemented polished taper slip stems are a popular choice for total hip arthroplasty. They may have a square shoulder (CPT®; Zimmer, Warsaw, IN, US) or a rounded shoulder (Exeter®; Stryker, Kalamazoo, MI, US). Femoral stem pull-out after attempted closed reduction of a total hip arthroplasty CPT® cemented stem is an occasional complication (Figs 1–3). We believe that if a polished taper slip stem is used, a small amount of cement should be placed over the shoulder of the prosthesis

to prevent this complication, especially for stems with square shoulders. A dislocation with a polished taper slip stem in situ without any cement over the shoulder is an indication for careful closed reduction in theatre under image intensifier guidance.

The utility of irrigation drainage following video-assisted pancreatic necrosectomy

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BACKGROUND

In severe pancreatic necrosis, a minimally invasive approach has been preferred to reduce morbidity when necrosectomy is indicated. Percutaneous drainage followed by video-assisted retroperitoneal debridement usually needs to be repeated for effective treatment.^{1,2} We describe a new technique that augments and facilitates continued removal of debris.

TECHNIQUE

Prior to surgery a retroperitoneal percutaneous catheter drain is inserted. The patient is placed in the supine position with the left side elevated 30–40 degrees. A 5-cm subcostal incision is made in the left flank in the mid-axillary line close to the exit point of the percutaneous catheter. The catheter is followed until the necrotic area is encountered. Necrosectomy is then performed using long graspers, ensuring copious irrigation and suctioning with visualisation using a 5-mm laparoscope. Once no further necrotic pancreatic tissue can be seen and the irrigation fluid becomes clear, the percutaneous catheter is removed and a triple-lumen sump drain is placed in the cavity (Figs 1 and 2). The triple-lumen sump is sutured securely to the skin. This catheter is set up for continuous irrigation with saline at

Figure 1 Three-way sump drain