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

Figure 2 Computed tomography of the abdomen: sump drain in peripancreatic fossa

50–80 ml/hour. Irrigation is maintained until the outflowing drainage is clear and no further debris is seen. This can be continued for up to 10 days postoperatively.

DISCUSSION

Placement of a triple lumen sump is relatively simple after a tract is formed by the retroperitoneal percutaneous catheter and allows for continued removal of necrotic debris following video-assisted debridement. The addition of this step to the procedure may therefore eliminate the need for repeated necrosectomies.^{1,2}

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Technique to maintain anatomic reduction when performing open reduction internal fixation for Salter–Harris type III distal tibial medial malleolus fracture

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BACKGROUND

When operative intervention is chosen for the treatment of a Salter–Harris type III distal tibial medial malleolus fracture, it is necessary to achieve an anatomic reduction and absolute stability while minimising damage to the physis. This can be challenging if

there is a significant horizontal component to a medial malleolus fracture (Fig 1) as there is a tendency for a partially threaded cancellous screw, placed parallel to the physis (transepiphyseal), to displace the medial malleolus fragment distally. We describe an option that can be used to maintain the reduction while causing minimal damage to the physis.

TECHNIQUE

The fracture is exposed and any interposing soft tissue removed from the fracture site. Under x-ray guidance, the fracture is reduced and

Figure 1 Anteroposterior radiography of the right ankle showing a Salter–Harris type III distal tibial medial malleolus fracture with a significant horizontal component

Figure 2 Smooth K-wires are passed across the fracture (and the physis) in order to maintain an anatomic reduction while the fracture is fixed using a cannulated, partially threaded cancellous screw.