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.

Figure 3 Intraoperative radiography showing maintenance of the reduction, with no distal displacement caused by the insertion (and lag effect) of the screw

the reduction maintained by passing two smooth K-wires across the fracture site: one anterior in the tibia and one posterior (Fig 2). A transepiphyseal guidewire can then be placed between these two wires. After position is confirmed on x-ray, a 4mm cannulated, partially threaded cancellous screw can be placed (Fig 3). Once some compression is achieved, the smooth K-wires can be removed.

DISCUSSION

Although the exact technique is not original, it highlights important considerations around fixation of paediatric fractures. This method has advantages over other potential fixation options; as the K-wires are removed afterwards, there is less risk of growth arrest compared with tension band wiring and an anatomic reduction is more easily achieved (and maintained) than with a buttress plate.

Botox in reverse: a useful adjunct for acromial fractures

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BACKGROUND

The incidence of postoperative acromial fractures has been reported to range from 1.4–4%.¹ These fractures can be difficult to manage as the reverse arthroplasty relies on the deltoid being placed under tension to achieve a mechanical advantage.² However, following a fracture, it actively mobilises the fracture site and any fixation needs to be able to overcome this distraction

force. The union rate for those fractures affecting the base of the acromion or scapular spine is around one-third.³ This demonstrates that the management of these fractures after reverse arthroplasty remains difficult.

TECHNIQUE

Patients with acromial fractures after a reverse arthroplasty are often self-referred back to the clinic with sudden onset pain with no preceding trauma typically between 6 and 12 weeks after surgery. Radiographs can reveal the fracture (Fig 1).

Figure 1 Axillary x-ray taken 9 weeks postoperatively, demonstrating the acromial base fracture.

Figure 2 Six-month postoperative axillary x-ray showing healing of the fracture.