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A helpful technique for removing resurfacing acetabular components

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BACKGROUND

Removing well-fixed, cementless acetabular components has been made considerably easier since the introduction of rotating handle devices, including the Explant Acetabular Cup Removal System (Zimmer, Warsaw, IN, USA), that preserve bone stock by extracting the cup using a curved cutting blade matching the external diameter of the prosthesis.[1] Explant is supplied with 22-, 26-, 28- and 32-mm femoral head sizes and is not designed to remove resurfacing acetabular components with internal diameters over 32 mm. Birmingham Hip Resurfacing acetabular components (Smith and Nephew Orthopaedics, Warwick, UK) can be removed with Explant using specially designed inserts. These inserts do not allow for universal adaptation of the Explant, which therefore remains incompatible with the inner diameters of many other resurfacing components. It is possible to obtain custom-made devices but this incurs expense and a lag time.

Figure 1 A ball of bone cement is placed within the acetabular component during the dough phase.

Figure 2 Indent the centre of the cement with the 32-mm head on the Explant handle.

TECHNIQUE

To allow removal of a 50-mm outer diameter, 45-mm inner diameter, well-fixed resurfacing acetabular component, we placed a ball of bone cement within the acetabular component during the dough phase (Fig. 1) and indented the centre of the cement with the 32-mm head on the Explant handle (Fig. 2). Once the cement had cured, Explant was then used to remove the cup in the normal fashion.

DISCUSSION

This is an economic, effective and adaptable method that can be utilised in cups of unusual internal diameter without the need to order a costly custom-made attachment. Until Explant and similar devices come with multiple head sizes to fit all resurfacing cups, this will remain a useful technique.

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A technique for applying a non-adherent, tri-laminate dressing for hypospadias repair

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BACKGROUND

The aim of dressings in hypospadias repair is to maintain haemostatic pressure over the wound and maintaining the phallus in an upright position. It should be easy to apply and comfortable. The

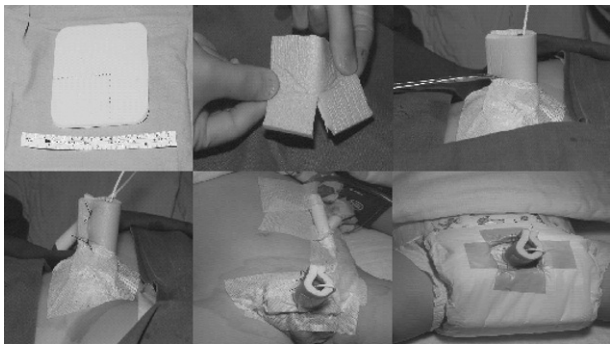

Figure 1 Application of a non-adherent, tri-laminate (Allevyn) dressing.

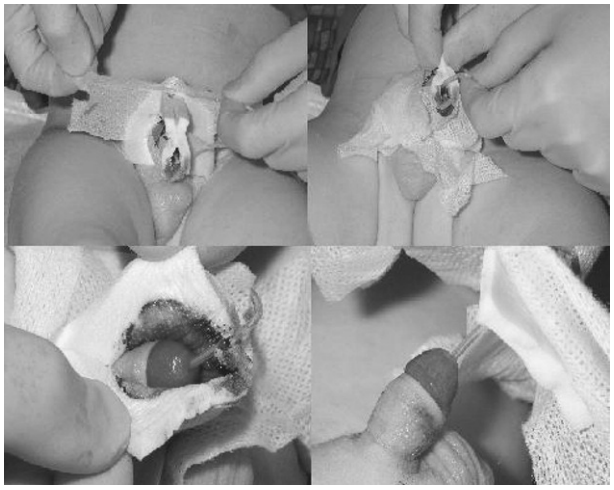

Figure 2 Dressing removal.

dressing should also be easy to remove with the least discomfort and distress to the patient and their family. Most dressings are bulky, hard to apply or remove, and may fall off in an active child.[1–3] We describe a dressing using Allevyn (Smith & Nephew Healthcare, Healthcare House, Hull, UK).

TECHNIQUE

The lower end of dressing is split to form two equal lateral flaps which will sit on the pubo-scrotal area and secure with adhesive plaster. The rest of the dressing is rolled into a cylindrical shape wrapping round the penile shaft and is closed on the dorsal aspect using two interrupted silk stitches. The top end of the dressing is left open to allow the urinary catheter to come through (Fig. 1). Removal of the dressing is carried out after either 2 or 5 days depending on the type of repair. The plaster is sprayed with an alcohol-based disinfectant and stitches are cut. The dressing, being non-adherent, is easily separated off from the wound (Fig. 2).

DISCUSSION

Allevyn has a unique tri-laminate structure, inner non-adherent, central absorbent and outer water- and microbial-proof layers. None of the 85 dressings after repair (63 Mathieu's, 11 Duckett's and 11 Bracka's) dislodged prematurely. All dressings were removed on the ward with minimal distress to the patients. There was no early wound infection. This non-adherent and tri-laminate dressing is simple to apply and compatible with early discharge from hospital.[4]

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L-Configuration re-attachment of distal biceps tendon rupture

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BACKGROUND

In distal biceps tendon ruptures, re-attachment to the radial tuberosity should ensure adequate tendon to bone contact for optimal healing.

TECHNIQUE

Using a transverse incision at the cubital crease, we dissect to the radial tuberosity into which two suture anchors (5.0 mm FASTIN RC, Mitek, UK or 3.5 mm Twinfix, Smith-Nephew, UK) are inserted, each with two suture strand pairs. The tendon is held outside the wound during suture passing. Each pair of distal anchor sutures (Fig. 1, X1) is passed through the distal part of the tendon. One strand is passed in a zigzag fashion through the tendon (Fig. 1, C and D) whilst the other (Fig. 1, A and B) is passed straight posterior to anterior. The four strands of the proximal anchor (Fig. 1, X2) are passed to form two mattress sutures through the proximal tendon when tied (Fig. 1, E and F). Tightening is performed in a specific sequence, initially pulling on strands A and B to position tendon to bone, and then tightening these to the corresponding suture strand of their pair. The two suture pairs are tied to each other. Following this, the mattress sutures of the proximal anchor are tied individually and then over the tendon to each other, creating a box type pattern. The second