

'Explanting' the well-fixed, cemented acetabular implant

H Arshad, N Chirodian

Norfolk and Norwich University Hospitals NHS Foundation Trust, UK

CORRESPONDENCE TO

Homa Arshad, E: homabird@yahoo.co.uk

BACKGROUND

Aseptic loosening is the most common indication for revision of a cemented acetabular implant. Removal of loose components is straightforward. Revision surgery for malposition, infection or polyethylene wear may require the removal of a well-fixed acetabular component. This can be achieved with the use of osteotomes, reamers and drills.^{1,2} We describe a rapid and straightforward technique that may be used as an alternative, as well as discussing its limitations.

TECHNIQUE

The acetabular rim is exposed as usual. The Explant® Acetabular Cup Removal System (Zimmer, Swindon, UK) is selected, sized 2mm larger than the acetabular component. The blade of the device is pushed into the bone–cement interface and is used to circumscribe first the rim and then the full radius of the cement mantle surrounding the

implant. Typically, the process takes less than five minutes and the whole cement mantle emerges, complete with its key holes (Fig 1).

DISCUSSION

We would caution against use of this technique in certain circumstances. It is difficult to maintain the Explant® seated in a good position if the implant is not well fixed or if there is gross polyethylene wear. We use different techniques where the acetabular wall is thin or the cement mantle is eccentric.

References

1. Masri BA, Mitchell PA, Duncan CP. Removal of solidly fixed implants during revision hip and knee arthroplasty. *J Am Acad Orthop Surg* 2005; **13**:18–27.
2. Sabboubeh A, Al Khatib M. A technique for removing a well-fixed cemented acetabular component in revision total hip arthroplasty. *J Arthroplasty* 2005; **20**: 800–801.

A soft, inflatable patient support

S Shaw, M Kaushal, K Halbert

Wrightington, Wigan and Leigh NHS Foundation Trust, UK

CORRESPONDENCE TO

Simon Shaw, E: patitifa@hotmail.com

BACKGROUND

Patient support is frequently required during just one part of a procedure (eg the pelvis for the perineal portion of an abdominoperineal resection of the rectum). This is commonly achieved by placing a gel patient positioner underneath the pelvis. However, this positioner can remain in place for a long time and we had noticed that patients complained occasionally of back pain after the operation. It was thought that this might be attributable to the placement of the support under the pelvis.



Figure 1 Removed acetabular component



Figure 1 Intravenous fluid pressure bag at end of operating table

TECHNIQUE

An intravenous fluid pressure bag is placed under the pelvis at the start of the procedure. To protect the patient from direct contact with the bag and the plastic components of the device, the bag is placed under a gel pad. The pump protrudes over a lateral edge of the operating table. Having reached the point when the modified position is required, the bag is inflated for that portion of the procedure only.

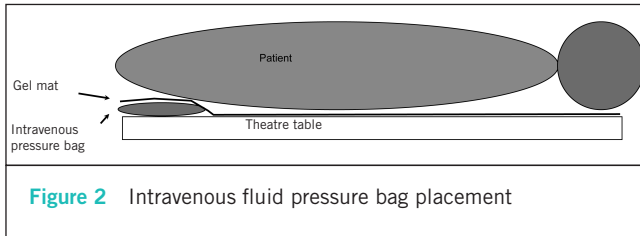


Figure 2 Intravenous fluid pressure bag placement

DISCUSSION

Since adopting this technique, no patient has complained of back pain. The technique can be applied easily to other procedures, either where a variable position is required or an unnatural position is to be avoided for the length of the procedure. Commercial inflatable patient positioners are available but we propose that this is a cheap and effective alternative. It is important that the patient is protected from the hard, plastic components of the pump mechanism.

A readily available alternative to Chinese finger traps for fracture reduction

KSN Akhtar, D Akhtar, J Simmons

Imperial College Healthcare NHS Trust, UK

CORRESPONDENCE TO

Kash Akhtar, E: surgery@me.com

BACKGROUND

Closed reduction of forearm and hand fractures can be performed with Chinese finger traps.¹ These are applied individually to the fingers and the limb is suspended, with gravity providing countertraction to disimpact the fracture by ligamentotaxis. The fracture fragments are manipulated once length is restored. Chinese finger traps are a valuable tool that can maintain traction while a cast is applied and can also be useful during fracture fixation.² They are not readily available in many hospitals, however, particularly out of hours.

TECHNIQUE

Strips of Tensoplast[®] tape (2.5cm x 4.5m; BSN medical, Hull, UK) are placed over the thumb and each finger in turn. A strip is placed over the dorsal and palmar aspects of each digit, ensuring that the metacarpophalangeal joints are covered to prevent shearing and blister formation. Approximately 1 inch of Tensoplast[®] is left loose distal to the fingertip and pinched together (Fig 1). A silk suture is passed through each of these loose ends, the needle is removed and the resulting silk loops are tied to a drip stand.



Figure 1 Modified finger traps

DISCUSSION

This technique ensures that each digit is suspended individually in a similar manner to Chinese finger traps. Gravity can be used to facilitate ligamentotaxis and fracture reduction. It is our practice to place a padded arm board below the arm as a 'safety net' but we have not experienced a hand falling out of this arrangement. This technique is particularly useful if there is no assistant available.

References

1. Earnshaw SA, Aladin A, Surendran S, Moran CG. Closed reduction of Colles fractures: comparison of manual manipulation and finger-trap traction: a prospective, randomized study. *J Bone Joint Surg Am* 2002; **84**: 354–358.
2. Haddad FS, Goddard NJ. Acute percutaneous scaphoid fixation. A pilot study. *J Bone Joint Surg Br* 1998; **80**: 95–99.