



Figure 2 Checking compatibility between the osteotomised femoral head and neck and the implant components

(Fig 1). It then allows the surgeon either to match the centres of the prosthetic and original heads or increase/decrease the offset as required. The same step can be repeated after inserting the final femoral stem to confirm the correct size of prosthetic head to be used.

DISCUSSION

While most of the previously described intra-operative techniques require insertion of pins, the use of intra-operative x-ray or additional kits, our technique is a safe and non-invasive method that requires no additional equipment, cost or time (Fig 2).

References

1. Sarin VK, Pratt WR, Bradley GW. Accurate femur repositioning is critical during intraoperative total hip arthroplasty length and offset assessment. *J Arthroplasty* 2005; **20**: 887–891.
2. Papadopoulos AX, Tsota I, Megas P. Methods for estimating leg length discrepancy: emphasis to the planning and performance of total hip arthroplasty. *Acta Orthop Traumatol Hellenica* 2002; **53**(4).

Pin site cover: a simpleton’s approach

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Pin site complications after orthopaedic procedures include skin indentation and wire migration.¹ A simple technique can be incorporated into daily practice to offset the above. After the wire is fixed and the wire tip is bent, a Primapore® dressing (Smith & Nephew, Hull, UK) is cut in the middle and secured around the pin to prevent skin indentation. To further augment this, a second Primapore® is crimped



Figure 1 Primapore® dressing secured around pin



Figure 2 Second Primapore® dressing adhered over tip

and adhered over the tip to prevent the wire getting caught in the padding and migrating. This method is cheap, readily available and easy to apply. We have avoided the above complications in a series of 57 cases.

Reference

1. Sharma H, Taylor GR, Clarke NM. A review of K-wire related complications in the emergency management of paediatric upper extremity trauma. *Ann R Coll Surg Engl* 2007; **89**: 252–258.