appears to pass vertically makes it easier to visualise the projected direction of the guide wire.

Methods: Fifty Specialist Registrars, thirty participating in the London hip meeting 2009, ten from Oxford and ten from Northern deanery orthopaedic rotations were involved in the study. They were presented with standard AP and rotated images of the femoral neck on paper using 135 degree template to replicate the DHS guide.

The participants were asked to mark the entry point on the intertrochanteric area of femur on the image where they would have placed the guide wire. They did this on both standard AP and rotated images aiming for the centre of the head of the femur.

Results: Thirty-seven Specialist Registrars (74%) were able to accurately mark their entry point on rotated images on their first attempt as compared to eighteen trainees (36%) managing to place it correctly first time on the standard image. Thirteen trainees (26%) were able to mark their entry point correctly on both standard AP and rotated images with equal accuracy.

Conclusion: Coren et al. argue that human vision can more easily judge horizontal and vertical lines rather than oblique lines. Thus, rather than use the standard anterior–posterior projected image of the hip, we should routinely rotate the intensifier image so that the guide wire appears to be passing in a vertical direction. By rotating the image (Fig. 2) in this way it becomes significantly easier to visualise the projected direction of the guide wire and in doing so ensure its accurate final placement thereby minimising possible complications.


First time patellar dislocation in adults—consensus of management among the orthopaedic surgeons in UK

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Background: Management of first-time patellar dislocations in adults has received more attention recently as it mainly affects young adults who have an active lifestyle. These injuries have greatly reduced the level of activity in this group of population. Non-operative treatment has been the traditionally accepted option. Unfortunately the outcomes have not been satisfactory. Recent studies have brought to light, the associated soft tissue injury which could be operatively treated. The results of operative treatment in terms of early recovery to an active lifestyle have been promising.

Aims and objectives: Our aim was to know the current practice among the clinicians in the UK who manage first-time patellar dislocations. We have performed a questionnaire survey gathering the opinion of one hundred orthopaedic consultants registered with the British Orthopaedic Association.

Method: We used an online questionnaire survey and emailed it to the members of the British Orthopaedic Association.

Results: This is a currently ongoing study. The present status of our survey showed that non-operative treatment has still remained the most favoured approach to the initial management among seventy percent of the surgeons. Further investigations with an MRI or diagnostic arthroscopy have been routinely used by more than eighty percent of the surgeons. Skyline views of the patella have been used after initial suspicion of associated osteochondral fractures.

Conclusion: The pathophysiology of patellar dislocation is better understood with the aid of MRI. There is a growing trend towards operative treatment. Selecting the right operation for the right patient is challenging. A randomised controlled trial of the various treatment options would aid us in analyzing the benefits and would educate about the possible pitfalls that need to be avoided.


Outcome of internal fixation of periprosthetic femoral fractures with locking compression plates

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Background: Periprosthetic fractures of the femur present a challenging problem both in terms of fracture management, and patient factors specific to this population; they are usually elderly, frail with co-morbid factors such as osteoporotic bones and other systematic diseases such as cardiovascular or respiratory problems. The treatment of periprosthetic fractures is complex and challenging and requires the skills of both trauma surgery and revision arthroplasty.

Objectives: To conduct a case notes review of patients who underwent this treatment to evaluate the outcomes. This is to complement the literature research findings to compare the local results in a District General Hospital differ from results reported in the literature.

Setting: A District General Hospital (DGH).

Design and methods: Systematic literature review and retrospective case series study, Level IV of evidence.

Patients: From July 2007 to March 2009, a consecutive series of eight patients with peri-prosthetic femoral fractures were treated with a Locking Compression Plate (LCP); three total hip replacements (THR) and five total knee replacements (TKR).

Outcome measure:

1- Clinical: time to full weight bearing, return to preoperative, hip and knee range of movements: This is difficult, as it was not always recorded, and incidence of complications: infection, non-union and failure of metal work.

2- Radiological: Union and Mal-union

Results: All fractures united, and all patients were able to fully weight bear. No incidence of metal work failure. There was one case of MRSA infection in a patient who was a previous carrier and was not given appropriate prophylaxis.

Conclusion: Locking femoral plate is an alternative satisfactory method for treating peri-prosthetic femoral fractures. It avoids the need for revision surgery in types B and C peri-prosthetic fractures with a well fixed implant, particularly in the elderly group who have a higher morbidity and mortality risk from such a major operation.


Sub-speciality orthopaedic surgeons: Another potential factor delaying hip fracture surgery

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Hip fractures are associated with significant morbidity and mortality, however effective medical and social input can improve outcome. Early surgical intervention, that within 48 h or ideally 24 h plays a significant role. Such targets must be managed within modern working NHS practice. Currently such cases are performed during fixed Trauma sessions. However, there is increasing sub-specialization within orthopaedics. Trauma involving the upper limb can often be delayed for the attention of the subspecialty surgeon during their trauma sessions. Within our unit Wednesday trauma sessions are supervised by an upper limb consultant and on alternate Tuesdays. We therefore assessed whether days of upper limb specific trauma sessions affected the delivery of care to hip fracture patients.

Data for this Trauma unit was obtained from the National Hip Fracture Database for a 12-month period from which 216 patients with complete data were included. Of the 216 patients 68 (31.5%) were medically unfit for surgery, 67 (31%) were delayed to surgery and 81 (37.5%) were operated upon within 24 h. The mean delay to surgery for those admitted on a Tuesday was 69.7 (range 22–174) hours compared to 27.1 h (range 29–65) on Thursday the most efficient day of the week with equal number of trauma sessions. The impact of CT findings on the decision to treat with surgery versus closed reduction and on the choice of surgical procedure was assessed. Surgery was not performed in 4 patients because CT scans showed no significant displacement of fragments previously judged displaced or “indeterminate” on radiographs.

The Foley catheter is described in the emergency treatment of penetrating cardiac injuries. It can be used to control bleeding from wounds in extremities, where bleeding vessels have retracted or simple pressure is unsuccessful at obtaining control due to the vessel depth.

Insert the catheter tip into the wound and inflate the balloon as appropriate to the wound size. If necessary it can be slightly over-inflated. Spigot or clamp the catheter and re-apply direct pressure to the wound and balloon. The pressure is transmitted within the wound providing temporary haemostatic control en route to the operating theatre.


Complex proximal humeral fracture should these be fixed?

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We retrospectively reviewed the results of 13 proximal humeral and mid shaft humeral fractures which went to delayed union/non-union by 3–6 months.

Patient underwent computed tomography (CT) scans to confirm non-union or assess the fracture pattern. CT scan indicated union in 4 patients where X-rays were not decisive. CT scans and radiographs were compared in the demonstration of fracture lines, displacement of fracture fragments, rotation of fragments relative to their normal positions, and status of the head and articular surface of the humerus.

The non-operative route was worth considering though there was long healing time of 6–12 months. All patients who underwent fixation would have preferred the early surgical fixation of fracture due to long morbidity associated with non-operative treatment.

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Operative treatment of closed fractures of clavicle in children

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Background: Fractures of the clavicle are common in both adults and children. Recent studies in the treatment of adult fractures have indicated that improved outcomes are achieved after open reduction and internal fixation. The aim of this study was to analyze outcomes after open reduction and internal fixation of displaced clavicle fractures in children.

Material and methods: We analyzed a retrospective case series of 12 children whose displaced clavicle fractures were treated with