

Letter to the Editor

Use of a Trochanteric Flip Osteotomy Improves Outcomes in Pipkin IV Fractures

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Published online: 19 December 2009
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To the Editor:

We were interested to read the article by Solberg et al. [3] entitled “Use of a trochanteric flip osteotomy improves outcomes in Pipkin IV fractures.” The authors reported that combined fractures of the femoral head and acetabulum are relatively rare injuries and the debate continues regarding optimal surgical management of these injuries. We commend the authors on their excellent results and would like to add our support to their selection of this surgical approach. St George’s Healthcare NHS Trust provides a supraregional service for pelvic and acetabular trauma referrals. We corroborate the authors’ observation that a trochanteric flip osteotomy during the course of a posterior approach allows excellent access to the femoral head and acetabular fragments through one incision. However, we note some differences in our practice and wish to bring these to the authors’ attention.

While describing the surgical approach, Solberg et al. explained that they tag and release the piriformis tendon but preserve the short external rotators. This contrasts with the approach originally described by Siebenrock et al. [2], which is the technique we tend to follow. Releasing the

gemelli and obturator internus close to their insertion at the posterior trochanteric crest improves exposure of the posterior wall and facilitates application of a buttress plate for osteosynthesis. We do not believe this approach jeopardizes the vascularity of the femoral head. The retinacular vessels are identified and protected during surgery. The obturator externus and quadratus femoris, however, are not released, thus preserving the deep branch of the medial circumflex artery.

Solberg et al. identified coexisting labral tears in all their patients and repaired seven of 12 tears by direct osteosynthesis. The technique of osteosynthesis is not described and a brief description would be appreciated. We also have found coexistent labral tears that we have repaired using Mitek suture anchors to exposed cancellous bone at the acetabular rim.

We also administer low molecular weight heparin (eg, Fragmin) 6 hours postoperatively. Subsequently, warfarin is commenced with a loading regimen and is continued for 3 months. We do not routinely perform duplex ultrasound screening, although high-risk patients would be considered for a vena cava filter.

Solberg et al. reported one case of wound dehiscence in their series and we would be interested to know if a cause was identified. Prophylaxis for heterotopic ossification remains controversial with a recent review [1] stating the benefit of prophylactic radiotherapy when compared with nonsteroidal antiinflammatory drugs. Another systematic review [4] however, concluded the opposite. In our practice, we reserve prophylactic radiation for high-risk patients, for example, those who have a coexisting head injury or a history of heterotopic ossification.

We once again commend the authors on their contribution and look forward to their clarification of these issues.

(Re: Solberg BD, Moon CN, Franco DP. Use of a trochanteric flip osteotomy improves outcomes in Pipkin IV fractures. *Clin Orthop Relat Res.* 2009;467:929–933.)

No reply to this letter was received from Solberg et al.

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