FEMORAL NECK ARTHROPLASTY AFTER FAILED RESURFACING: BRIEF REPORT

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Surface replacement of the hip was introduced as an alternative to conventional replacement. Unfortunately, its theoretical advantages have been overshadowed by the high incidence of early failure (Head 1981; Jolley, Salvati and Brown 1982; Bell et al. 1985). If failure necessitates removal of the prosthesis, we advocate preservation of the femoral neck stump for articulation. We report five such cases.

Patients and Methods. Five patients, each of whom had a Wagner resurfacing arthroplasty, later required excisional arthroplasty for loosening: three were aseptic, and two septic. The acetabular and femoral components were removed but the femoral stump was left intact (Fig. 1), except in patient B who had an associated femoral neck fracture. In no case was any further acetabular bone stock resected. The femoral stump was placed in the acetabulum without any soft tissue interposition and the wounds closed primarily over suction drains. The patients were placed in traction for six weeks then allowed up taking as much weight as they would tolerate using walking aids. A shoe raise was used to compensate for leg length discrepancy.

Results. These are summarised in Table I. Except for patient B who had a femoral neck fracture, they were very satisfactory.

Fig. 1

Discussion. In Girdlestone's arthroplasty the entire femoral neck and the cartilage of the acetabulum are resected (Girdlestone 1943). In four of our five cases the femoral stump was not resected. Such relative lengthen-

Table I. Results in five patients

Patient	Follow-up (months)	Pain	Walking	Activities	Hip movement in degrees				
					Flexion	Abduction	Adduction	Medial rotation	Lateral rotation
A	71	None No analgesics	No cane Walks 60 min	Independent farmer Stairs normal	100	30	20	45	20
B	30	Moderate Simple analgesics	Cane indoors Crutch outdoors Walks 10 min	Not working No sports Stairs difficult	115	60	60	70	70
C	51	Mild with exercise No analgesics	No cane Walks 60 min	Dancing, tennis, cycling Stairs normal	90	30	20	40	10
D	91	None No analgesics	No cane Walks 60 min	Normal housework Stairs, good leg first	80	20	20	20	10
E	24	Mild NSAID	Two canes Walks 10 min	Not working Needs assistance with ADL*	90	30	25	40	10

* activities of daily living

ing of the femoral neck lever arm improves tension in the pelvi-trochanteric muscles, thus mitigating the abductor lurch; abductor power in no case was less than strength 4. Leg length discrepancy was 5 cm in three patients, 4 cm in one and 2 cm in the other. Moreover, trochanteric impingement on the acetabulum is reduced, thereby retaining functional abduction. We do not think that

trochanteric osteotomy and distal placement is indicated, as four of our five patients recovered good abductor strength. We believe that the procedure described provides long term salvage after failed resurfacing arthroplasty and should be considered in young patients in preference to revision to a total joint replacement, arthrodesis, or a conventional Girdlestone arthroplasty.

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LIPOFIBROMATOUS HAMARTOMA OF THE ULNAR NERVE AT THE ELBOW: BRIEF REPORT

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Lipofibromatous hamartoma is an uncommon lesion of peripheral nerves first described in 1953 by Mason. Several reports of this condition have appeared (Johnson and Bonfiglio 1969; Silverman and Enzinger 1985), but most cases have involved the median nerve in the distal forearm, wrist or palm and presented with carpal tunnel syndrome. Only two cases of involvement of the distal ulnar nerve have previously been reported (Silverman and Enzinger 1985).

Case Report. A 59-year-old man presented with an 18-month history of progressive weakness of his left hand with some numbness around the elbow but no gross disturbance of sensation in the ulnar distribution. On examination, he had normal grip strength but loss of fine finger movements with paralysis and gross wasting of the ulnar intrinsic muscles. The ulnar-supplied forearm flexors were normal. There was minor sensory impairment in the ulnar distribution. Diffuse thickening of the ulnar nerve was palpable in the region of the ulnar groove behind the distal humerus.

At operation, the ulnar nerve was found to be diffusely expanded by fibrofatty tissue for 12 cm of its length (Fig. 1); 5 cm distal to the elbow it tapered to normal size but was pale and somewhat sclerotic. The branches to flexor carpi ulnaris were involved and one

Fig. 1

was excised for histology. Diffuse involvement of the nerve prevented the removal of abnormal tissue; the nerve was simply decompressed, its bulk precluding transposition. At follow-up there was slight sensory improvement but no recovery of motor function.

Pathology. Two specimens were received for pathological examination. Each was irregular, fusiform, firm, white and translucent. They measured 1.8 and 2 cm in