the humerus after the first fracture, it must originally have been more displaced than Figure 1 indicates, since disruption of the intervening brachialis is a requirement for the artery to come into contact with the humerus (Wray 1965).

The likely explanation for complete occlusion following the second fracture is that the already kinked artery was further injured and compressed by swelling in the cubital fossa (Lipscomb and Burleson 1955; Eppright and Wilkins 1975). Although the brachial artery may be occluded by being impaled on a bone spicule (Birnstingl 1982), or by being attached to the fracture fragments (Brown 1952), chronic adherence of the artery to an old fracture site has not, to our knowledge, been reported before.

No benefits in any form have been received or will be received from a commercial party related directly or indirectly to the subject of this article.

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STABLE OSTEOCHONDritis DISSECANs – DOES THE LESION UNITE?

E. J. P. CRAWFURD, R. J. H. EMERY, P. M. AICHROTH

The management of osteochondritis dissecans of the femoral condyle is controversial; most surgeons remove unstable lesions, but the treatment of stable lesions varies between those who treat them conservatively and those who are more aggressive and remove or drill them. Until recently there has been little scientific basis for advocating any particular treatment. We formed a clinical impression that stable lesions in the classical position on the medial femoral condyle had a poor prognosis and therefore undertook a retrospective review of such cases.

Fig. 1

Patients and methods. We reviewed 31 knees in 28 patients with arthroscopically confirmed osteochondritis dissecans of the femoral condyle treated at Westminster Children's Hospital. The management had been to arthroscope all patients with radiographic evidence of osteochondritis dissecans and, with the use of a hook, to

assess the stability of the fragment. Stable fragments were left in situ whereas unstable fragments were removed and the resultant crater curetted till bleeding bone was reached.

Results. There were 14 males and 14 females with a mean age at onset of symptoms of 12 years (range 8 to 22). The mean interval between arthroscopy and review was 7.5 years. Of the 31 lesions, 21 were considered stable at arthroscopy and were left in situ.

At review, 13 of the 21 stable lesions had healed; their anatomical distribution is shown in Figure 1. Further analysis showed that of the 10 lesions in the classical position on the medial femoral condyle only three had healed, whereas lesions elsewhere in the knee had all healed with only one exception (10 out of 11) (Fig. 2). There was no correlation between healing and the size of the lesion, the age of onset or the sex of the patient.

Fig. 2

Conclusion. These results confirmed our clinical impression that stable osteochondritis dissecans in the classical position on the medial femoral condyle does not often heal spontaneously, whereas elsewhere in the knee such lesions heal well. We therefore feel that the present method of management needs reappraisal.

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