CORRESPONDENCE

We welcome letters to the Editor concerning articles which have recently been published. Such letters will be subject to the usual stages of selection and editing; where appropriate the authors of the original article will be offered the opportunity to reply.

Letters should normally be under 500 words in length, double-spaced throughout, signed by all authors and fully referenced. The edited version will be returned for approval before publication.

TROCHANTERIC OSTEOTOMY

Sir,

In the brief report in your January 1993 issue entitled 'An extended trochanteric osteotomy for revision total hip replacement' (1993; 75-B:158-9), the authors state that there are only rare indications for osteotomy of the greater trochanter in primary hip replacement. This may be the position in North America, where medicolegal activity affects medical practice and makes many surgeons wary of elevating the trochanter lest litigation follows nonunion.

In the UK, exposure of the hip by trochanteric osteotomy has been part of the Charnley low-friction arthroplasty since its inception (Charnley 1972, 1979); it gives unrivalled access to the acetabulum and the medullary canal. Many surgeons still perform all hip replacements by this method; reattachment of the trochanter can now be achieved with a low rate of nonunion (Wroblewski and Shelley 1985).

Peters et al cite improved acetabular exposure as a benefit of their 'extended trochanteric osteotomy', but such a large trochanteric fragment is difficult to retract, and forms a definite impediment to acetabular access. In addition, the necessary dissection of the vastus lateralis must compromise knee function and gait postoperatively. Finally, the disturbance of up to one-third of the circumference of the femur for up to 10 cm below the vastus tubercle must impair fixation of the revision femoral component, whether cemented or cementless, since it will be inserted before replacement of the large fragment. This loss of fixation will surely cause an increased rate of loosening.

I would respectfully suggest that there are already excellent methods of obtaining exposure in total hip revision surgery, and of securing trochanteric union after osteotomy. There would appear to be no merit in the 'extended trochanteric osteotomy'.

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Charnley J. The long-term results of low-friction arthroplasty of the hip performed as a primary intervention. *J Bone Joint Surg [Br]* 1972; 54-B:61-76.

Charnley J. *Low friction arthroplasty of the hip.* Berlin, etc: Springer-Verlag, 1979.

Peters PC Jr, Head WC, Emerson RH Jr. An extended trochanteric osteotomy for revision total hip replacement. *J Bone Joint Surg [Br]* 1993; 75-B:158-9.

Wroblewski BM, Shelley P. Reattachment of the greater trochanter after hip replacement. *J Bone Joint Surg [Br]* 1985; 67-B:736-40.

Author's reply:

Sir,

I agree with Mr Manning that a trochanteric osteotomy at primary hip replacement gives unrivalled access. I did not intend to give the impression that this technique is not used in the USA, but I do consider that where a primary total hip arthroplasty can be done easily without a trochanteric osteotomy, some potential complications can be avoided.

The extended trochanteric osteotomy provides better acetabular exposure than no trochanteric osteotomy, and we have seen no compromise of knee function or gait post-operatively caused by the osteotomy or the dissection of the vastus lateralis. We do, however, forbid active abduction exercises for six weeks.

I must emphasise that this approach is recommended only for revision hip surgery. We generally use long femoral implants, usually porous-coated, and a significant portion of the implant can be placed into intact femoral shaft bone. One of the main advantages of our osteotomy is that there is some good bone in the trochanteric fragment: the problem of attaching very thin avascular bone to a poor bony bed is avoided.

The extended osteotomy is not indicated for all revision patients; it is a method which provides better femoral and acetabular exposure, while allowing secure reattachment of a large bony fragment.

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INTRA-ARTICULAR FRACTURES OF THE CALCANEUM

Sir,

We would like to comment on the two papers on calcaneal fractures by Eastwood and her colleagues in your March 1993 issue (1993; 75-B:183-8 and 189-95). The first gives absolute measurements for the displacement of fragments after intra-articular fractures and a classification that assists in operative management. We feel that there are fundamental flaws in this study.

First, the paper reports many radiological measurements, but the method is described only briefly. There is no indication as to which CT cut was used or how the axis of each fragment was defined. How were angles measured from the curved undersurface of the talus? We feel that these factors, together with the variation of the level of CT cut between patients, and the often poor definition of the images, do not allow measurements to be made with the accuracy necessary to report results in millimetres or degrees. Rotation of the lateral fragment about the transverse axis, clearly shown in Figures 1 and 2, is not mentioned, although it is usually greater than that about the longitudinal axis, and comprises the principal element of the depression that requires the 'elevation' as understood in previous studies. In addition, the results given for the proportion of the facet comprised by this lateral fragment are meaningless, because the width of the part of the facet on the lateral fragment varies continuously in the anteroposterior direction. The most useful measurement would have been of the relative area of facet involved, but this is not directly measurable from discontinuous CT cuts.

Secondly, the classification given is based entirely on the images of the lateral wall of the calcaneum. The true appearance