East and Central African Journal of Surgery: another Canadian connection

The problems of delivering an acceptable standard of surgical care to African people will largely be solved by African health professionals working in Africa, for it is they who know the right questions to pose in order to find practicable solutions. In order to build the research capacity required to discover these solutions, it is essential to support autochthonous African scientific publication, so the new editorial linkage between the *Canadian Journal of Surgery* (*CJS*) and the *East and Central African Journal of Surgery* (*ECAJS*) is to be applauded, as is the work put into this project by the Canadian Network for International Surgery.[1]

The Ptolemy Project, run out of the Office of International Surgery[2] at the University of Toronto, provides full-text access to the University of Toronto Library for 100 of our research partners in the Association of Surgeons of East Africa (ASEA), the professional association that owns the *ECAJS*. We have undertaken to provide electronic publishing of the *ECAJS* through Bioline/CITD Press at the University of Toronto and expect to have the first electronic issue of the journal up on the Web by December 2002. The *ECAJS* currently has a circulation of 500, mostly members of the ASEA, and as it is not presently indexed in PubMed, interesting papers presented in the journal go unrecognized in the rest of the world. Electronic publication of the journal will make it available to a larger readership and should help improve the impact of the journal. We believe this is an important adjunct to the editorial support of the *CJS*, and we share the goals of gaining international recognition for the *ECAJS* and eventually getting it indexed.

Injury is predominantly a surgical disease, and in terms of the burden of disease in Africa, it ranks between malaria and tuberculosis. Despite the magnitude of the burden of injury, it is unlikely that in the foreseeable future it will receive funding at the level currently given to communicable disease, so it is vital to look for innovative ways to help the African surgeons who daily combat the injury pandemic. There are about 500 surgeons in East Africa who deal with the surgical needs of some 200 million people, so there is considerable leverage to strategies designed to improve health by building surgical education and research capacity in Africa. The *ECAJS* is an important lever in this endeavour.

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References

1. Lett RR. *East and Central African Journal of Surgery*: the Canadian connection. *Can J Surg* 2002;45:244-5.
2. Web site of the Office of International Surgery. Available: www.utoronto.ca/ois (accessed 28 Nov 2002).

Complete slipping of the capital femoral epiphysis after hematogenous osteomyelitis

The cause of slipped capital femoral epiphysis is mostly unknown (idiopathic), although it may be associated with endocrine disorders (e.g., hypothyroidism or administration of growth hormone), renal osteodystrophy, malnutrition and radiation therapy.[1] The association of septic arthritis of infancy with epiphyseal separation is a known entity;[2] however, occurrence in adolescents is unusual.

An 11-year-old premenarchal, nonobese girl presented with pain in the left hip for 1 month. She came to us because of inability to bear weight on the affected lower limb for 1 month. She had been trying to walk using a stick for support. There was no history of trauma. She had been admitted to the pediatric ward of the hospital 2 months earlier for management of pyopneumothorax, for which chest tube drainage was needed and antibiotics were administered parenterally. Associated pain in the left hip at that time was not thoroughly investigated and subsided within 1 week. Examination revealed an afebrile girl of average build and nutrition, weighing 22 kg. Radiography revealed a complete separation of the capital femoral epiphysis.

Under general anesthesia, the hip was exposed via a Smith-Petersen approach. The capital femoral epiphysis appeared completely separated, and the femoral neck revealed cloacae. Infected granulation tissue was present inside the hip joint (which, on histopathologic examination showed a chronic inflammatory reaction). The soft tissues were thoroughly debrided. After reduction, the epiphysis was pinned using threaded Moore's pins. Antibiotics were given parenterally for 2 weeks then orally for another 4 weeks. The girl was kept in a plaster of Paris hip spica for 6 weeks. Gradual weight-bearing using axillary crutches was instituted over the next 6 weeks.

The pins were removed at 1 year, after ascertaining that epiphysiodesis had occurred. Follow-up at 2 years revealed a satisfactory functional outcome[3] (painless stable hip, > 70° range of motion and ability to perform activities of daily living). There was 2 cm shortening of the affected limb. Radiography revealed epiphysiodesis in coxa vara with resorption of the femoral neck and evidence of

avascular necrosis of the capital femoral epiphysis (Fig. 1).

Complete slipping of the capital femoral epiphysis secondary to hematogenous osteomyelitis is hitherto unreported in adolescent children. There are various pointers to the cause of the slip being secondary to osteomyelitis. These are the absence of trauma, absence of any endocrinologic abnormality in a nonobese patient, association with a significant source of metastatic infection (pyopneumothorax) and a temporal relationship in the evolution of symptoms. The intraoperative finding of cloacae in the femoral neck and the presence of infected granulation tissue are definitive evidence of osteomyelitis. In this case, the diagnosis of the slip was missed initially while the patient was being treated for chest infection. This is an all too common error in slipping of the capital femoral epiphysis, and may delay the diagnosis for months or years.[4] A high level of awareness among pediatricians is recommended and a low threshold should be kept for obtaining a hip radiograph in children with hip pain.

A similar case of incomplete slipping of the capital femoral epiphysis secondary to septic arthritis of the hip in an adolescent has been reported.[5] It was managed by incision, drainage and in situ pinning. Our case differs because in our patient there was no history of trauma, complete separation of the epiphysis, delayed treatment, open reduction and a satisfactory functional outcome.

Our rationale for choosing open reduction and pinning was governed by our attempts to achieve débridement, obtain tissue for biopsy and culture, restore normal anatomy and achieve epiphysiodesis. The girl eventually had a satisfactory functional outcome despite radiologic evidence of avascular necrosis of the capital femoral epiphysis.

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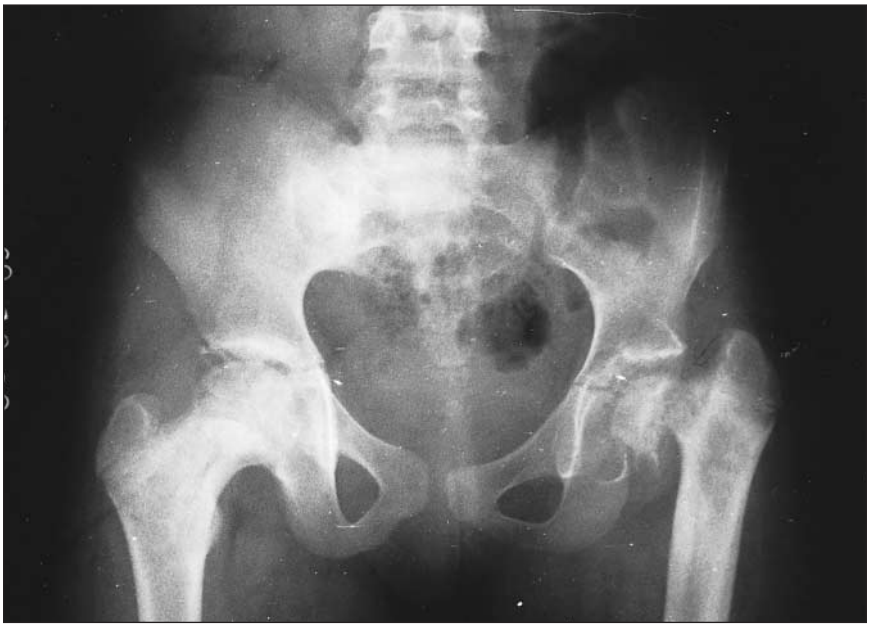

FIG. 1. Radiograph of the hips 1 year after open reduction for slipped capital femoral epiphysis in the left hip. There is epiphysiodesis in coxa vara with resorption of the femoral neck and evidence of avascular necrosis of the capital femoral epiphysis.

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References

1. McAfee PC, Cady RB. Endocrinologic and metabolic factors in atypical presentations of slipped capital femoral epiphysis. Report of four cases and review of the literature. *Clin Orthop* 1983;180:188-97.
2. Choi IH, Pizzutillo PD, Bowen JR, Dragann R, Malhis T. Sequalae and reconstruction after septic arthritis of the hip in infants. *J Bone Joint Surg Am* 1990;72: 1150-65.
3. Hunka L, Said SE, MacKenzie DA, Rogala EJ, Cruess RL. Classification and surgical management of the severe sequelae of septic hips in children. *Clin Orthop* 1982;171:30-6.
4. Causey AL, Smith ER, Donaldson JJ, Kendig RJ, Fisher LC 3rd. Missed slipped capital femoral epiphysis: illustrative cases and a review. *J Emerg Med* 1995;13:175-89.
5. Marx RG, Wright JG. Slipped capital femoral epiphysis after septic arthritis of the hip in an adolescent: report of a case. *Can J Surg* 1999;42:145-8.

Medical management of osteoid osteoma

We read with interest the article by Ilyas and Younge that appeared in the December issue of the Journal on the subject of medical management of osteoid osteoma.[1]

As the authors point out, there are a number of different options currently available for the treatment of this condition, and although it has been known for some time that medical management is successful, it may take years for the condition to resolve. Most patients are unwilling to wait for medical resolution, so more invasive procedures have been utilized. Over the last 10 years, since the development of the radiofrequency ablation procedure by Rosenthal and colleagues,[2] surgery for treatment of these lesions has been in rapid decline. Radiofrequency ablation is now considered the standard procedure for osteoid osteomas.[3] Although the authors do

make passing reference to this in their introduction, we believe it is important to emphasize that in most instances this is the ideal way of treating these lesions.

Radiofrequency ablation has the advantage of being a day-care procedure.[4] It is very much like that for a percutaneous bone biopsy and is becoming widely available in any centre that receives a large number of orthopedic referrals. Patients tolerate the procedure well, and with a success rate greater than 90% it is clearly highly efficacious.[3] As only a tiny core of bone is removed, the risk of pathologic fracture is minimal.

Although medical management can be successful and is an option for those unwilling to undergo any surgical or interventional procedure, radiofrequency ablation should, in most instances, be the preferred treatment for osteoid osteoma.

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References

1. Ilyas I, Younge DA. Medical management of osteoid osteoma. *Can J Surg* 2002;45:435-7.
2. Rosenthal DI, Alexander A, Rosenberg AE, Springfield D. Ablation of osteoid osteomas with a percutaneously placed electrode: a new procedure. *Radiology* 1992;183:29-33.
3. Rosenthal DI, Hornicek FJ, Wolfe MW, Jennings LC, Gebhardt MC, Mankin HJ. Percutaneous radiofrequency coagulation of osteoid osteoma compared with operative treatment. *J Bone Joint Surg Am* 1998;80:815-21.
4. Rosenthal DI, Hornicek FJ, Wolfe MW, Jennings LC, Gebhardt MC, Mankin HJ. Decreasing length of hospital stay in treatment of osteoid osteoma. *Clin Orthop* 1999;361:186-91.

(Drs. Younge and Ilyas reply)

We thank Drs. Munk and Huk for dragging us into the modern world! There is no doubt that radiofrequency ablation is now the treatment of choice for osteoid osteoma, if available. We admit to giving it poor coverage in our article.

We initially started our study on non-steroidal anti-inflammatory drug treatment for osteoid osteoma because we felt that medical treatment as championed by Kneisl and Simon[1] was underused and we had observed that most patients were still being subjected to open surgery. We believe that patients should at least be given the choice, and that medical treatment would be the treatment of choice in situations where surgery would be difficult or hazardous, such as in the neck of the femur.

During the time of our study, radiofrequency ablation was proving its value, and there is little doubt now that it is the preferred treatment as it is minimally invasive, safe, effective and easy for an experienced operator to perform.

We think that the point we made about giving the patient the option of medical treatment or surgery is still valid in hospitals where radiofrequency ablation is not available, as in many developing countries. Medical treatment can also be used during a long waiting period, as is seen often in the Canadian medical system and in the 10% of cases where radiofrequency treatment fails.

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Reference

1. Kneisl JS, Simon MA. Medical management compared with operative treatment for osteoid osteoma. *J Bone Joint Surg Am* 1992;74(2):179-85.

Books and Other Media Received
Livres et autres documents reçus

This list is an acknowledgement of books and other media received. It does not preclude review at a later date.

Cette liste énumère des livres et autres documents reçus. Elle n'en exclut pas la critique à une date ultérieure.

Controversies & Conversations in Cutaneous Laser Surgery. Kenneth A. Arndt and Jeffrey S. Dover. 354 pp. Illust. AMA Press, Chicago. 2002. Paperbound. US$150. ISBN 1-57947-261-3

Lecture Notes on General Surgery. 10th ed. Harold Ellis, Roy Calne and Christopher Watson. 392 pp. Illust. Blackwell Publishing, Oxford. 2002. Paperbound. £16.95. ISBN 0-632-06371-8