

**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 Surgery² 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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**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 outcome³ (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 slip-

ping 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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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



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.