

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.<sup>4</sup> 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.<sup>5</sup> 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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(Presented at the Annual Conference of the Indian Orthopaedic Association, 2001, Ahmedabad, India)

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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.<sup>1</sup>

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,<sup>2</sup> surgery for treatment of these lesions has been in rapid decline. Radiofrequency ablation is now considered the standard procedure for osteoid osteomas.<sup>3</sup> 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.

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.<sup>4</sup> 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.<sup>3</sup> 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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(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<sup>1</sup> 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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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