subsequent growth and progressive deformity. Treatment to correct the deformity is by corrective osteotomy or by resection of the epiphyseal bridge.

Very rarely an osseous bridge may resolve spontaneously. Langenskiold (1967) reported a ten-year-old child in whom corrective osteotomy was followed by spontaneous resolution of the epiphyseal bar such that normal growth of the epiphyseal plate resumed and no further surgery was required.

In our patient resolution of an osseous bridge occurred without any treatment. Perhaps growth of the surrounding normal epiphysis distracted the bridge to the point at which it broke down. Clearly this can only happen if the bridge is very localised. In our case not only did normal growth resume but there was also, ultimately, complete resolution of a varus deformity.

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.

REFERENCES


PROSTHETIC REPLACEMENT OF A CHONDROSARCOMA OF THE UPPER END OF THE FEMUR: A 43-YEAR FOLLOW-UP

A. C. BINGOLD, A. J. L. PERCY

In January 1951 a 31-year-old woman was treated for low-grade chondrosarcoma in the intertrochanteric region of the left femur. This was resected and replaced with a custom-made acrylic prosthesis (Bingold 1972). The outcome was satisfactory for 3.5 years until the patient fell and broke the prosthesis at the head-neck junction. After a few weeks a steel implant was inserted with a successful result. An 18-year follow-up of the patient was reported (Bingold 1972). We now present a 43-year follow-up.

Progress since 1972. The head of the steel prosthesis gradually eroded the acetabulum and caused increasing hip pain. In 1974 a third replacement was carried out using a titanium prosthesis with a cemented polyethylene cup. The patient’s immediate progress was satisfactory, but three days after surgery she fell on to her left hip dislocating the head of the implant and fracturing the upper end of the remaining femur. The prosthesis was reduced and the fracture repaired with three screws and acrylic cement. For a number of years she was comfortable, but gradually the repaired portion of the proximal femur weakened and the stem of the implant perforated the lateral cortex.

In 1983 another prosthesis was inserted, 2.5 cm longer than the previous one. Progress was good and the patient led an active life until she fell again in December 1990, sustaining a fracture below the collar of the prosthesis (Fig. 1). The lower end of the metal stem was threatening to perforate the cortex. At operation, the prosthesis was found to be loose, with three defects in the distal portion of the femur which required bone grafting. Full weight-bearing was allowed after three months and by 1992 (Fig. 2) she was leading a reasonably normal life.

In 1994, over 43 years after her first operation, the patient was well, could walk three to four miles, drive a car, and do some gardening. The 3 to 4 cm shortening was partially corrected by a 2 to 3 cm shoe raise. The patient preferred to use a stick because of osteoarthritis in both
knees, but could walk short distances without it.

**Discussion.** In 1943 Moore and Bohlman reported a patient with a giant-cell tumour of the upper end of the femur which was treated by local resection and a vitallium implant, but follow-up lasted only 2.5 years, because the patient died from cardiac failure. Our follow-up of the first operation of this type to be performed in the UK spans 43 years. Each of the implants had a cuff to receive the upper end of the remaining femoral shaft to improve fixation. Professor Zarek suggested that there should be three windows in the cuff to allow some blood supply to the femoral stump and this appears to have been successful. Two of the revisions were due to falls, but on each occasion the limb was salvaged by an enthusiastic approach with expert technical support.

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**REFERENCES**


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**RECURRENT LOCKING OF THE WRIST DUE TO DORSAL MIDCARPAL SUBLUXATION**

**M. A. C. CRAIGEN**

Midcarpal instability of the wrist is uncommon in the absence of injury and is extremely rare in children (Gerard 1980; Johnson and Carrera 1986; Lichtman et al 1993). Patients with ligamentous damage to the wrist often complain of a painful click or clunk, but true locking is rare and has been reported only as a result of loose bodies (Needoff and Frostick 1994; Ono et al 1994). We describe a child who presented with a locked wrist due to dorsal subluxation of the midcarpal joint.

**Case report.** A ten-year-old girl complained of a ‘dislocated right thumb’, but there had been no injury. She reported eight previous episodes, always when asleep or just going to sleep. On two occasions she had attended hospital but the ‘dislocation’ had reduced before radiographs had been taken. The previous episodes had been relieved by movement, which had caused reduction with a loud clunk. One similar episode had involved her left shoulder locking in internal rotation but had resolved with a clunk after passive external rotation by her mother.