

# Corrections of a Severe Flexion Deformity and Slight Hyperextension of the Cervical Spine

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## Description

As the magnitude of resection increases, the ability to correct deformity improves, but also the risk of complication increases. Therein, an understanding of potential applications and complications is helpful. The technique for accurate biplane osteotomy at the level of the lesser trochanter for the treatment of slipped capital femoral epiphysis by making reasonably accurate roentgen graphic measurements is described and illustrated. After graduating from Columbia College of Physicians and Surgeons and spending a year abroad studying pathology, he joined the staff of the Hospital for Joint diseases. He was a quiet, complex individual with wide-ranging interests in philosophy, history, and music. He had a broad interest in orthopedic problems and wrote papers on an extraordinary variety of clinical subjects. He is best remembered for his work on osteotomy of the upper end of the femur, particularly the pelvic support osteotomy. This paper is of historic interest because it contains a clue to the thought processes involved in the development of an idea. Corrections of a severe flexion deformity and slight hyperextension of the cervical spine was produced safely at the level between the seventh cervical vertebra and first thoracic vertebra in a woman, forty-four years old. The osteotomy was performed posteriorly under local anesthesia; the ossified annulus fibrosis was ruptured anteriorly by manipulation under nitrous oxide and oxygen anesthesia while the spinal canal was exposed and protected by the surgeon. Full correction of the deformity was attempted only under controlled conditions after the patient was fully awake and after the spine was securely immobilized in a full spinal brace equipped with a jury-mast and a turnbuckle to raise the chin. The turnbuckle was unthreaded slowly and the cervical spine was extended in stages while the patient was closely observed and frequently examined to test her sensory perceptions, reflexes, and muscle power. The problem of instability of reduction of congenital dislocation and congenital subluxation of the hip has been studied. The basic cause of this instability is the abnormal direction in which the entire acetabulum faces. An operation, innominate osteotomy, has been designed to correct the abnormal direction of the entire acetabulum. The principle of innominate osteotomy is

redirection of the acetabulum so that the reduced dislocation or subluxation, which was stable previously only in the position of abduction and flexion, is rendered stable in the functional position of weight-bearing. Some clinical and other observations are made on cavus deformity of the foot, and a new surgical procedure is presented for the correction of anterior pes cavus. This procedure includes fasciotomy in the sole according to the technique of Steindler and a V-osteotomy of the tarsus that permits the correction of deformity at the most prominent point without the disadvantages of the classic techniques (shortening of the foot, delay in consolidation, and interference with tarsal motion). The results in seventeen feet followed for from two to six years have been encouraging.

## Joint Inflammation

Widening of the ankle mortise following fracture can be a subtle diagnosis requiring special radiographs to fully appreciate the extent of shortening and rotation of the fibula. Once this fibular shortening has been recognized, a lengthening and rotational osteotomy can be conducted with use of a special compression/distraction device and bone graft. A series of 23 cases demonstrates that reconstructive lengthening osteotomy is well worthwhile when there is absent or minimal osteoarthritic change, irrespective of the time from the original injury. Most osteoarthritis of the hip results from chronic abnormal hip mechanics often associated with instability, impingement, or combinations of instability and impingement. The ethology of the mechanical problems in many hips is a surgically treatable anatomic abnormality, often a developmental deformity (dysplasia, Perthes disease, slipped epiphysis, femoral or acetabula retroversion, or reduced head-neck offset). The rationale of mechanically-based measures to prevent or treat osteoarthritis assumes the following: (1) correctable mechanical overload is a major etiologic factor in osteoarthritis; and (2) relief of the mechanical overload can prevent or improve osteoarthritis. The success of such mechanically-based joint-preserving measures depends largely on the completeness with which the joint-preserving treatment normalizes the mechanical environment of the hip. A limiting factor often is the amount of irreversible articular damage that is present at the time

treatment is begun. Articles have been published regarding Smith-Petersen osteotomies, pedicle subtraction procedures, and vertebral column resections. Expectations and complications have been reviewed. However, decision-making regarding which of the 3 procedures is most useful for a particular spinal deformity case is not clearly investigated. Articles have been published regarding Smith-Petersen osteotomies, pedicle subtraction procedures, and vertebral column resections. Expectations and complications have been reviewed. However, decision-making regarding which of the 3 procedures is most useful for a particular spinal deformity case is not clearly investigated.

## Nourishing Enhancements

Fifty-one osteoarthritic knees treated by high tibial osteotomy were followed for at least five years. Deterioration after an initial good result was uncommon (five cases). Most of the good results were in knees (thirty of forty-five) with mild varus deformity and good ligament stability. It is, therefore, possible to select the knee suitable for osteotomy from measurement of the preoperative standing roentgenogram. We recommend that tibial osteotomy be done only when there is less than 10 degrees of varus deformity. In a knee with more than 15 degrees of varus deformity there will be subluxation on weight-bearing

and tibial osteotomy is contraindicated. Different periacetabular and triple pelvic osteotomies are used to rotate a dysplastic acetabulum to a normal weightbearing position. If the acetabular fragment becomes too small or the acetabular artery is damaged, avascular necrosis (AVN) may result. On the other hand, if the osteotomies are situated too far from the acetabulum, free rotation in all directions may be impeded. In addition, all osteotomies should be clearly visible. Our modification considers these essentials. The osteotomy of the ischium also leaves the sacral ligaments intact and avoids pseudarthroses by its length. Fairly centered joints and decentered joints with an elongated acetabulum had a high percentage of normal and slightly pathologic values. In false acetabuli and high dislocations, this rate was diminished. Measurements of acetabular rotation that guarantee greatest pain relief have been evaluated for the future. In forty-five patients, twenty-three with congenital dislocations and the rest with paralytic or other disturbances, this new displacement osteotomy of the hip joint was done when other iliac osteotomies were considered ineffective. The patients seven to seventeen years old were followed two to ten years. Of the fifty-two procedures, forty were satisfactory. Most of the unsatisfactory results were in cases of myelodysplasia, peroneal atrophy, and cerebral palsy.