PREOPERATIVE DIAGNOSIS:, Displace subcapital fracture, left hip.,POSTOPERATIVE DIAGNOSIS: , Displace subcapital fracture, left hip.,PROCEDURE PERFORMED: ,
Austin-Moore bipolar hemiarthroplasty, left hip utilizing a medium fenestrated femoral stem with a medium 0.8 mm femoral head, a 50 mm bipolar cup.,PROCEDURE: , The patient was taken to OR #2, administered a subarachnoid block anesthetic and was then positioned in the right lateral decubitus position on the beanbag on the operative table. The right lower extremity was protectively padded. The left leg was propped with multiple blankets. The hip was then prepped and draped in the usual manner. A posterior incision was made on the posterolateral aspect of the left hip down to the skin and subcutaneous tissues. Hemostasis was achieved utilizing electrocautery. Gluteus fascia was incised in line with a skin incision and the muscle was split posteriorly. The external rotators were identified after removal of the trochanteric bursa. Hemostat was utilized to separate the external rotators from the underlying capsule, they were then transected off from their attachment at the posterior intertrochanteric line. They were then reflected distally. The capsule was then opened in a T-fashion utilizing the cutting cautery. Fraction hematoma exuded from the hip joint. The cork screw was then impacted into the femoral head and it was removed from the acetabulum. Bone fragments were removed from the neck and acetabulum. The acetabulum was then inspected and noted to be free from debris. The proximal femur was then delivered into the wound with the hip internally rotated.,A

mortise chisel was then utilized to take the cancellous bone from the proximal femur. The T-handle broach was then passed down the canal. The canal was then sequentially broached up to a medium broach. The calcar was then plained with the hand plainer. The trial components were positioned into place. The medium component fit fairly well with the medium 28 mm femoral head. Once the trial reduction was performed, the hip was taken through range of motion. There was physiologic crystalling with longitudinal traction. There was no tendency towards dislocation with flexion of the hip past 90 degrees. The trial implants were then removed. The acetabulum was then copiously irrigated with gentamicin solution and suctioned dry. The medium fenestrated femoral stem was prepared by placing a large segment of bone from the femoral head into the fenestration making it a little larger than the width of the implant to provide a press fit. The implant was then impacted into place. The 28 mm femoral head was impacted on the mortise stapler of the femoral stem followed by placement of the 50 mm bipolar cup. The acetabulum was once again inspected, was free of debris. The hip was reduced. It was taken through full range of motion. There was no tendency for dislocation. The wound was copiously irrigated with gentamicin solution. The capsule was then repaired with interrupted #1 Ethibond suture. External rotators were then reapproximated to the posterior intertrochanteric line utilizing #1 Ethibond in a modified Kessler type stitch. The wound was once again copiously irrigated with gentamicin solution and suctioned dry. Gluteus

fascia was approximated with interrupted #1 Ethibond. Subcutaneous layers were approximated with interrupted #2-0 Vicryl and skin approximated with staples. A bulky dressing was applied to the wound. The patient was then transferred to the hospital bed, an abductor pillow was positioned into place. Circulatory status was intact to the extremity at completion of the case.