there is more extensive damage to the acetabulum or to the head of the femur.  

**Discussion.** The technique we use applies a corrective force directly to the femoral head enabling reduction to be controlled and achieved with minimal trauma. The position of flexion and adduction relaxes the iliopsoas ligament and allows the femoral head to pass the obstruction of the posterior acetabular rim. There is no chance of conversion into an anterior dislocation. Excessive traction, which may damage the vascular supply to the femoral head, can be avoided.

The method is recommended for type I and type II traumatic dislocations and for dislocation of a hemiarthroplasty or total hip replacement.

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**


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**PRE-OPERATIVE PLANNING FOR INTRAMEDULLARY NAILING**

J. A. S. WATSON, J. P. HOLLINGDALE

Precise pre-operative planning reduces the complications associated with surgical procedures, particularly using complex forms of fracture fixation. Intramedullary nailing demands exact technique and a comprehensive range of implants. Although manufacturers produce a complete range of nails, budgetary restrictions may prevent a full set being available.

Pre-operative measurements from standard radiographs are subject to magnification and peroperative assessment may be too late to obtain a particular size of nail. We have devised a simple measuring device to overcome this problem.

**Materials and methods.** Our measuring device (Howmedica, London, England) is a stainless-steel cylinder, 16 cm in length tapering from 16 to 9 mm in 1 mm gradations. Each gradation is 20 mm long (Fig. 1).

A pre-operative radiograph of the contralateral long bone is taken with the device taped to the side of the leg. Direct measurements can be taken from this radiograph to determine both the length and diameter of nail required (Fig. 2). We have confirmed from a series of CT scans that the intramedullary diameters are usually the same in both femora.

We have used the method before inserting nails into 18 femora and 14 tibiae. Femoral nail sizes ranged from 340 to 460 mm in length and 12 to 15 mm in diameter. Tibial nail sizes ranged from 330 to 360 mm in length and 11 to 13 mm in diameter. The most frequently used sizes were $400 \times 12$ mm for the femur and $345 \times 11$ mm for the tibia.

The nail size selected before operation was used in all but two cases. In these it proved easy to ream to the next diameter; the length, however, was that chosen preoperatively. Of the 64 measurements taken (32 diameters and 32 lengths), 62 were clinically accurate (96.9%).

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DISLOCATION OF A TOTAL HIP PROSTHESIS BY A FALSE ANEURYSM

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Vascular injuries associated with hip surgery are rare but recognised complications (Ratliff 1985). They may produce immediate problems or present late as a false aneurysm. We report a case of false aneurysm of the common femoral artery caused by the anterior protrusion of a cemented cup. The increasing size of the aneurysm caused dislocation of the femoral component.

Case report. In 1978 a 53-year-old woman had a MacKee-Farrar total replacement for osteoarthritis of the right hip, performed through a posterolateral approach. In 1989 the prosthesis had been revised elsewhere for loosening and cranial migration of the cup. A threaded non-cemented cup could not be secured because of poor bone stock, so fixation had been achieved with polymethylmethacrylate cement. Postoperatively the patient was never without pain.

Six months after the revision she was referred to us because the persisting pain in the right thigh had become severe. The patient could hardly walk and her thigh had an increase in circumference of 20 cm compared with the other side. Hip movement was restricted and painful, and a thrill was palpable in the groin.

Radiographs showed lateral dislocation of the femoral head and a large soft-tissue mass (Fig. 1). Ultrasound studies showed pulsation in the pseudocapsule of the hip, which was adherent to a widened common femoral artery. Angiography showed a false aneurysm

Fig. 1

Fig. 2

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