



CASE REPORT OF BILATERAL UNSTABLE SCFE TREATED WITH PERCUTANEOUS CC SCREW FIXATION

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ABSTRACT

Introduction: SCFE is most prevalent in age 9 to 15 yrs, the treatment is to prevent additional slip progression, accomplish stabilization, while limiting the threat of avascular necrosis. **Aim:** To evaluate the functional outcome of bilateral SCFE treated with CC screw fixation. **Materials & Methods:** A 12 year old obese male child presented with chief complaint of right sided hip pain with difficulty ambulation for 1 to 2 weeks found out to have Right sided SCFE which was fixed with 2 CC screws and after 1 year similar presentation and management done on the left femur head as well. **Conclusion:** Surgical management of Bilateral Unstable SCFE with CC Screw fixation shown to be well healed proximal femoral physis with a remodelled femoral neck & ambulation without pain.

KEYWORDS :

INTRODUCTION

SCFE is a separation between the epiphysis and the metaphysis of the proximal femur. The most prevalent hip condition in children aged 9 to 15 is SCFE. It has been associated with endocrine abnormalities. SCFE treatment's key goals are to prevent additional slip progression, accomplish stabilisation and restoration of hip function, and avoid early hip OA while limiting the threat of avascular necrosis (AVN) and eventual proximal femoral deformity.

AIM

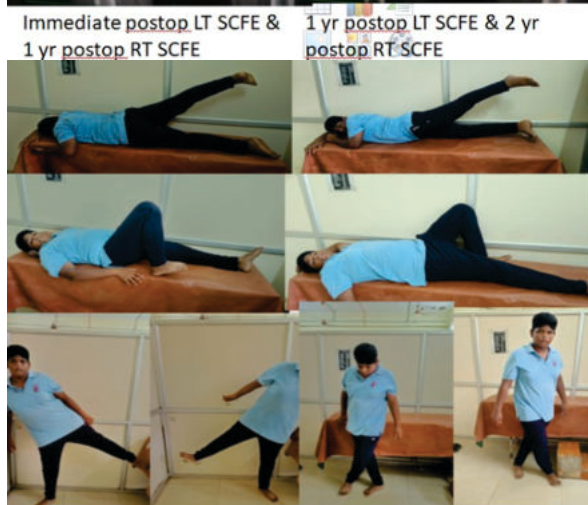
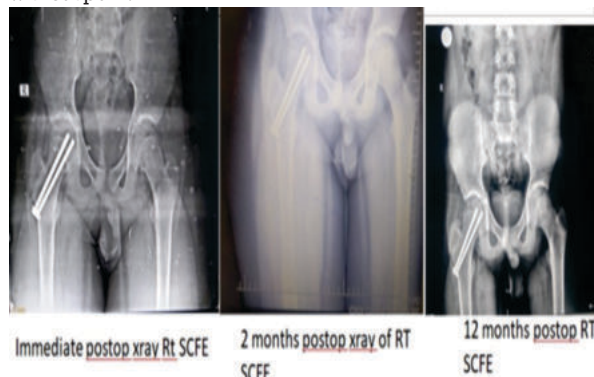
To evaluate the functional outcome of bilateral SCFE treated with CC screw fixation.

MATERIALS & METHODS

Pt in supine position with Carm on contralateral side. Under C arm, after identifying the femur neck at its longest, mark the skin along guidewire over the centre of femur head on AP view. Flex hip to 90 degree and abduct the hip to 45 degrees, align the guide wire along the neck in sagittal view. The point in which these two lines cross the femoral neck is the entry point for the guidewire. 1 cm incision on skin along this entry point over anterolateral aspect of proximal femur. Once position of guidewire is confirmed advance the wire to within 3 mm of the articular surface. Measure the guidewire with the cannulated screw depth gauge to determine the screw length. Use the cannulated drill over guidewire until 1 to 2 mm before the tip of the guidewire. Place 6.5 mm cannulated screw over the guidewire then guidewire removed. 2 CC screws are inserted into epiphysis.

RESULTS

At the 24-months & 12-month follow-up of RT SCFE & LT SCFE respectively, the patient was shown to be well-healed proximal femoral physis with a remodeled femoral neck, walking without pain.



Post op Full ROM of both hips

DISCUSSION

Percutaneous placement of cannulated screws continues to be a mainstay for the treatment of SCFE. Surgical management of Bilateral SCFE with CC screw fixation shown well healed proximal femur physis with remodelled femoral neck and ambulation without pain.

CONCLUSION

In unstable moderate-to-severe SCFE, the best reduction indications and technique remain controversial. There are many theories supporting one or two screws pinning technique. In this case we used two screws spinning fixation with excellent result.

REFERENCES

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