Dislocations of sternal segments in children are extremely rare lesions: only seven sterno-manubrial dislocations have been reported in the literature. We present a case of posterior sterno-manubrial dislocation in a 9-year old gymnast exercising on parallel bars. We preferred performing an open reduction and plate stabilization using an angular stable implant, because of pain and respiratory distress. This technique of stabilization has not been described in the literature before and present the advantage of combining a high stability with a reduced risk of iatrogenic retrosternal injury. The plate stabilization led to an immediate amelioration of symptoms. The plates could be removed 4 months after initial treatment. The body rapidly regained his sporting capabilities.

The author describes a new concept in the lengthening of the lower limb utilizing an intramedullary hydraulic lengthening nail. The straight telescoping nail is introduced in an antegrade manner after reaming the intramedullary canal. Lengthening up to eight centimeters can be achieved with this method. The pressure medium used to push the distal part of the telescope nail down the intramedullary canal is sterile arachis oil (peanut oil). Because arachis oil is the precursor of arachidic acid; which in turns forms the biologic precursor of eicosanoids, leakage of this medium into the body does not compromise the clinical condition or the safety of the patient cause. Distraction was applied in one step in six cases and in two steps in the other cases. The mean distraction rate was 1.6 mm (range 0.8-1.8 mm) for the femur and 1.3 mm (range 1.25-1.3 mm) for the tibia. Until now sixteen lengthening procedures were done, seven tibiae and nine femora. The indication for this procedure was in all cases post-traumatic shortening. The mean tibial lengthening was 5.5 cm (range 3-8 cm). The mean femoral lengthening was 4.8 cm (range 3-7 cm). In the beginning of this project we encountered two delayed union, one deep infection and two breakage of the distal nail. After changing the metal
alloy of the distal part from hardened stainless steel 440 C to a nitrogen alloyed version of 316 LVM stainless steel (ISO 5832-9), the breakage of the distal nail never recurred. The advantage of the described method is the reduced distraction time and the avoidance of an external fixation system.


A new method for the stabilisation of intertrochanteric fractures will be presented in this study. The operative technique consists of an alternative for the traditional lag screw. The implant used is called Twin Hook. This device consists of a cannulated nail with two oppositely directed apical hooks and is used in combination with a sliding plate. The purpose of this study is to give a description of the implant characteristics and operative technique and to give an overview of the preliminary results of the use of the Twin Hook in the department of Traumatology of the University Hospitals Gasthuisberg in Leuven, Belgium.


Recommendations concerning the most successful method of treating subtrochanteric fractures are confusing for several reasons. Subtrochanteric fractures are uncommon and are usually considered as a homogenous group whether they occur from minor trauma in older patients with weakened bone or from high-energy trauma in younger patients with normal bone. Reports on treatment of subtrochanteric fractures have often included intertrochanteric fractures and there have been no randomised trials comparing the different implants available so the choice has to be made from case series. In considering subtrochanteric fractures it is clinically preferable to use the concept of simple and complex fractures instead of a specific classification system. For simple fractures where closed reduction can be achieved, an intramedullary device such as the PFN or UFN-SB is preferred. The PFN is a good choice in elderly patients, giving them the possibility of early full weight-bearing. The UFN-SB should not be used in Seinsheimer types IIC and V fractures or in osteoporotic patients where there is a risk of migration when early weight-bearing is allowed. However, the UFN-SB is an option in patients with good quality of bone. For complex
fractures indirect reduction techniques followed by fixation with a plate device such as the 95-degree blade plate or DCS are preferred. But as there is insufficient reconstruction of the medial cortex, postoperative restricted weight-bearing must be observed. Thus in the elderly, these implants should be avoided.