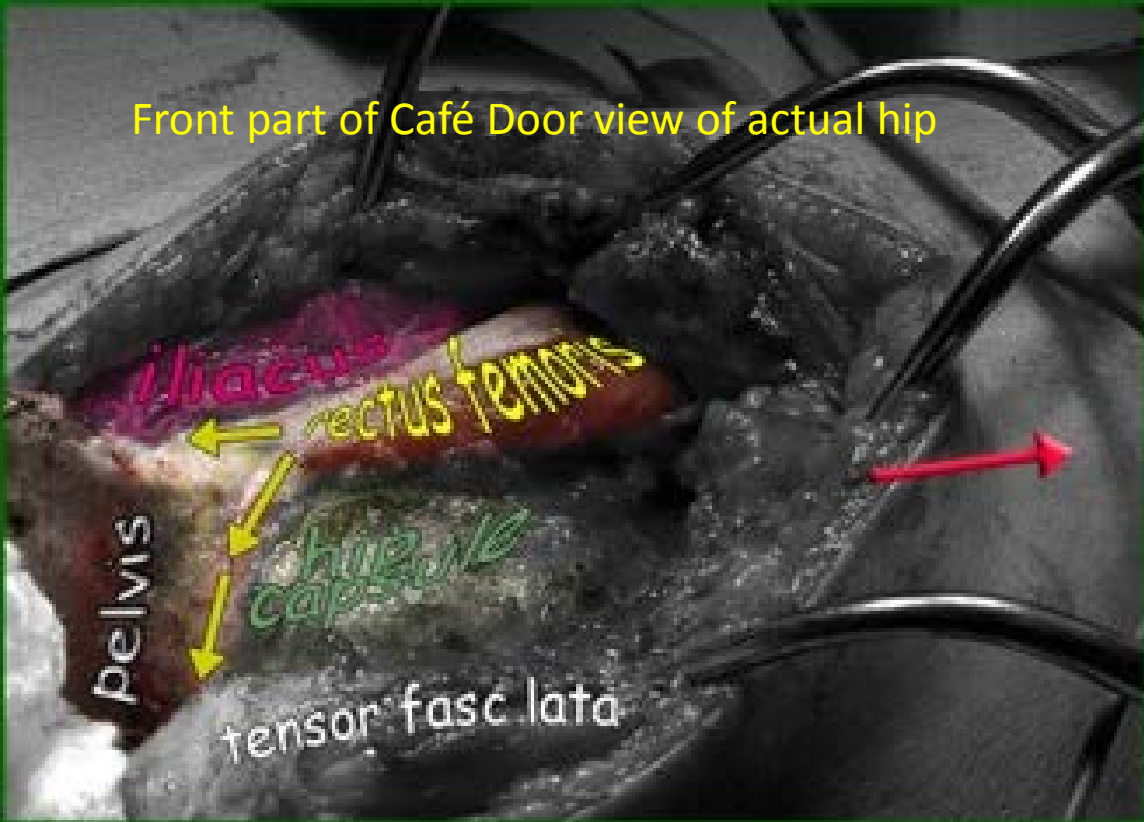


Café Door Extensile Exposure

by Roy M. Nuzzo, MD

Photography by Dr. Paul Jordan
Art & computer illustration, RMN

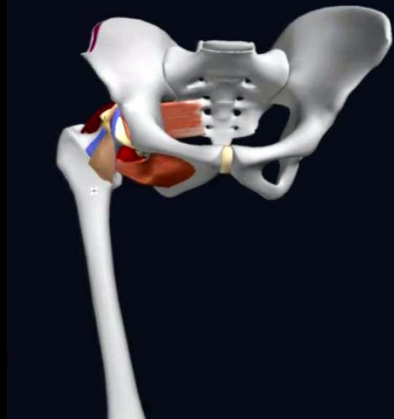
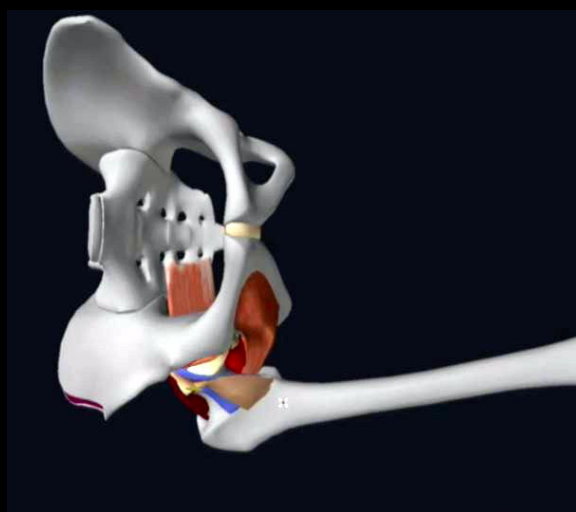
Front part of Café Door view of actual hip



* cut here
plate here
hope it's OK



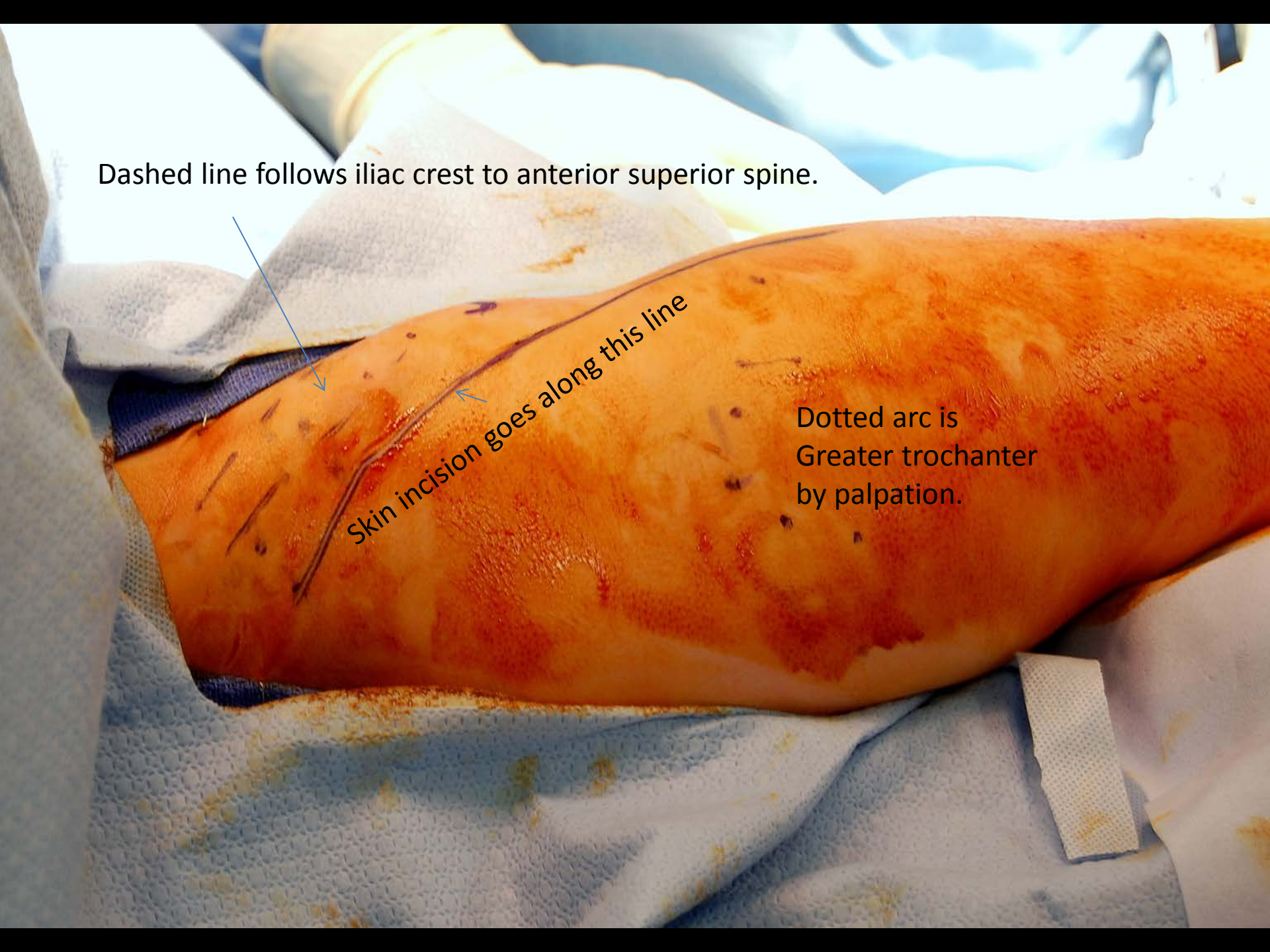
VRO
exposure
sees little



Dashed line follows iliac crest to anterior superior spine.

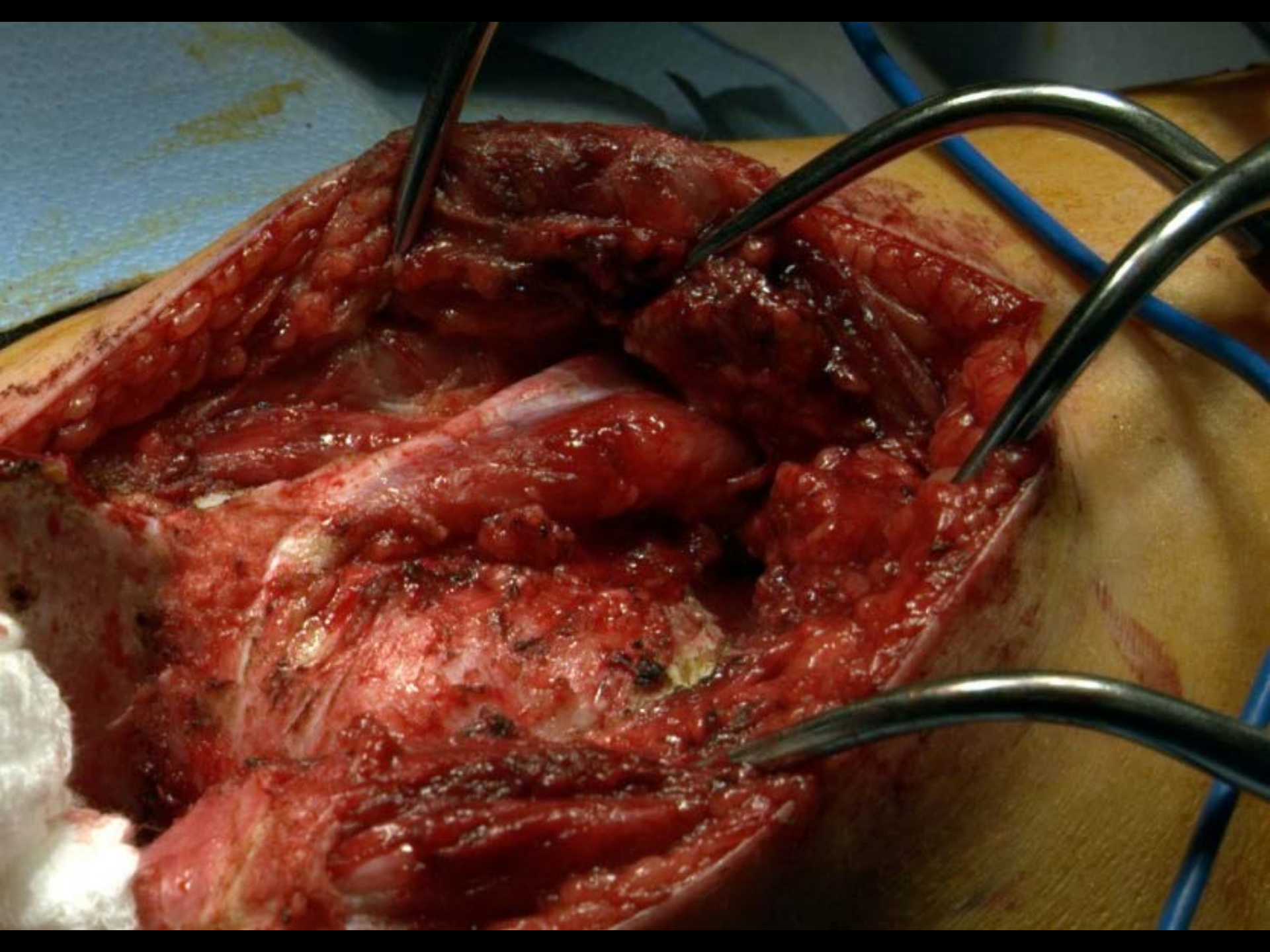
Skin incision goes along this line

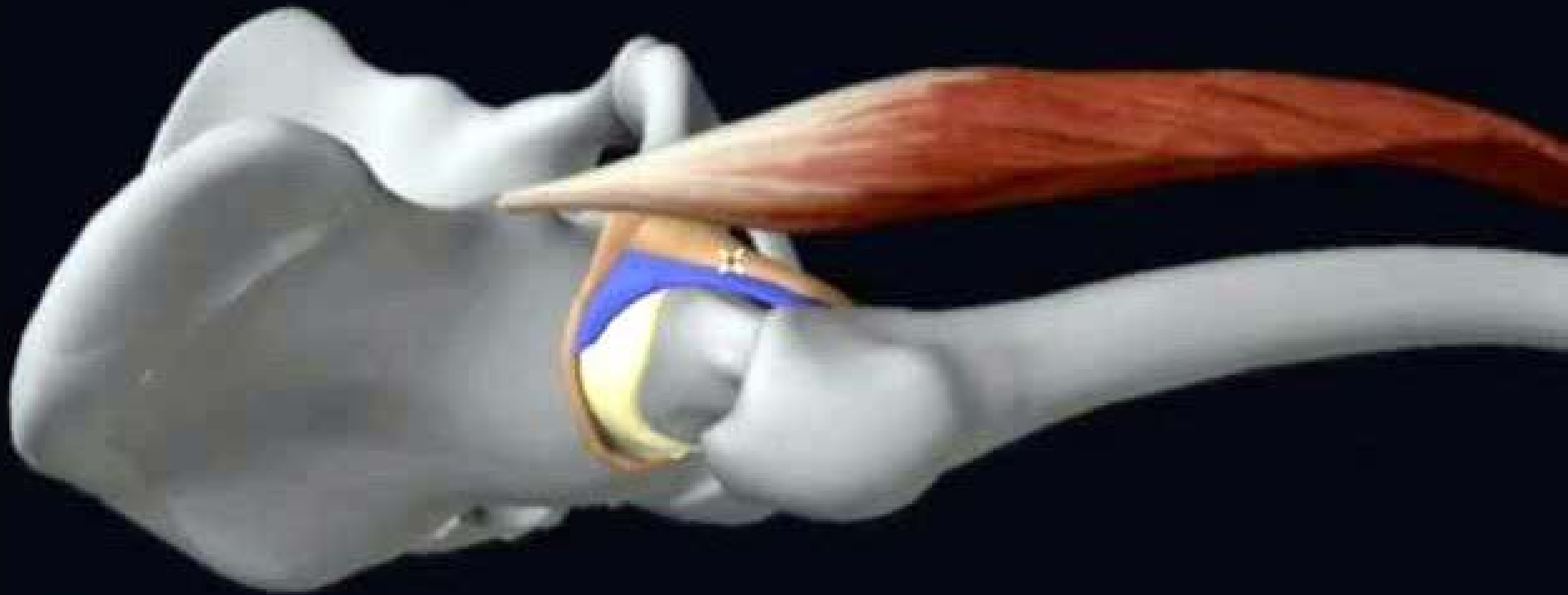
Dotted arc is
Greater trochanter
by palpation.



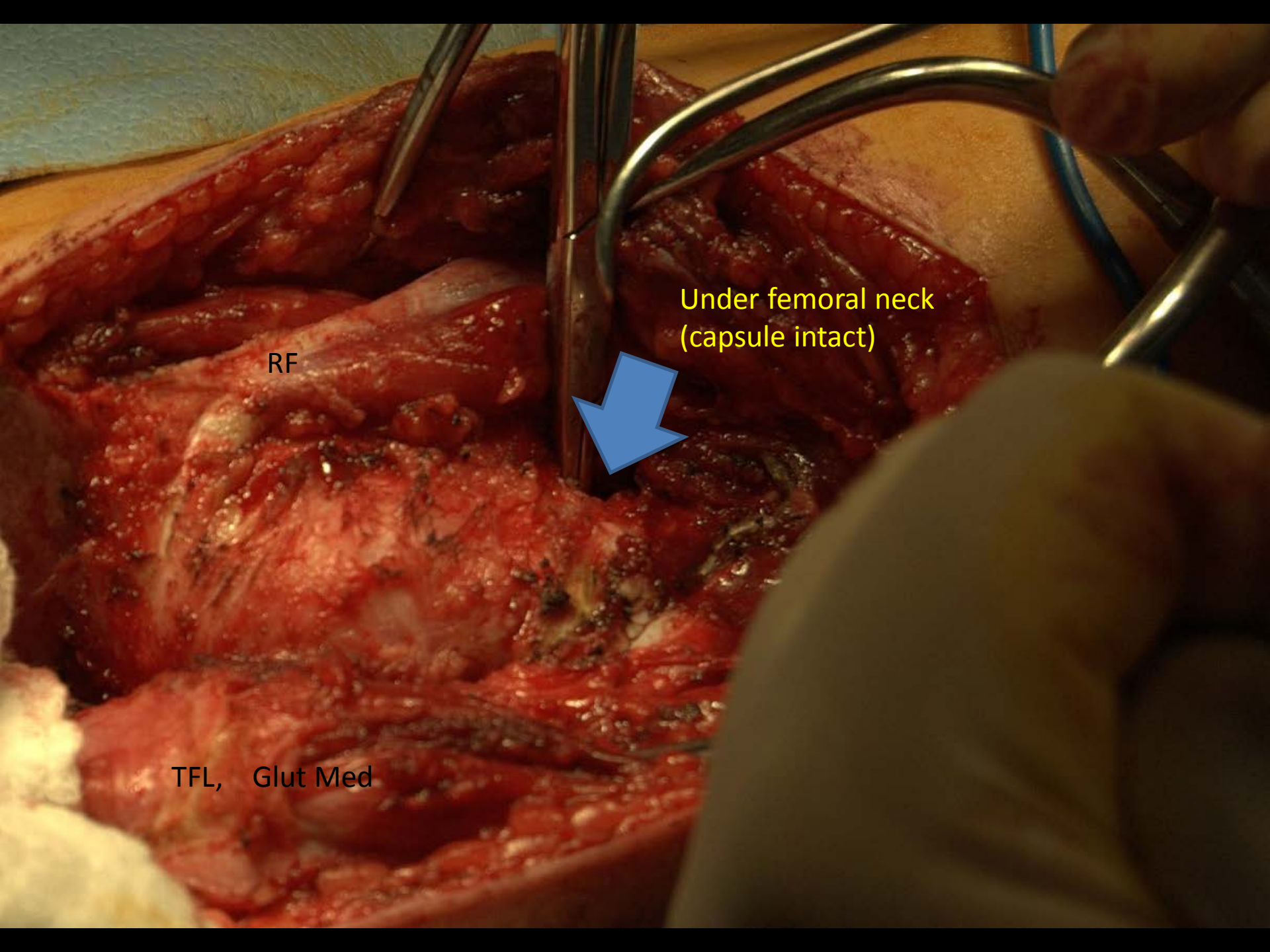
Interval between
sartorius & tensor







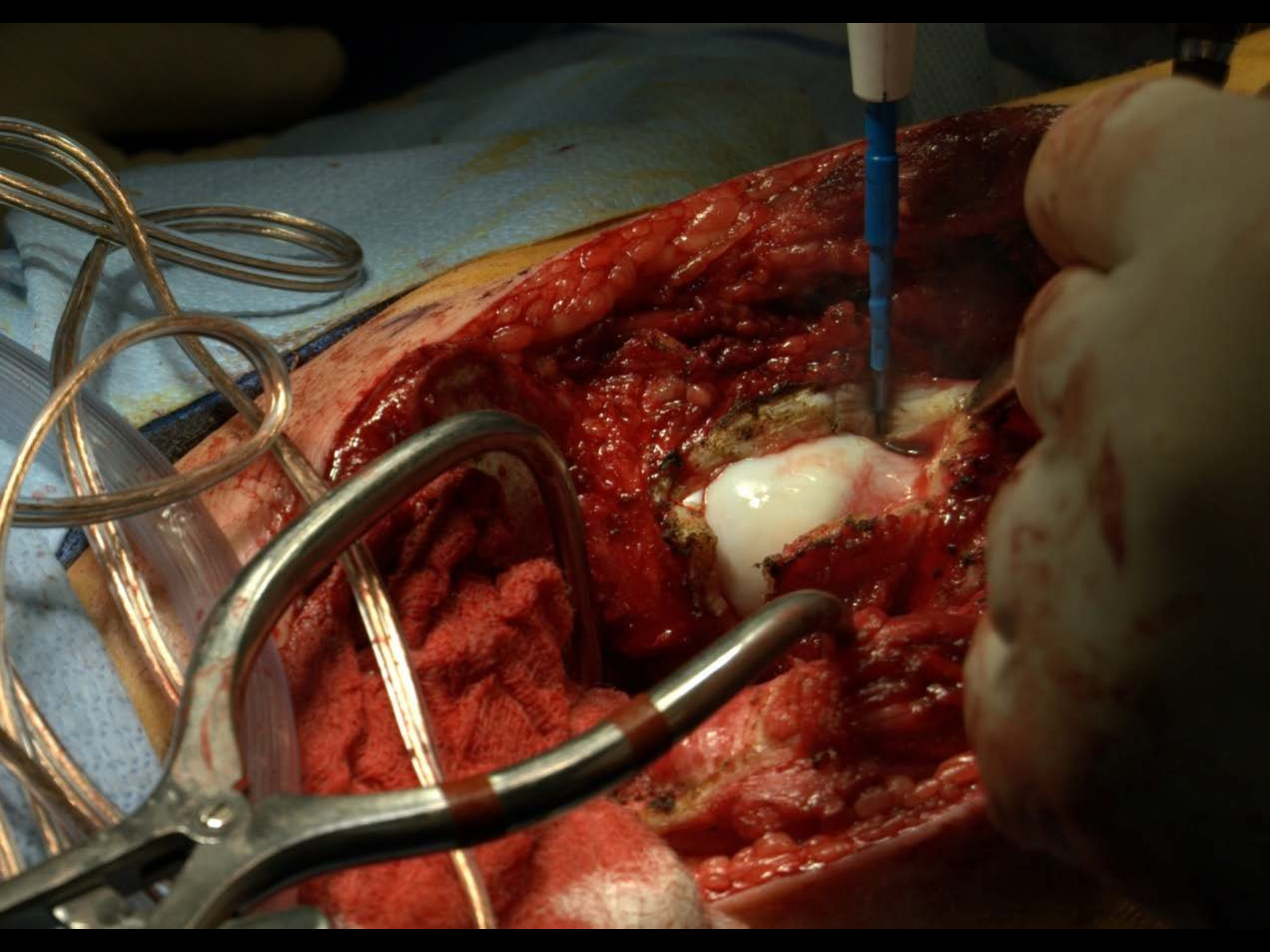
Normal: Femoral head in socket with some uncovering. Won't be this way when we start, though.

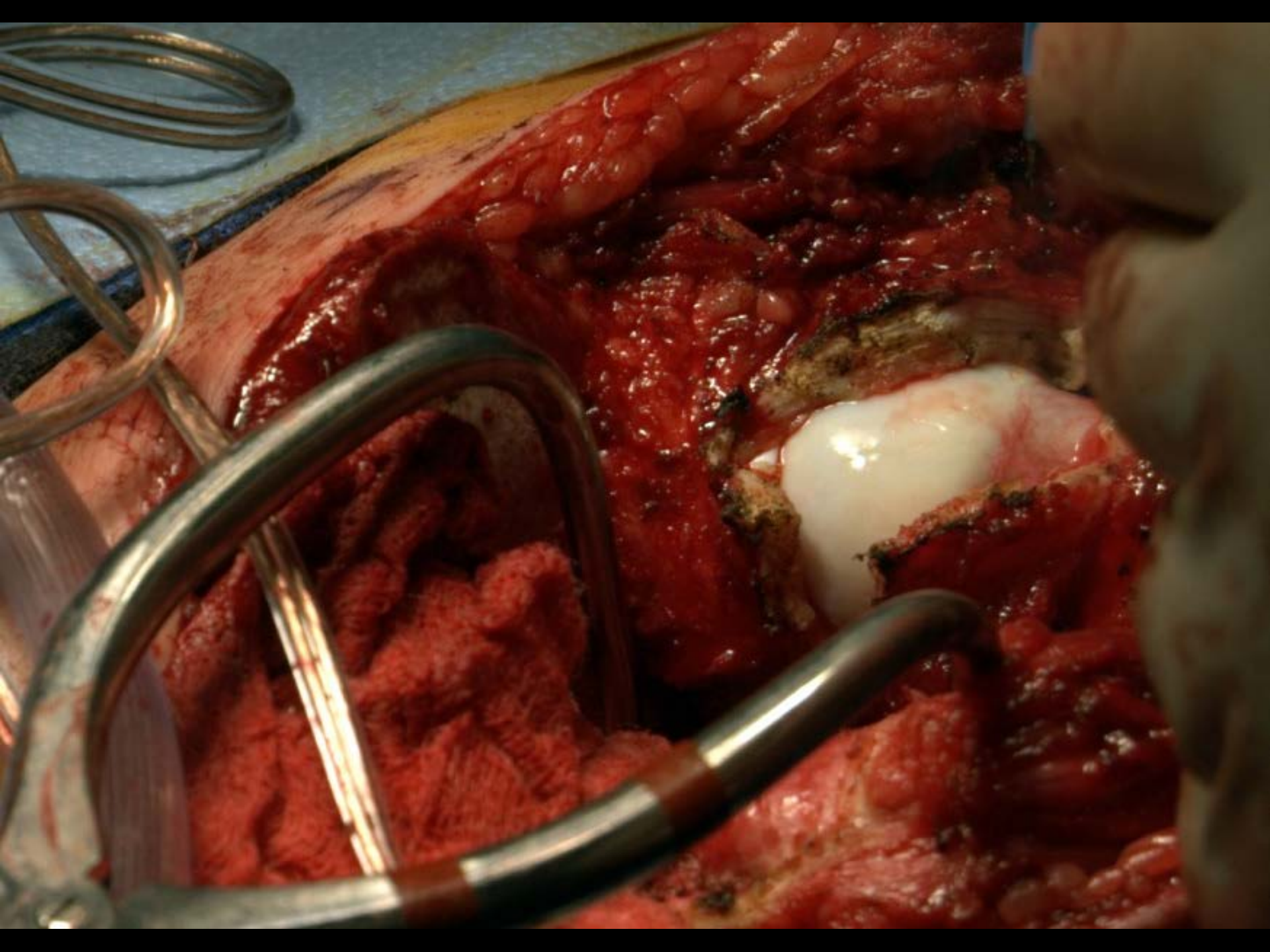


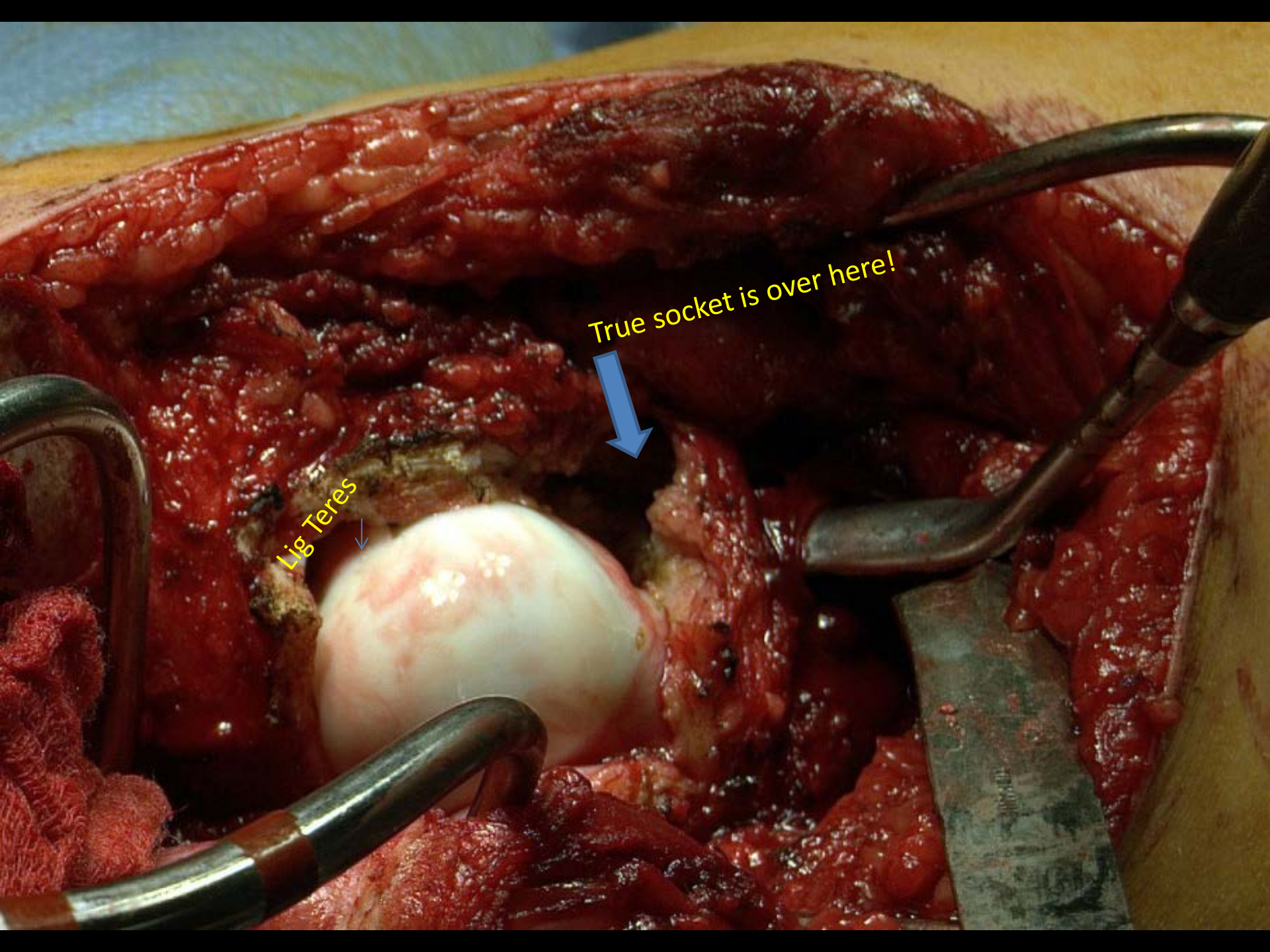
Under femoral neck
(capsule intact)

RF

TFL, Glut Med

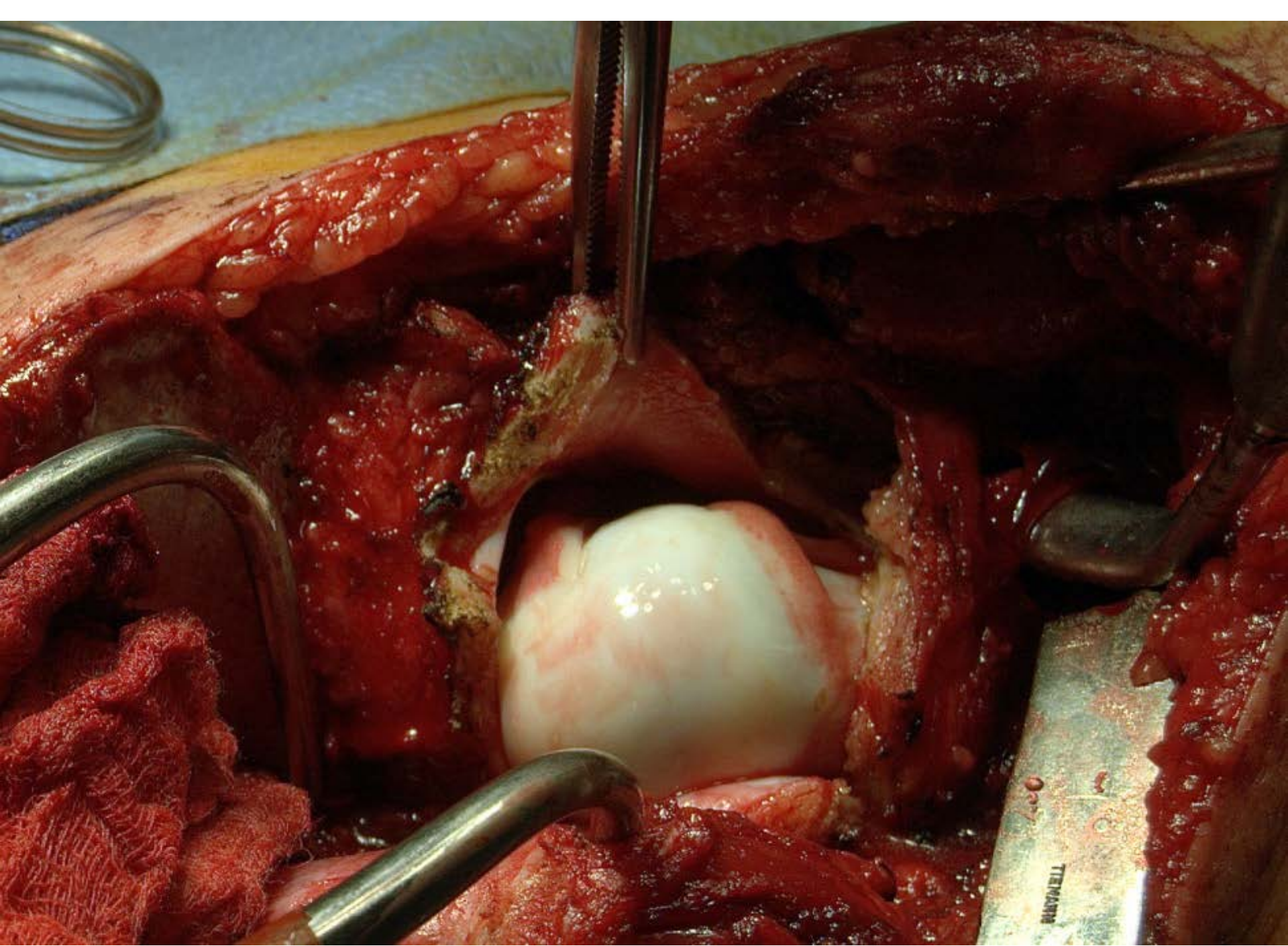


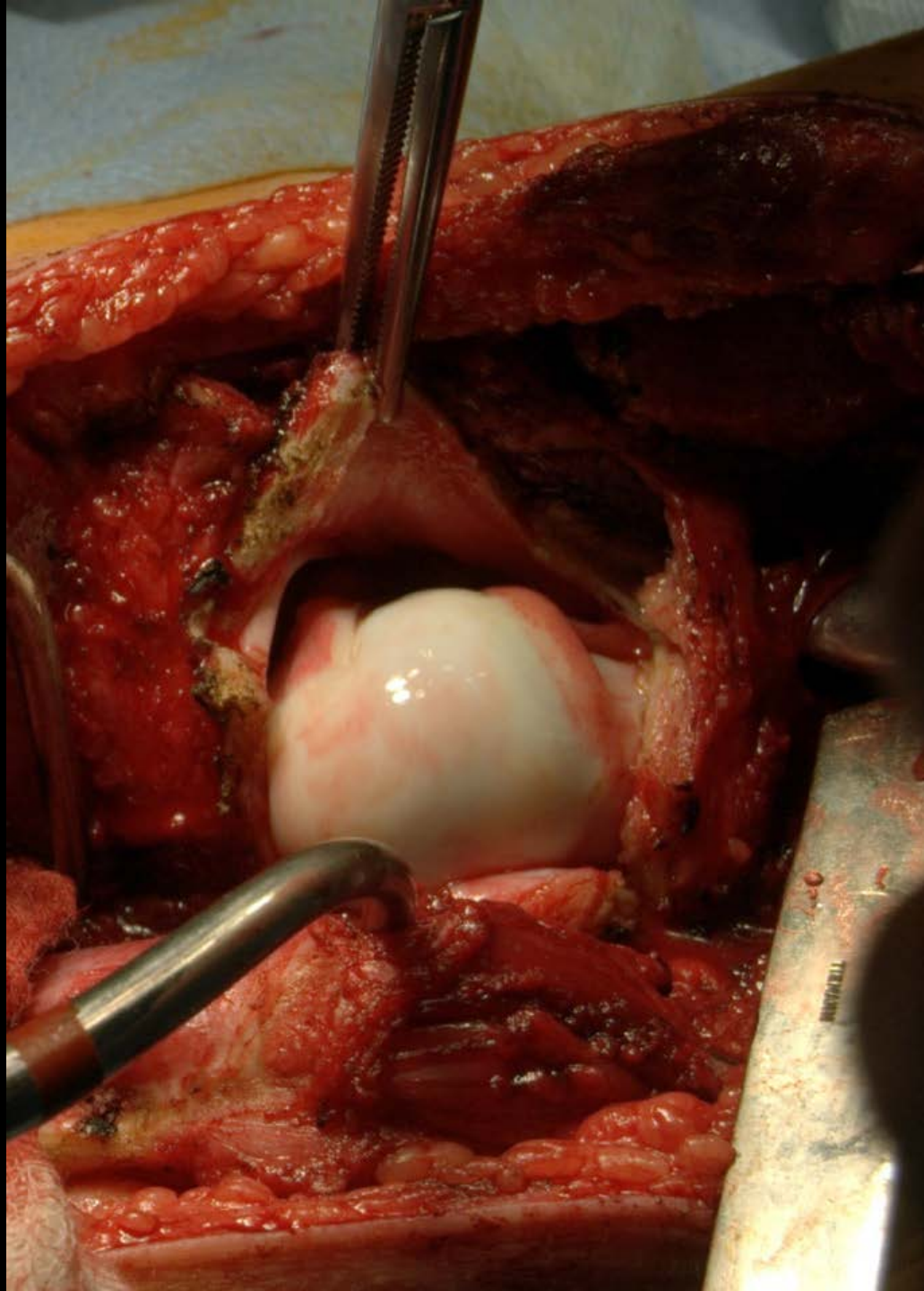




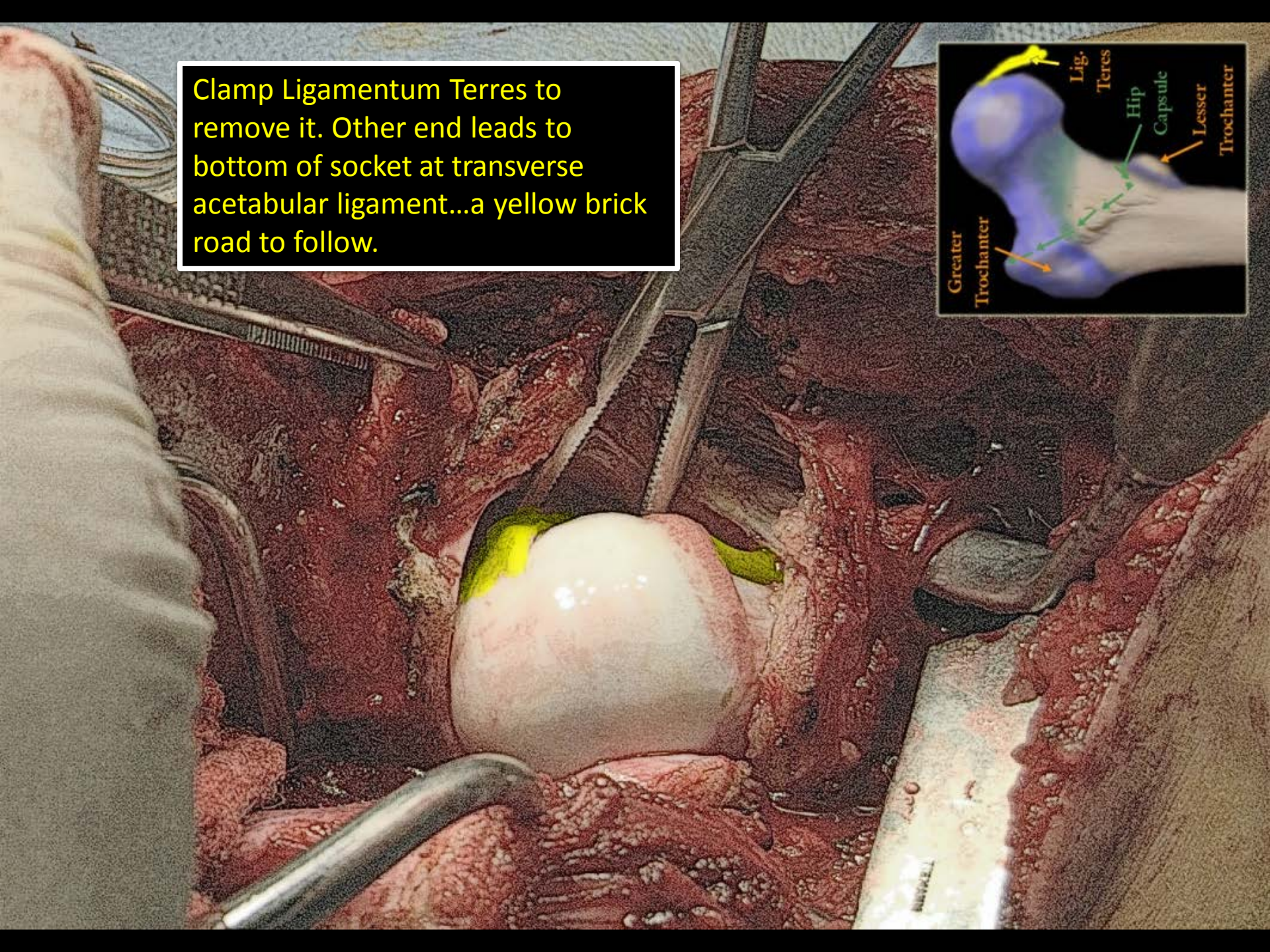
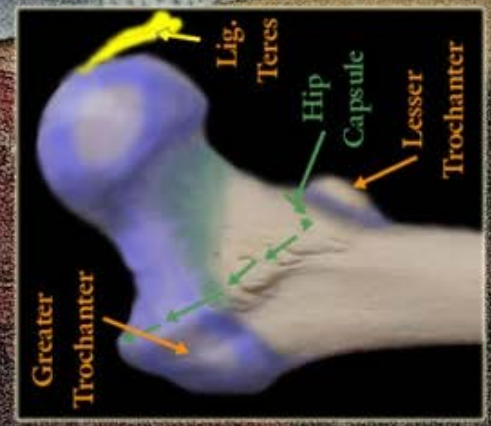
True socket is over here!

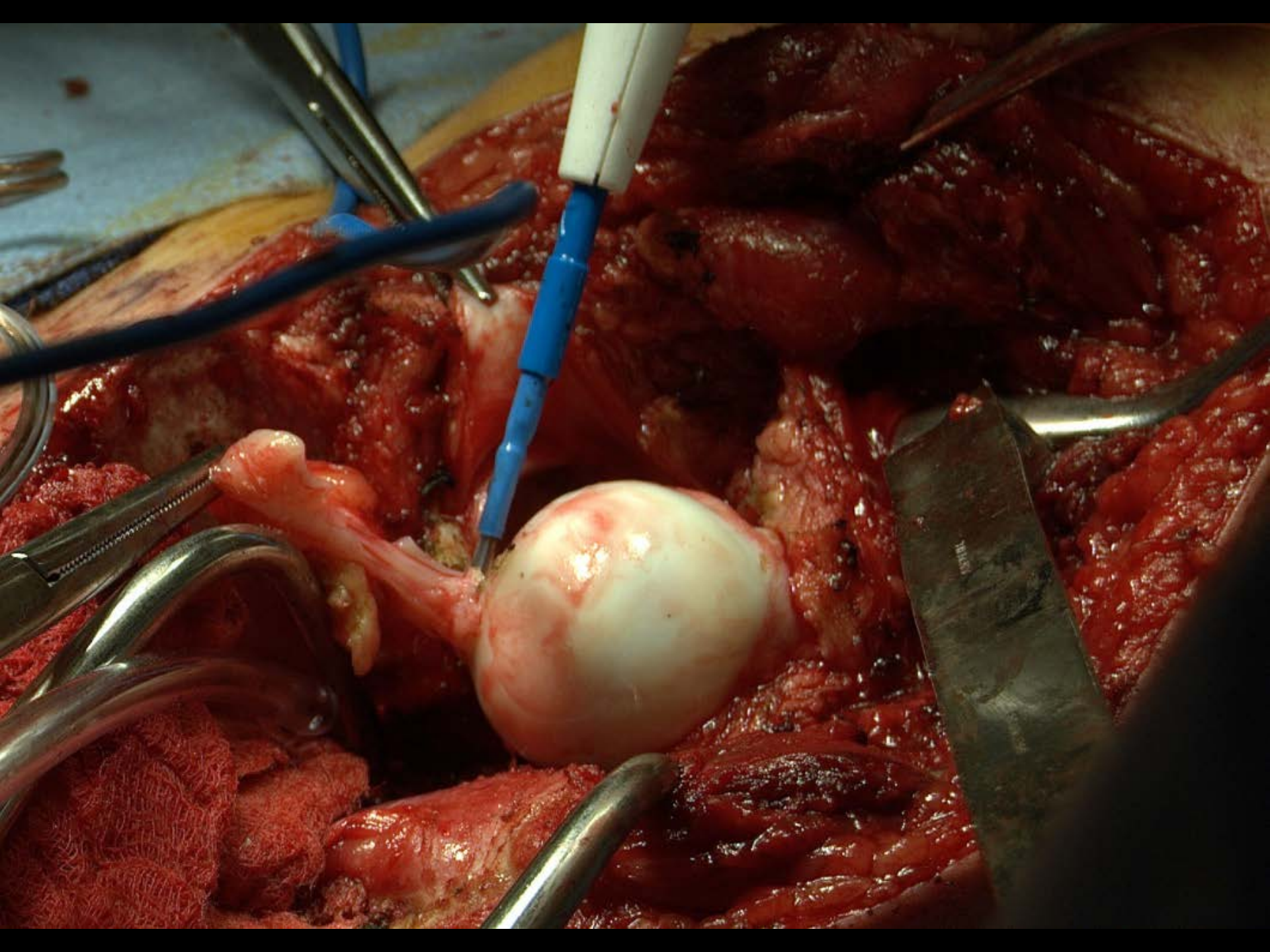
Lig Teres



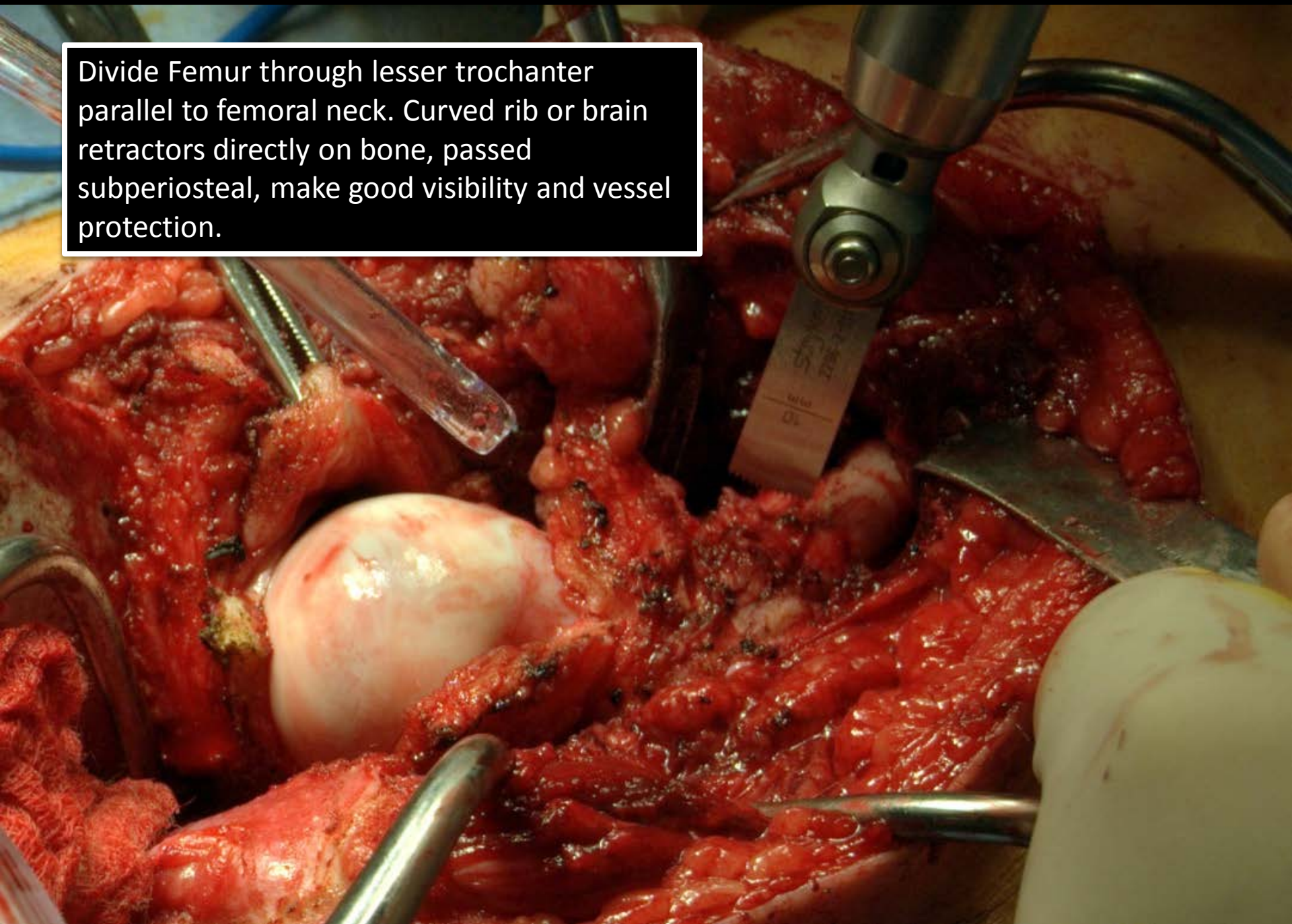


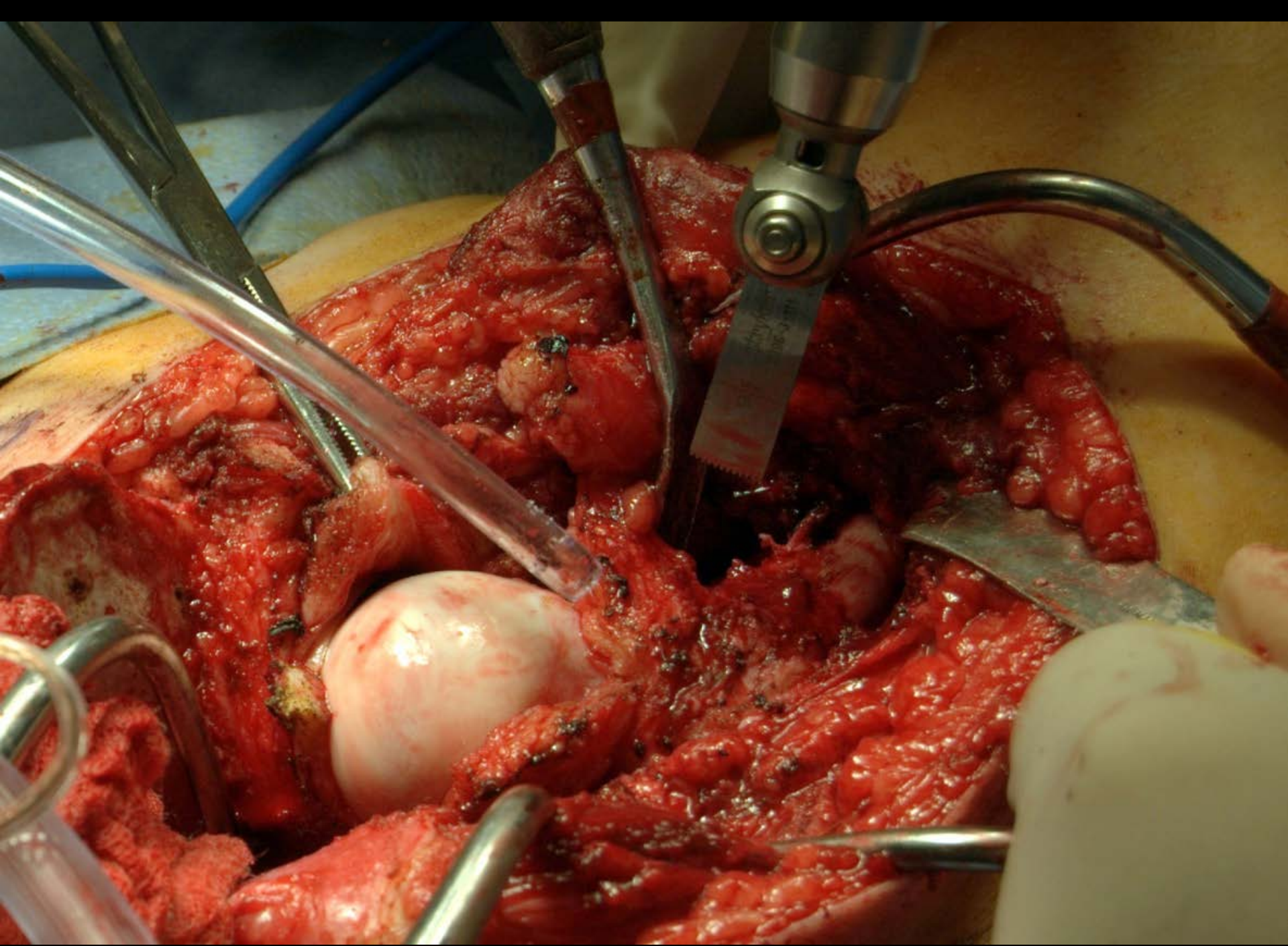
Clamp Ligamentum Terres to remove it. Other end leads to bottom of socket at transverse acetabular ligament...a yellow brick road to follow.

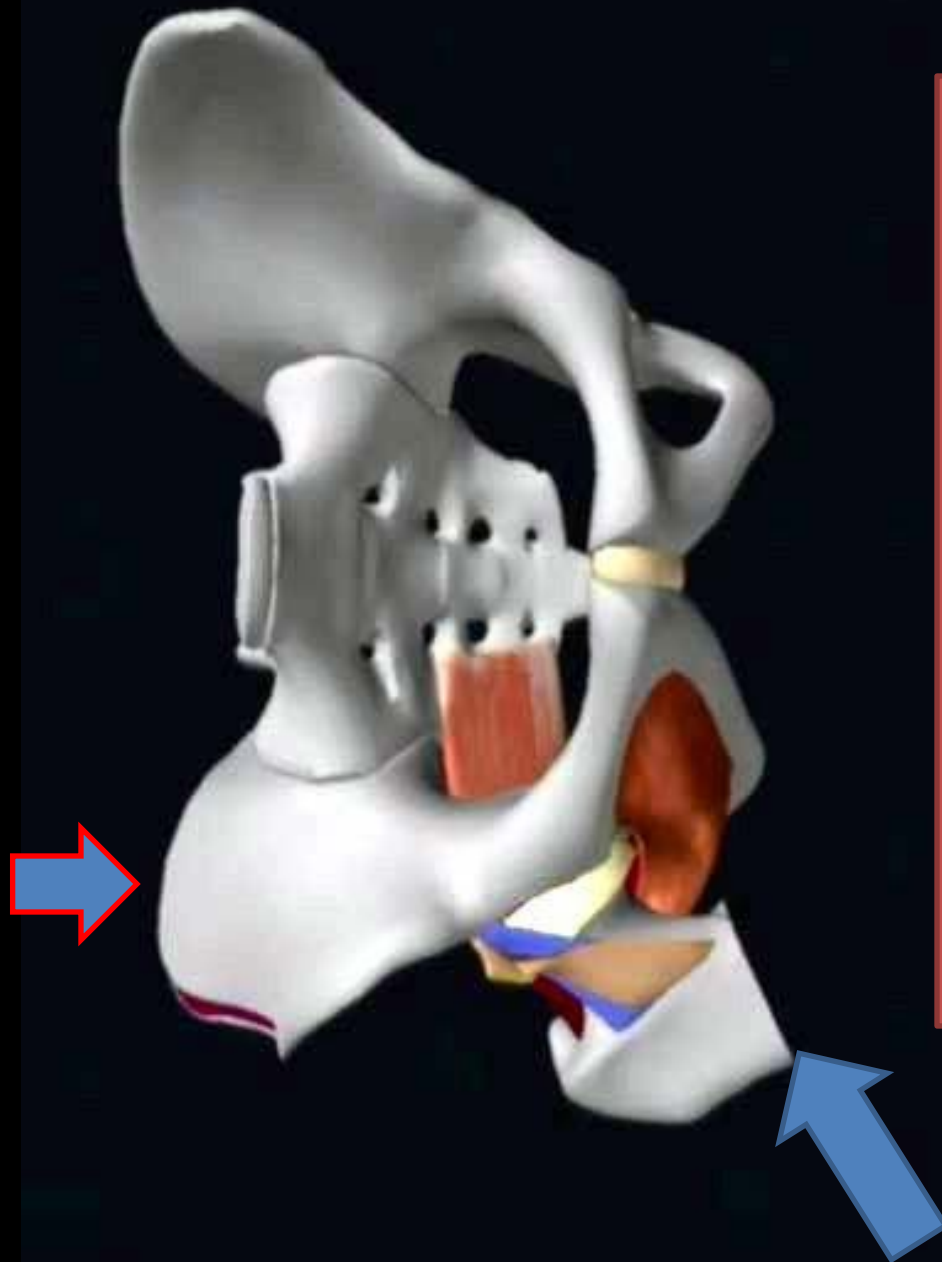




Divide Femur through lesser trochanter parallel to femoral neck. Curved rib or brain retractors directly on bone, passed subperiosteal, make good visibility and vessel protection.





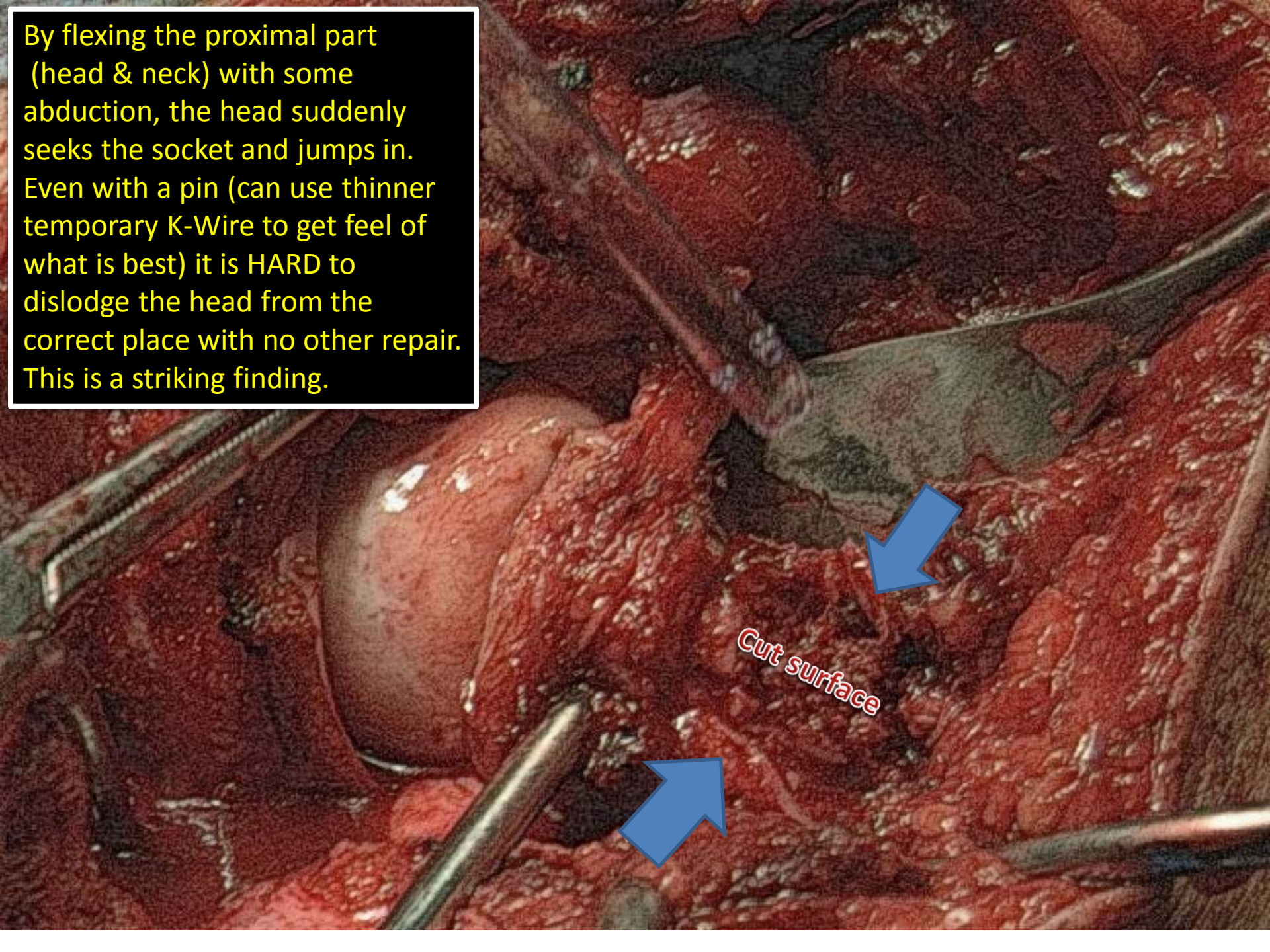


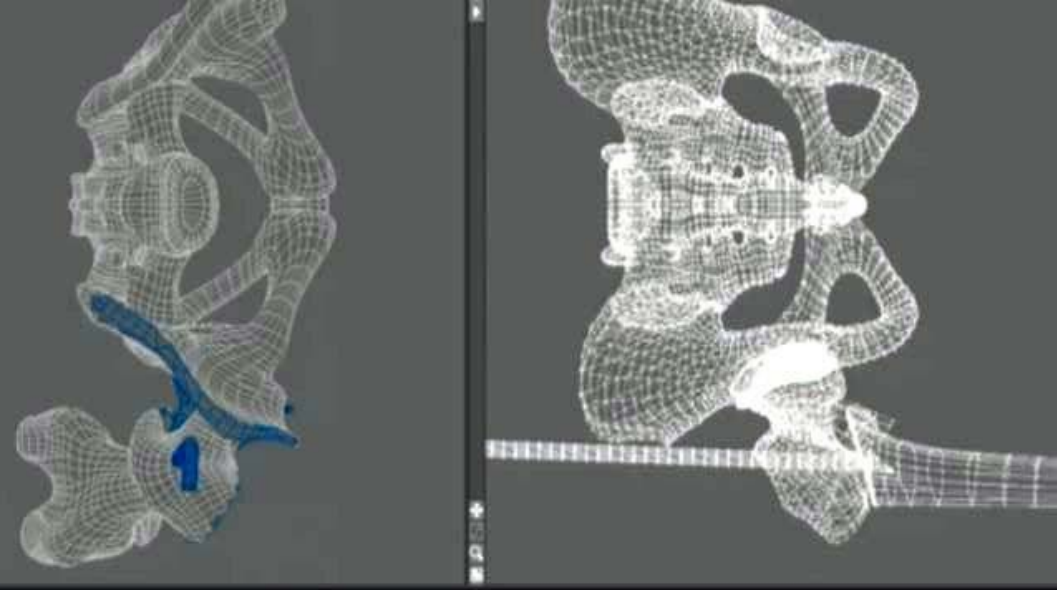
Also note that by taking off the full length of the top of the iliac crest (pelvic or iliac shortening), we get much of the relaxation we need and so do not typically need to further trim the femur to get the job done.

This step reduces the amount of leg shortening that we typically see with VRO where frustration at instability leads to greater & greater hunks of femur removed to hold reduction.

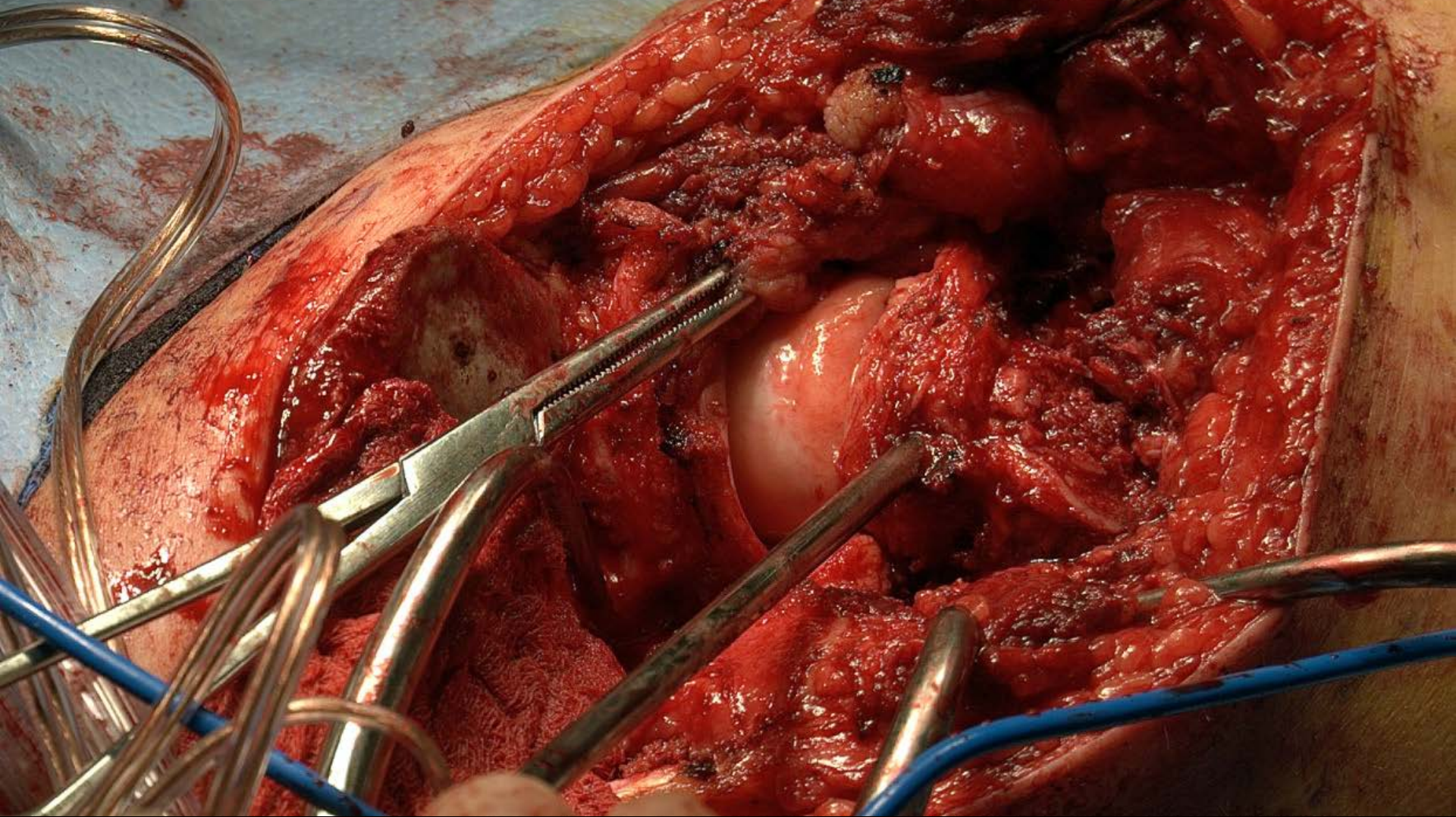


By flexing the proximal part (head & neck) with some abduction, the head suddenly seeks the socket and jumps in. Even with a pin (can use thinner temporary K-Wire to get feel of what is best) it is HARD to dislodge the head from the correct place with no other repair. This is a striking finding.

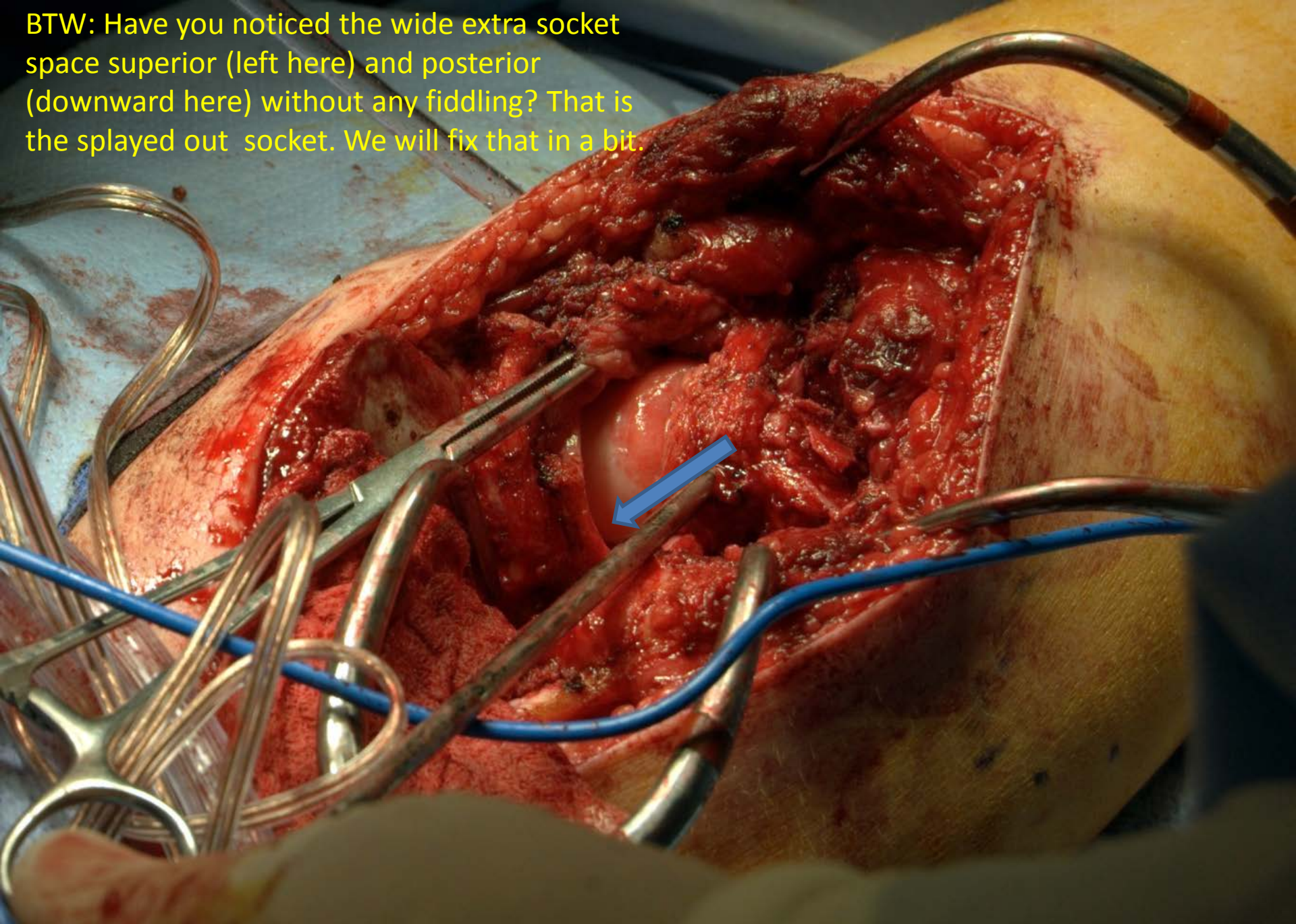




Staying clear of posterior femoral neck vessels set pin so as to get the degree of hip extension wanted while head is optimum. Can use K-Wire as temporary guide.

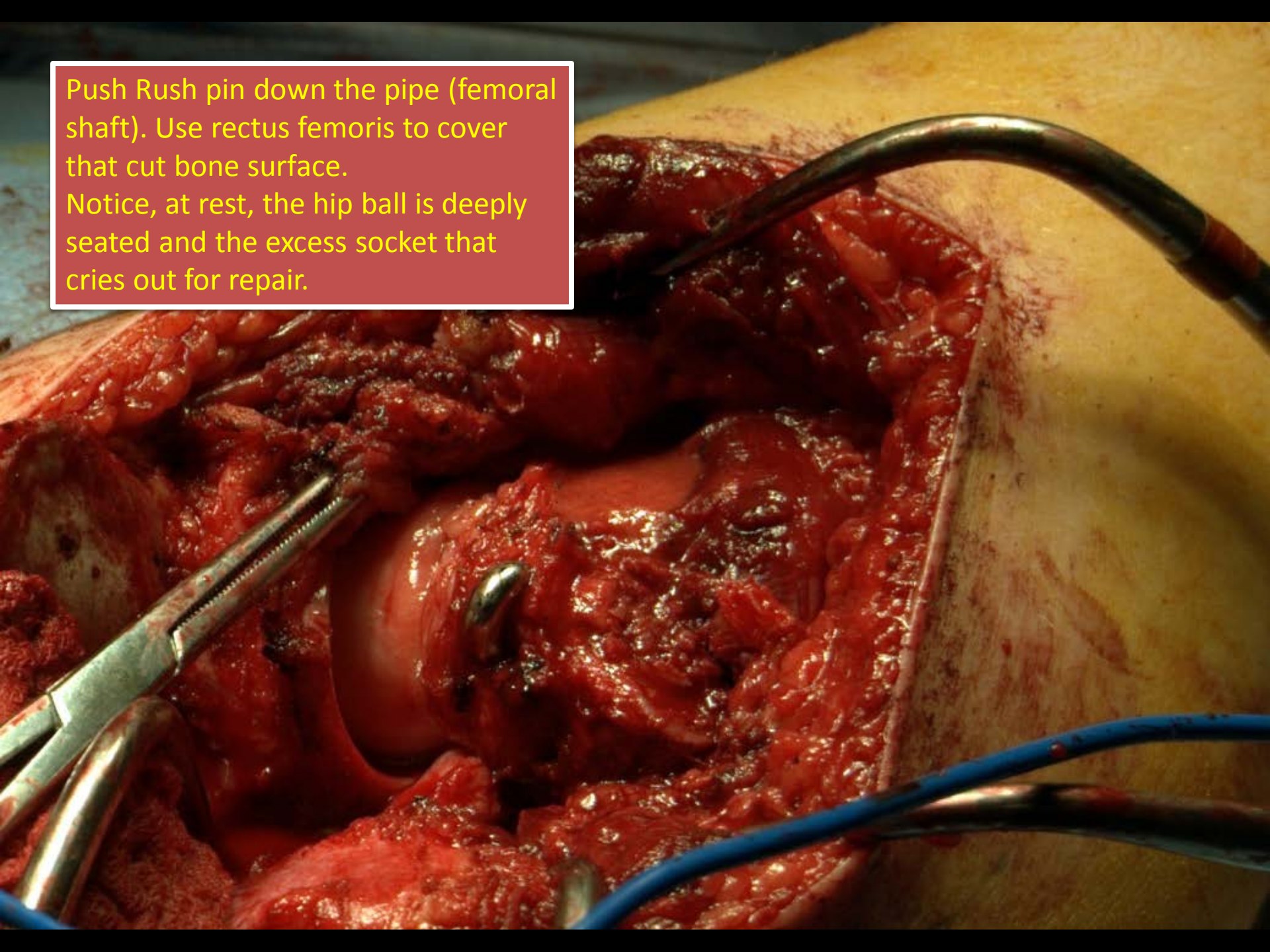


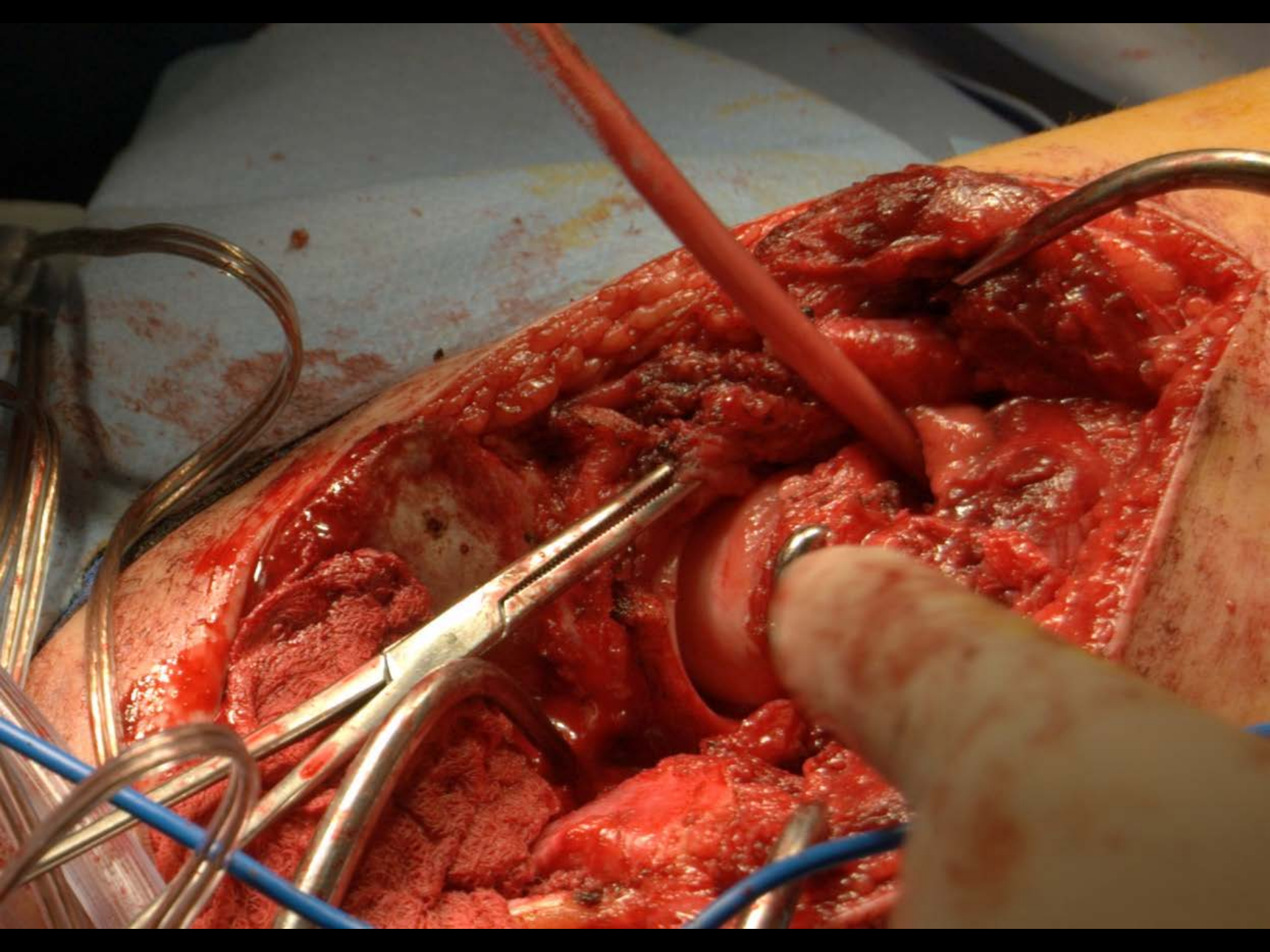
BTW: Have you noticed the wide extra socket space superior (left here) and posterior (downward here) without any fiddling? That is the splayed out socket. We will fix that in a bit.

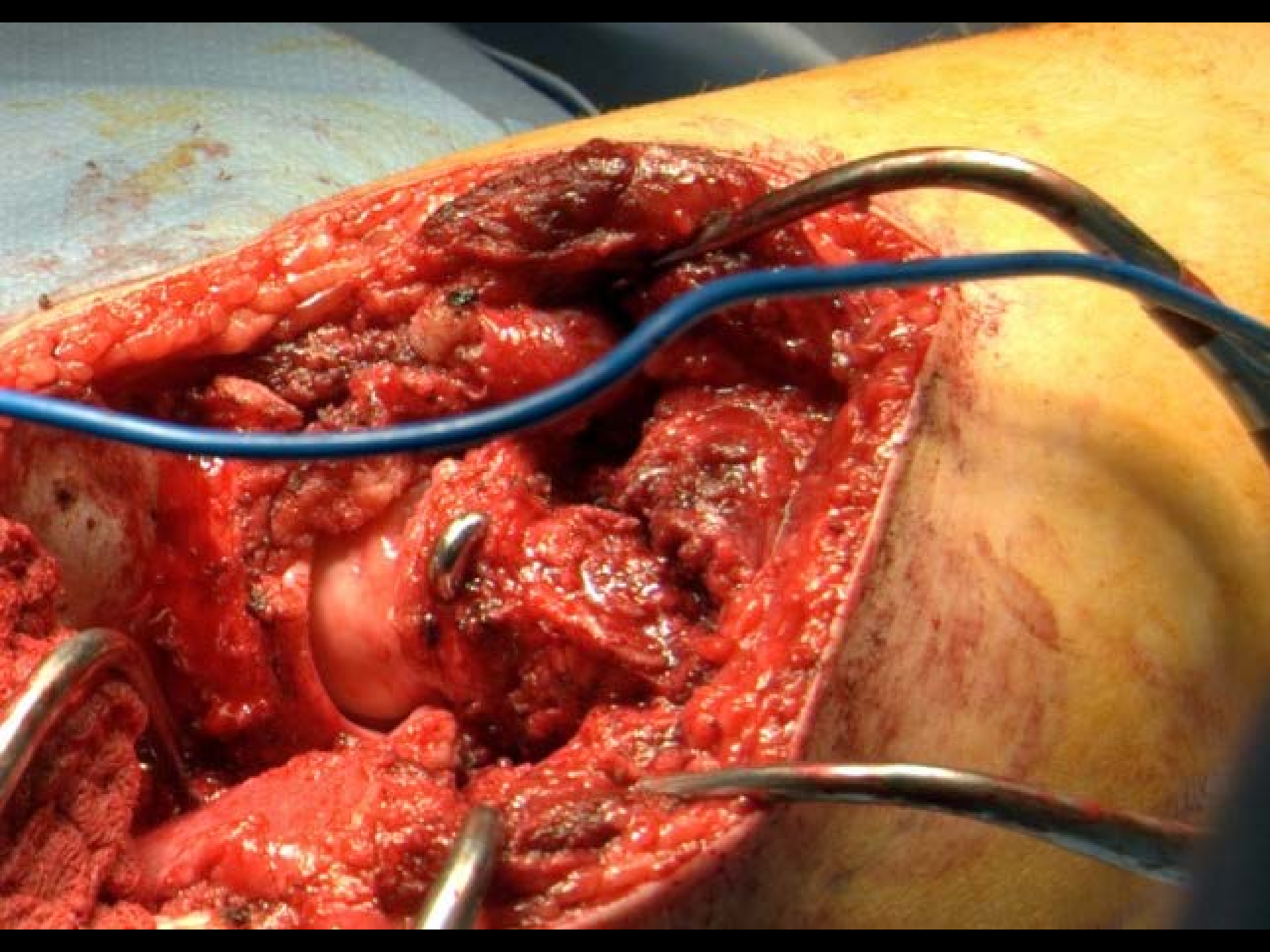


Push Rush pin down the pipe (femoral shaft). Use rectus femoris to cover that cut bone surface.

Notice, at rest, the hip ball is deeply seated and the excess socket that cries out for repair.



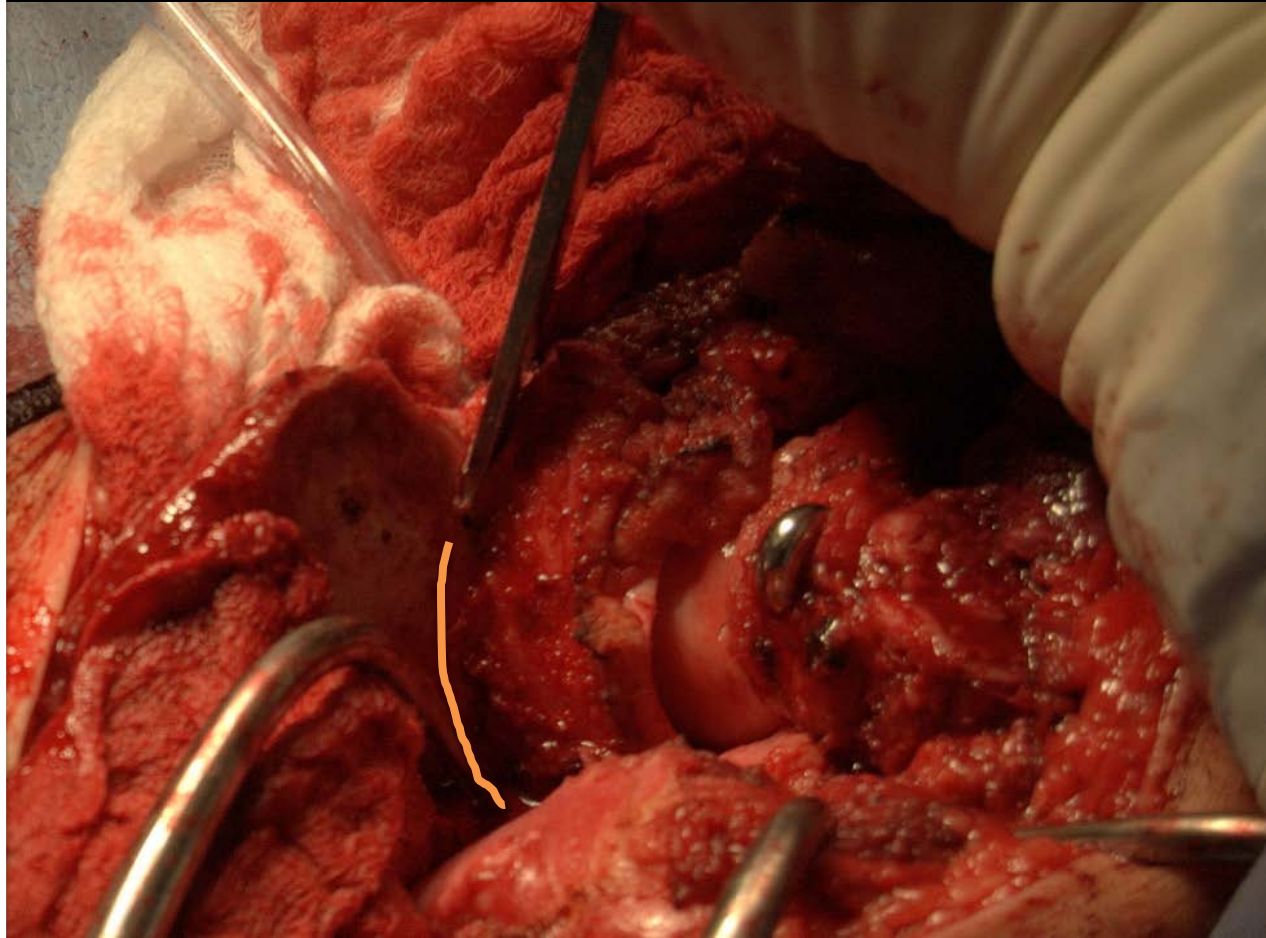


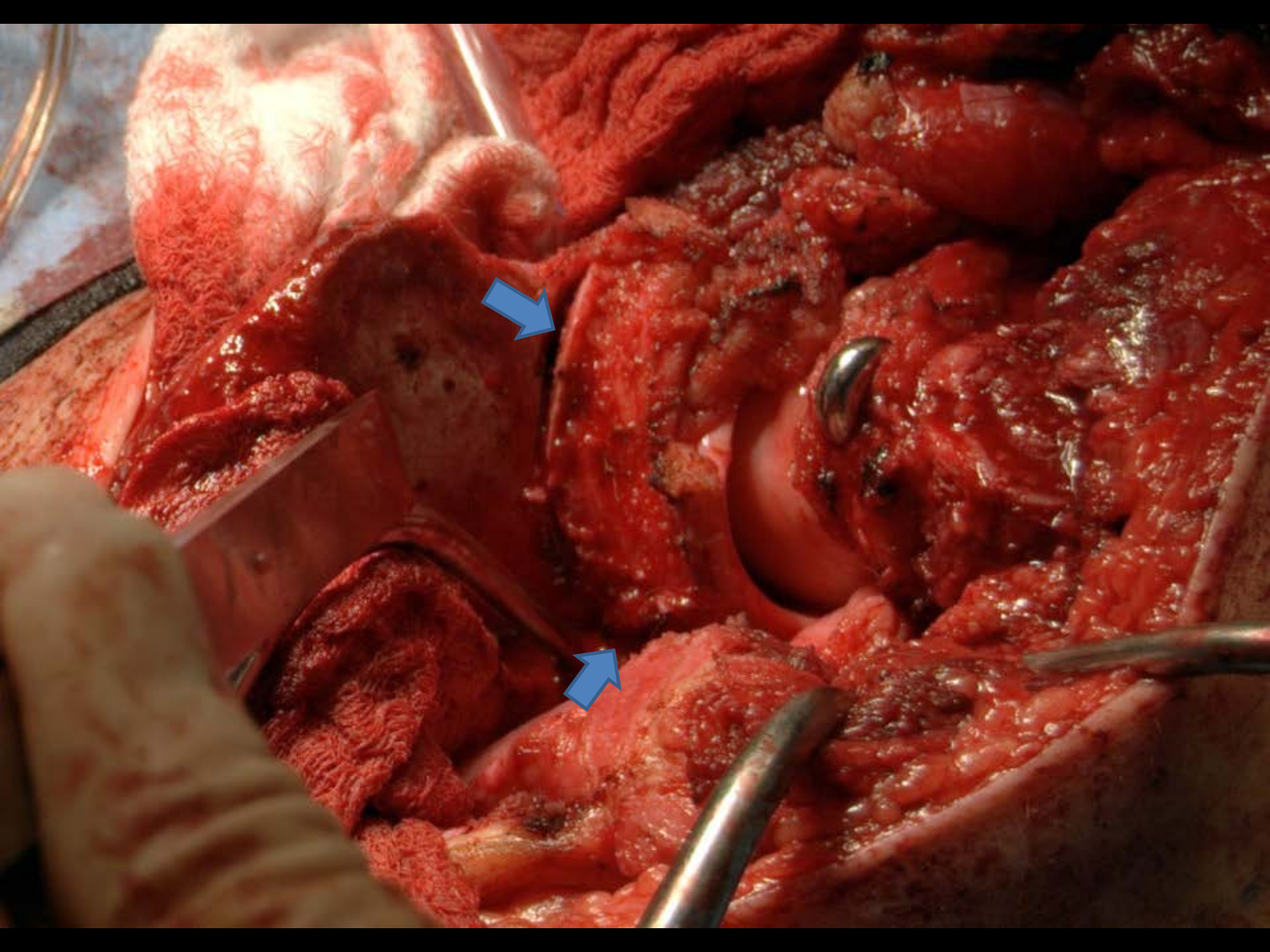


Starting through the AIS, the outer cortex(wall) of the ilium is cut parallel to the acetabulum, to but not through the medial iliac wall in a downward slant to get behind the acetabular wall inside the ilium.

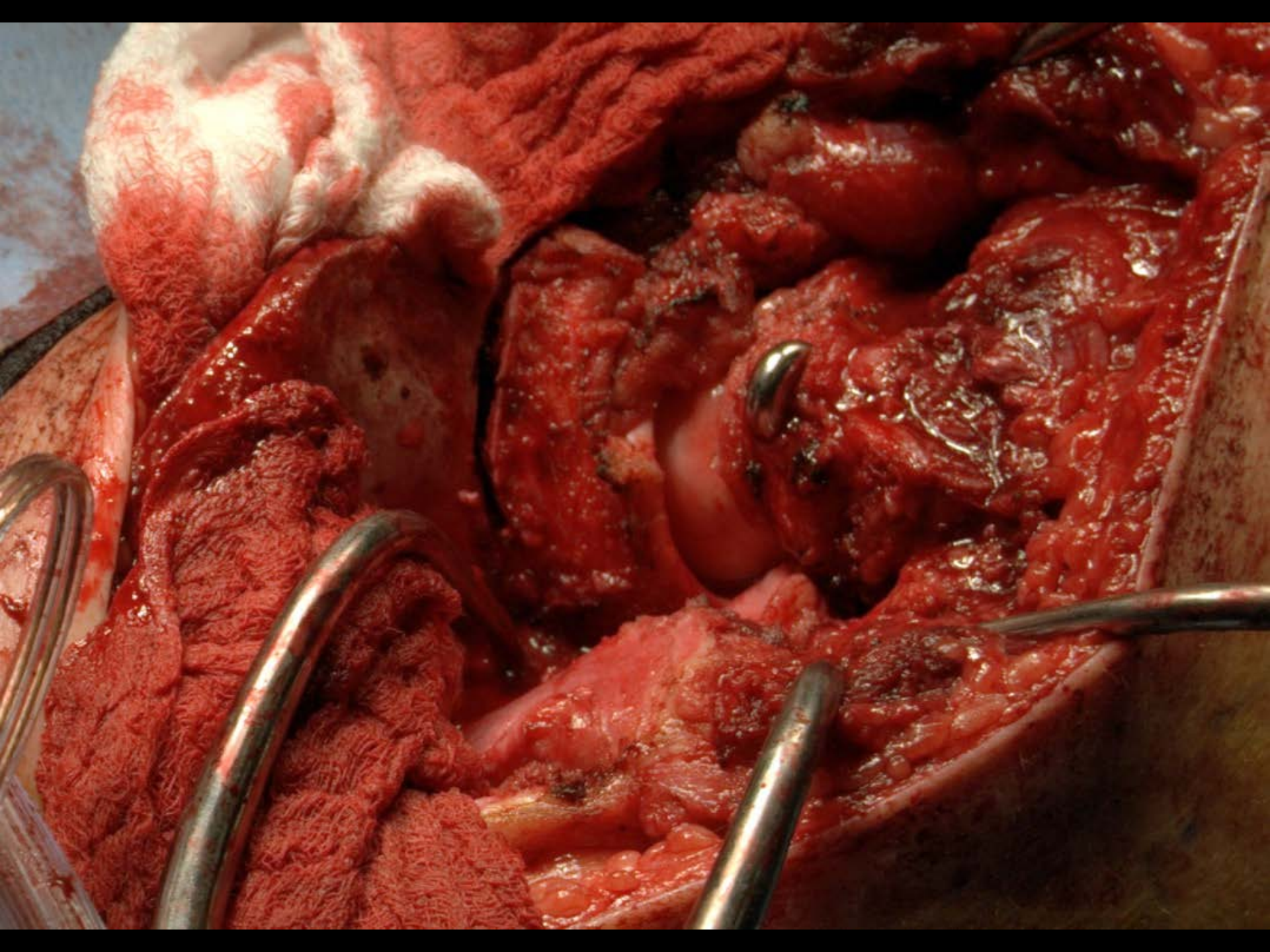
An over sized Cobb elevator (alias the shovel) then extends this path that parallels the sciatic notch (under direct vision with mixters in the notch from inside and outside the ilium).

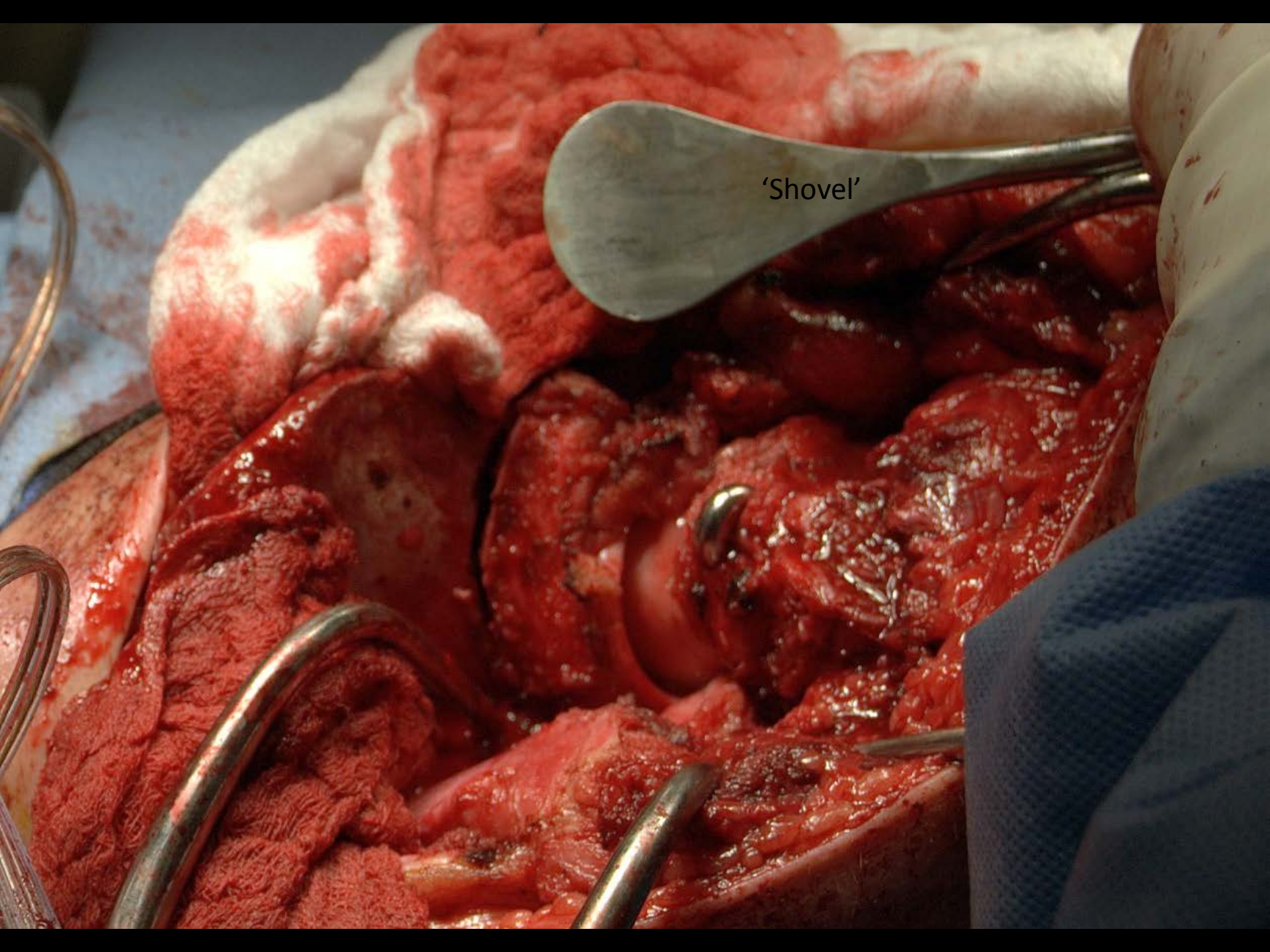
Smaller Cobb elevators are placed inferior to the shovel to more discretely reshape the socket and close the abnormal space flush to the femoral head.











'Shovel'

Unnamed

Similar to this,
as seen on x-ray



61 kVp

0.43 mA

6

50 

0 

OEC

Similar to this,
as seen on x-ray



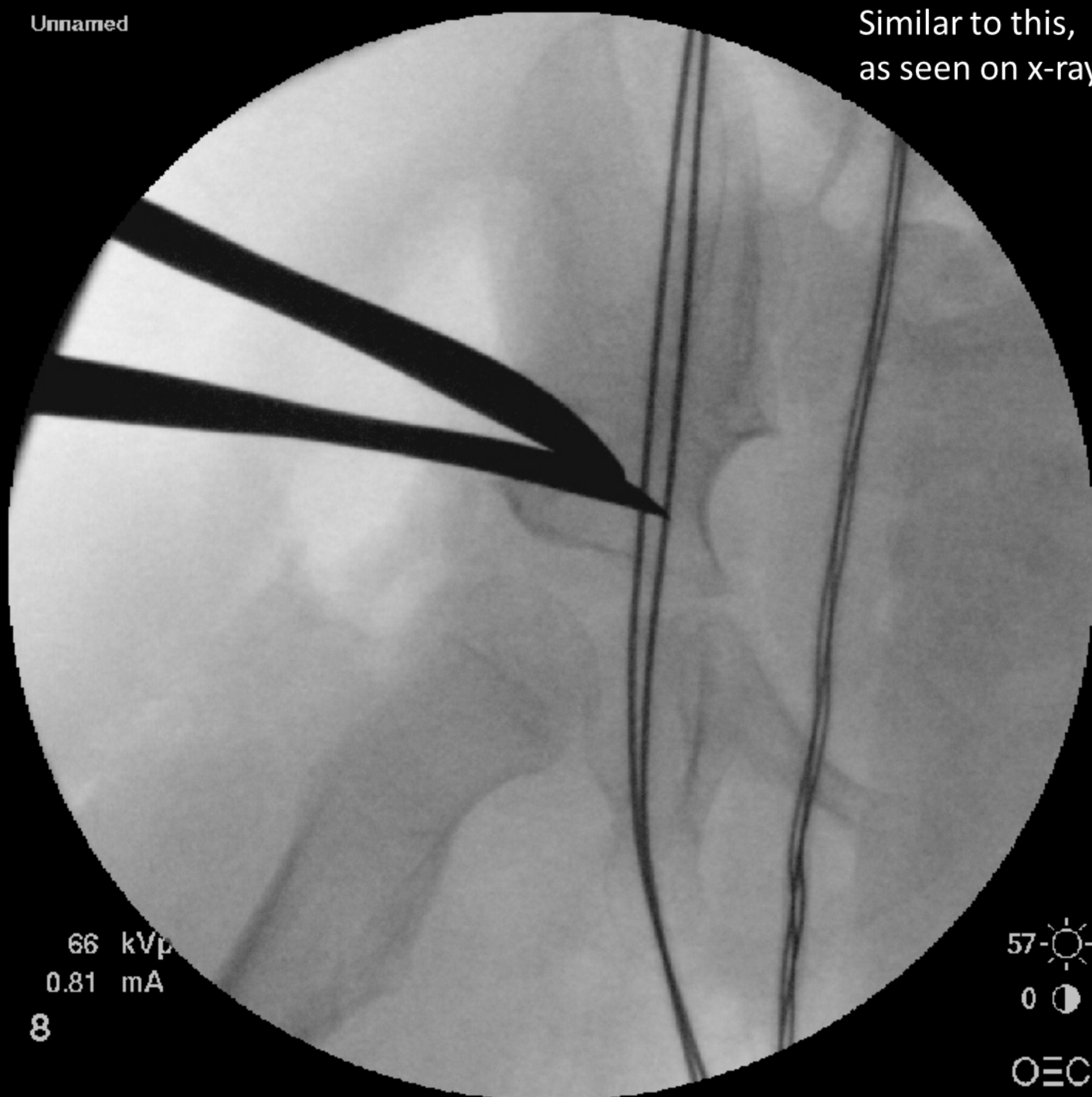
63 kVp
0.69 mA

7

54 
0 
OEC

Unnamed

Similar to this,
as seen on x-ray



66 kVp

0.81 mA

8

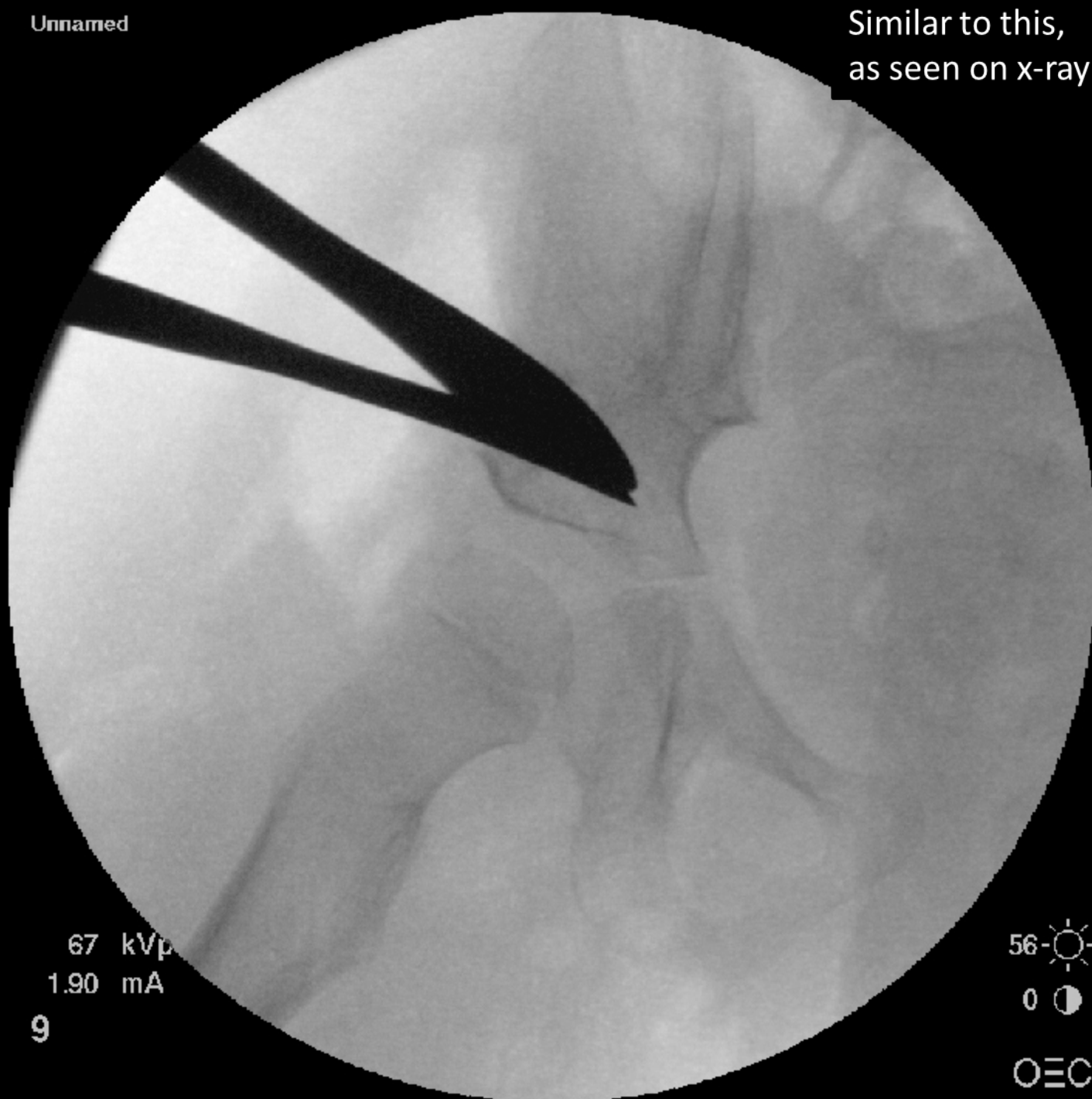
57 

0 

OEC 

Unnamed

Similar to this,
as seen on x-ray

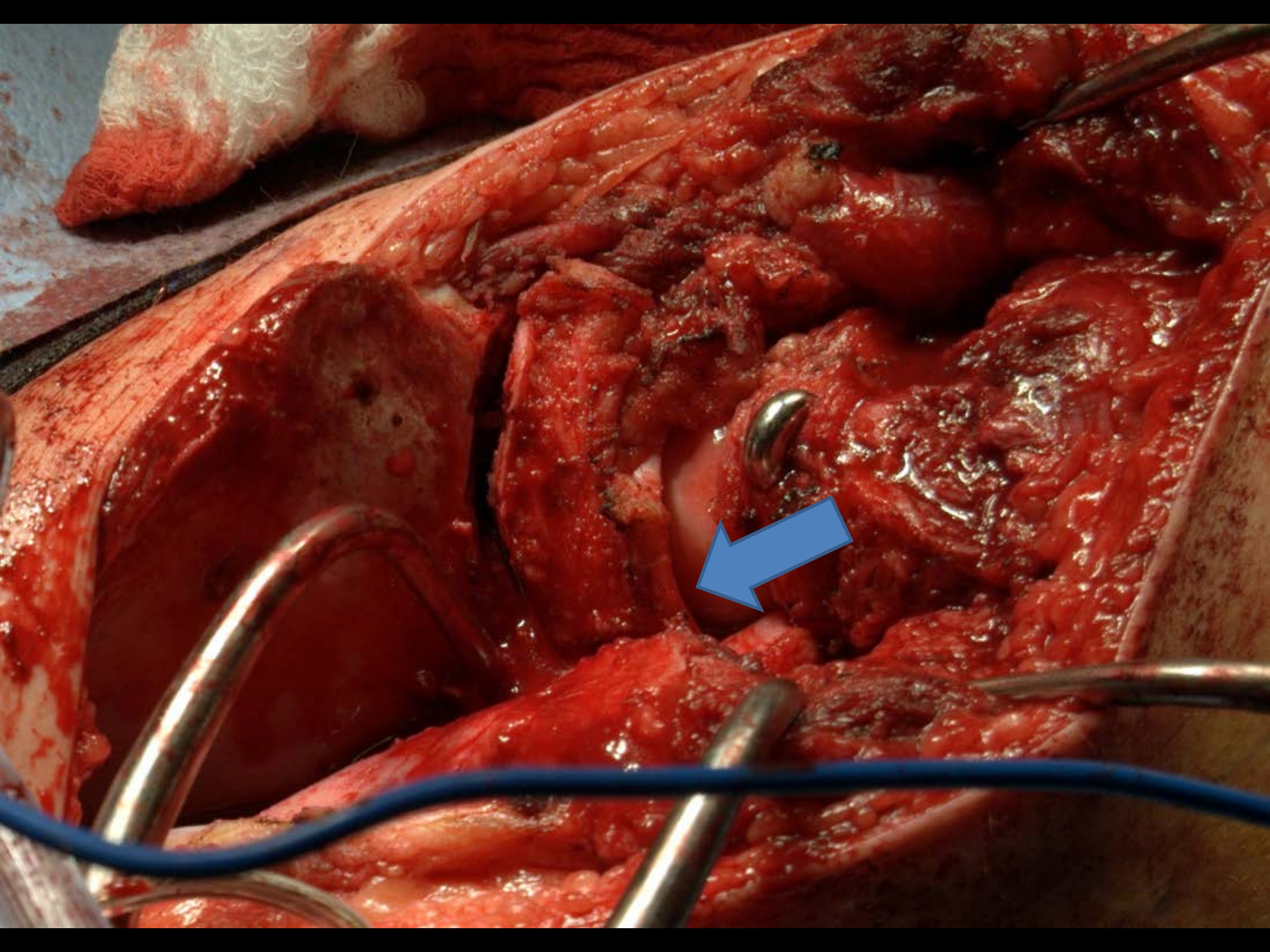


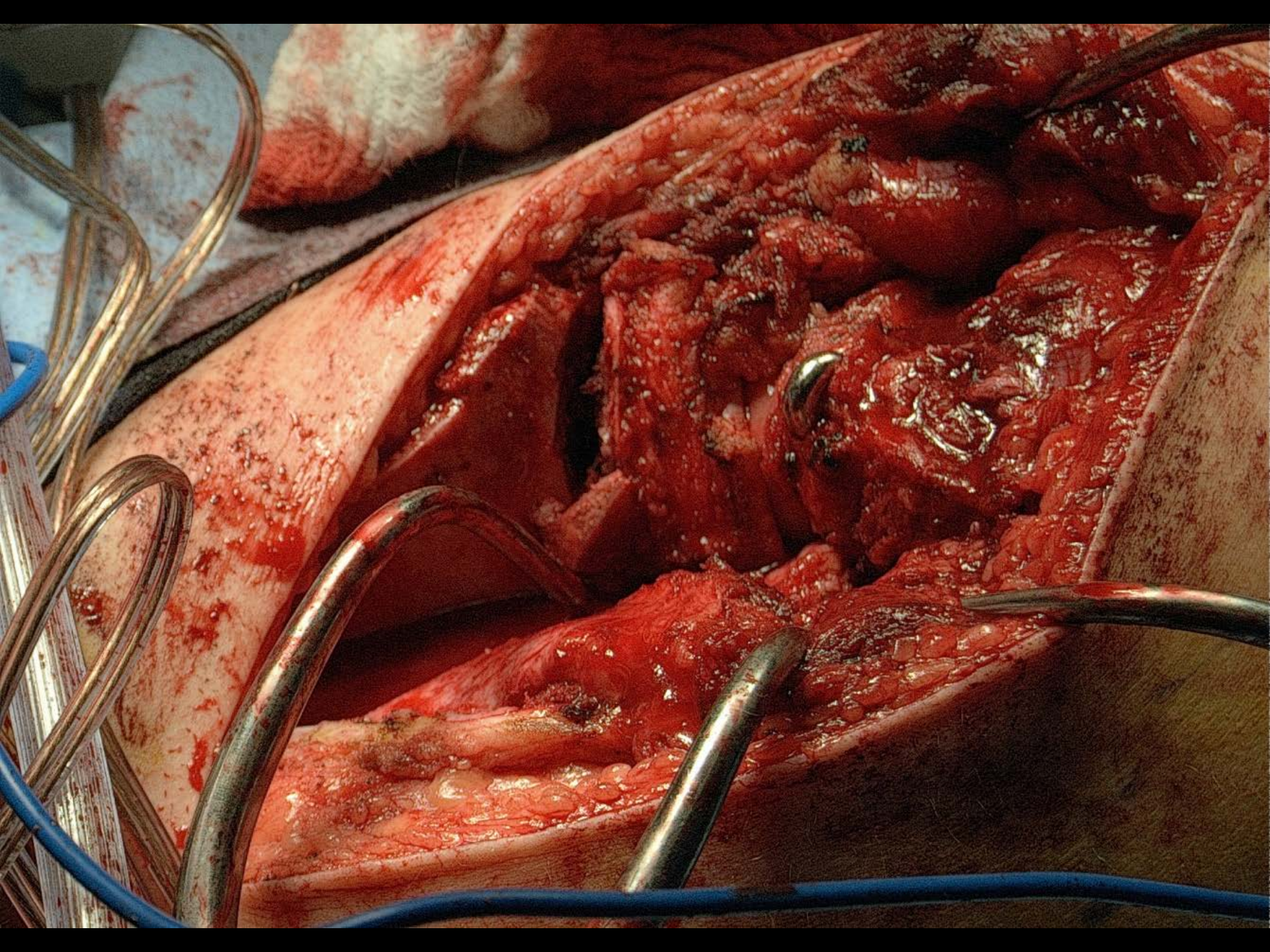
67 kVp
1.90 mA

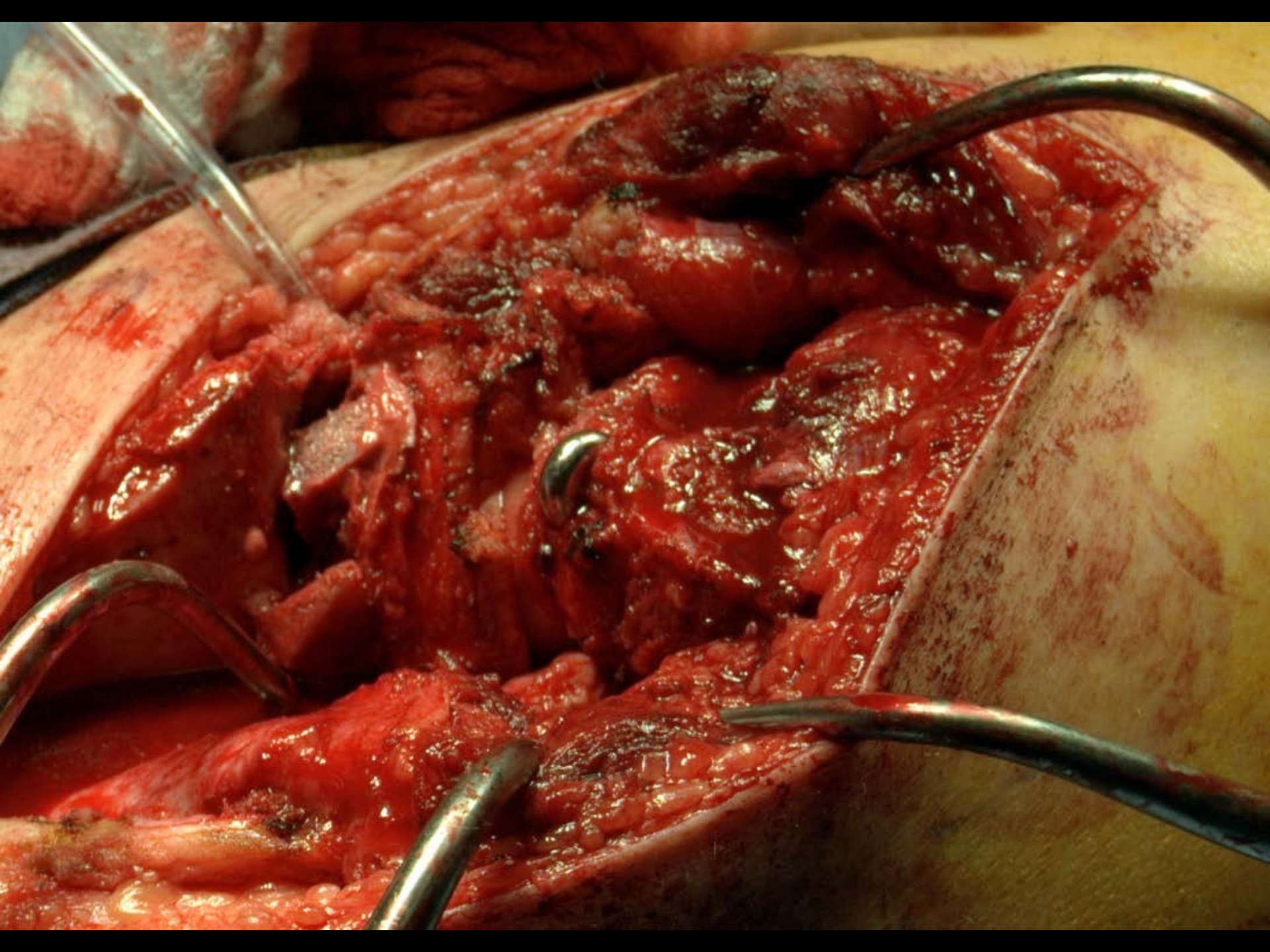
9



OEC







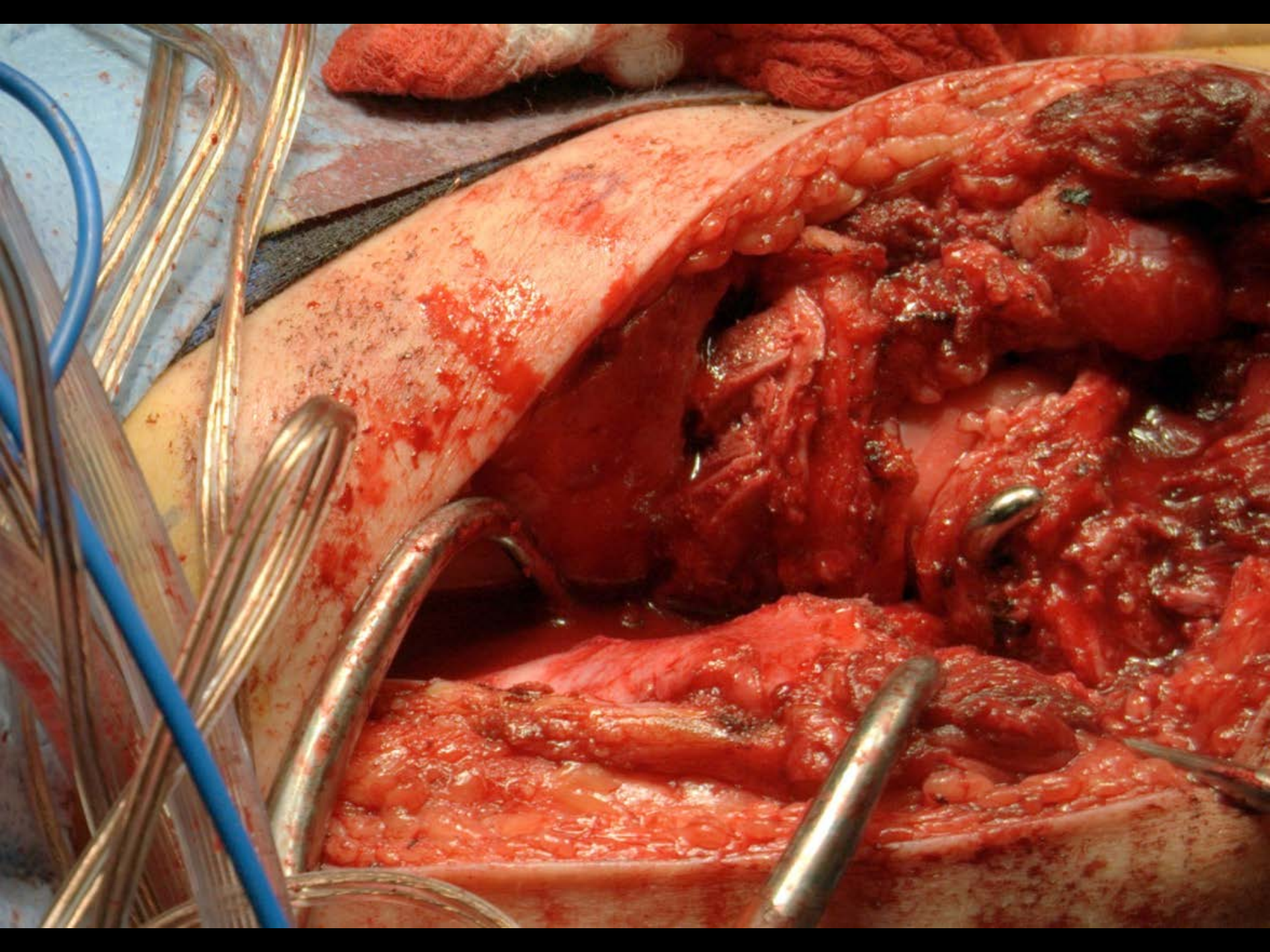
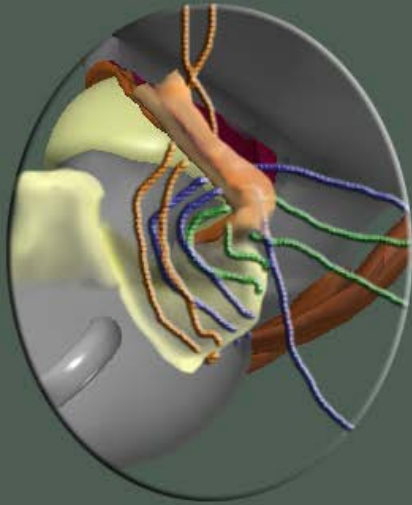


Illustration seen as other hip (left)



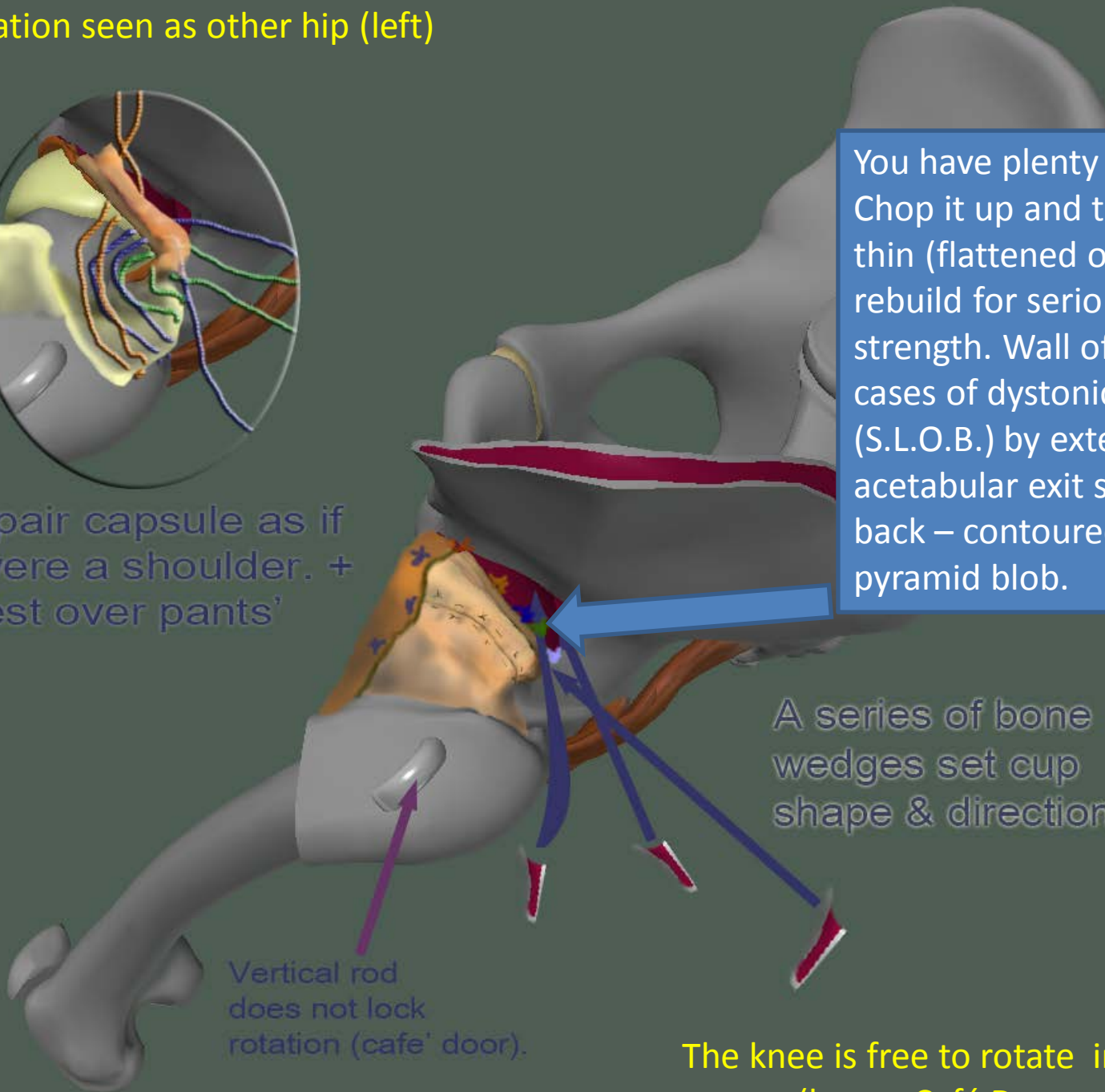
Repair capsule as if it were a shoulder. + 'vest over pants'

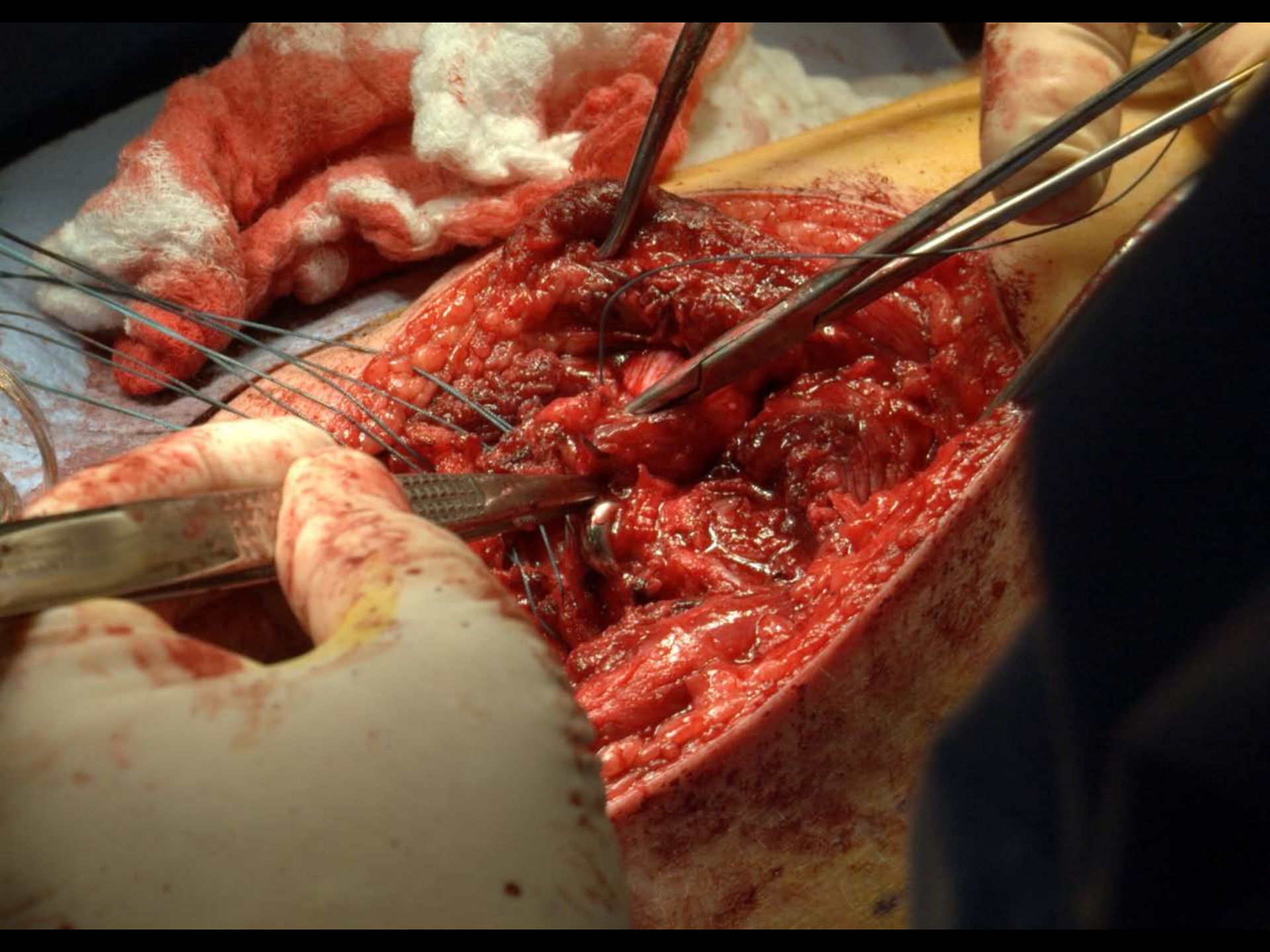
You have plenty of bone. Chop it up and thicken this thin (flattened out) area to rebuild for serious usage strength. Wall off egress in cases of dystonic neurology (S.L.O.B.) by extending over acetabular exit space top & back – contoured big pyramid blob.

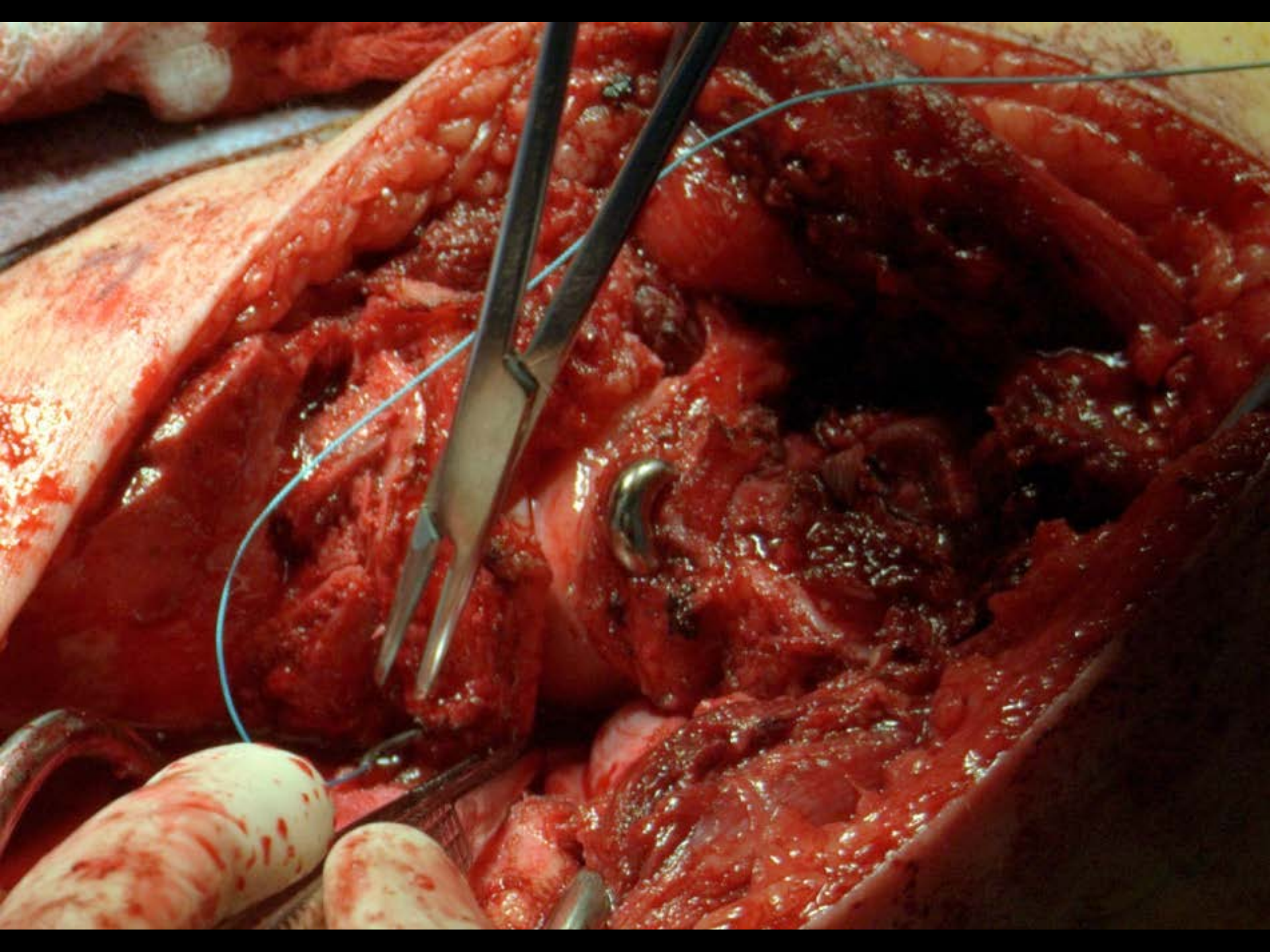
A series of bone wedges set cup shape & direction.

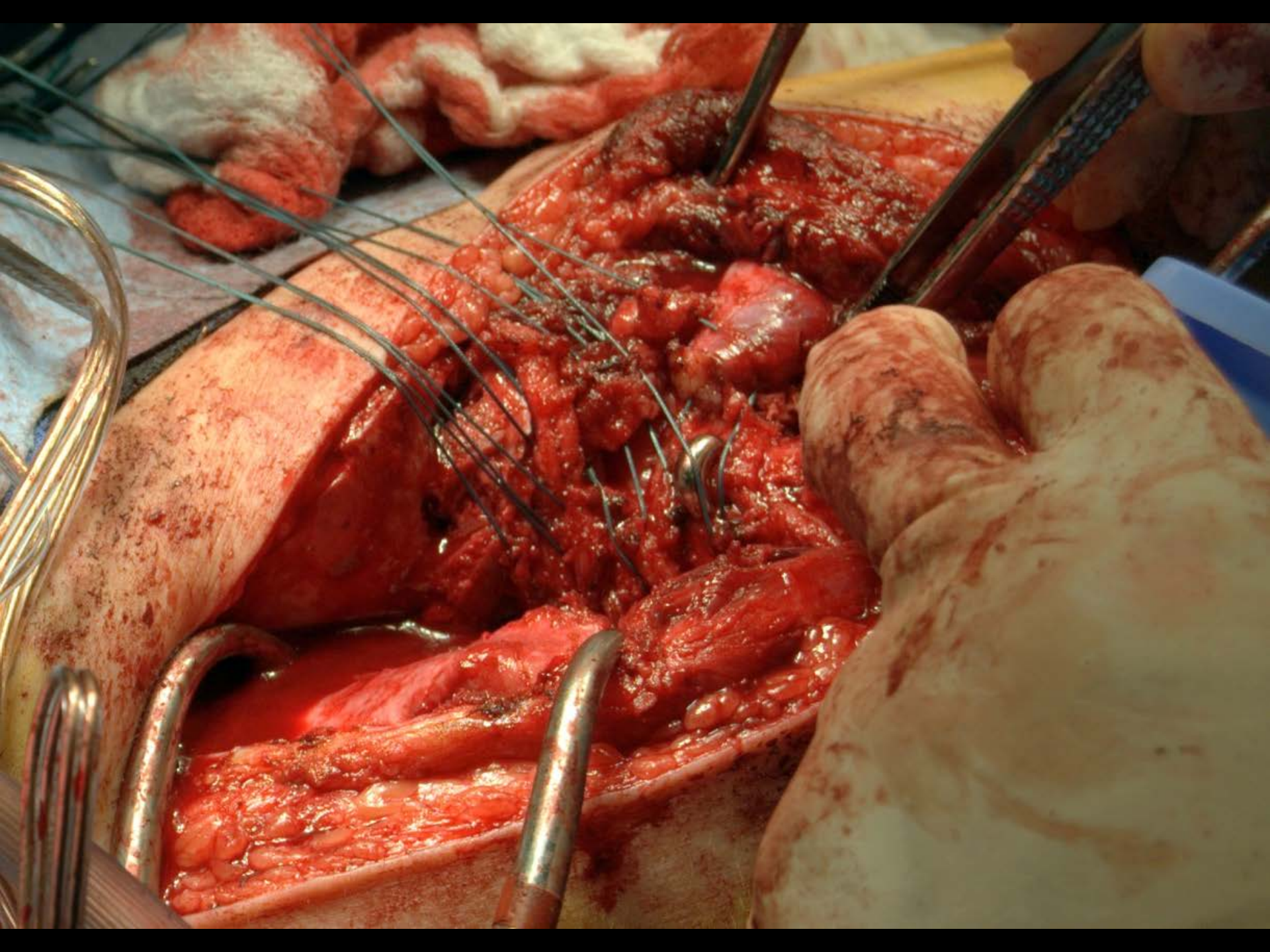
Vertical rod does not lock rotation (café' door).

The knee is free to rotate in-out (hence Café Door name).









Although an inch has been removed from top of ilium, the closure of the apophysis (& inner to outer iliac muscle sleeve) fits right to it. Shortening the ilium and peeling subperiosteal to inner & outer surfaces has allowed muscle to move downward and be happy at closure.

This hip can be (and is) flexed and extended without loss of position BEFORE closure.

Postop day one has PT doing likewise. Parents are taught to see direction of knee cap and to keep it turned straight ahead. PT shows them how to flex & extend 2 to 3 times a day. on Q local anesthesia clamping alternates with Schneider drain.

