Comment

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. Tables and figures should be included only if absolutely essential and no more than five references should be given.

Unilateral facet joint hypertrophy causing nerve root irritation

Massive unilateral facet joint hypertrophy of the lumbar spine was reported by Wilde *et al.* (*Annals*, September 1988, vol 70, p307) who considered that the aetiology was not fully understood. Morrison (*Annals*, January 1989, vol 71, p74) commented that healed trauma could be the cause. We suggest that unilateral facet joint hypertrophy in the spine could be due to post-traumatic myositis ossificans as demonstrated by a patient seen recently.

A 52-year-old male doctor was sitting in his stationary car, wearing a seat belt, looking to the right. A car shunted the rear of his car and he felt his head go back sharply. He developed neck stiffness with pain mainly on the left, radiating to the neck, shoulder and back of his left arm. Eight to twelve months after the accident he noticed increasing weakness of the left shoulder muscles. He still has restriction of neck movements to the left with slight wasting and weakness of the left deltoid and biceps muscles.

Serial X-rays of the cervical spine were taken after the injury. The initial X-rays (Fig. 1) showed minor degenerative changes at the C4–5 level, similar to those on a previous X-ray. Later X-rays (Figs. 2, 3) demonstrate the progressive development of a bony mass around the left C4–5 facet joint. This ectopic ossification is confirmed on a CT scan (Fig. 4). No movement was demonstrated at the left facet joint on flexion-extension views 4 years later.

We believe that the development after his injury of ectopic bone and unilateral radiculopathy at the left C4–5 facet joint in this patient is the result of post-traumatic myositis ossificans (PMO). This ectopic bone formation occurs after injury and is often seen in brachialis, quadriceps and thigh adductors. The bone is not formed directly within muscle fibres and is not an inflammatory lesion. Fibrodysplasia ossificans circumscripta is an alternative name sometimes used to decribe this condition *(1)*.

FIG. 1 Left lateral oblique X-ray of the cervical spine after the accident.

FIG. 2 X-ray 1 year later.

Whiplash injuries of the cervical spine causing musculoligamentous sprains of facet joints with periosteal tearing are becoming increasingly common when drivers or passengers are wearing a seat belt and either decelerate suddenly or are shunted from the rear. Although post-traumatic myositis ossificans around a facet joint in the cervical spine has not been

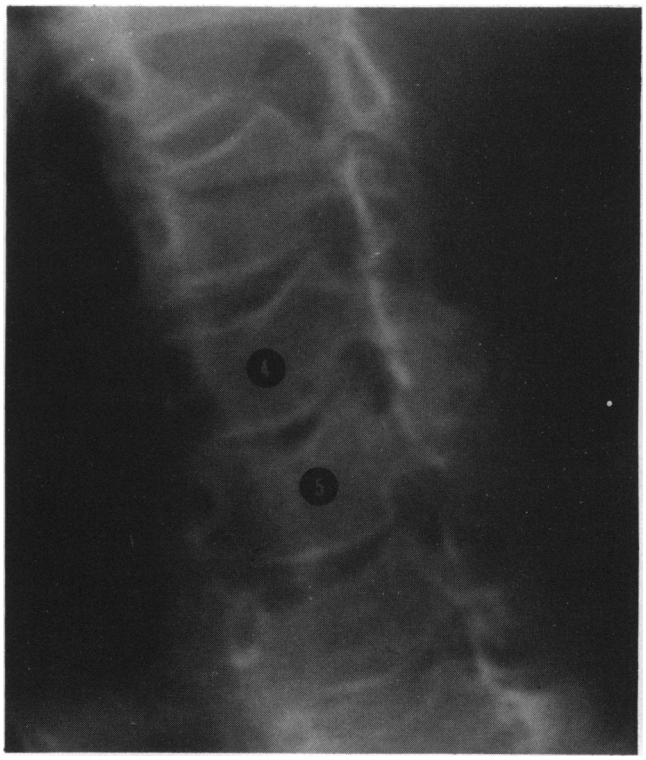

FIG. 3 X-ray 3 years later.

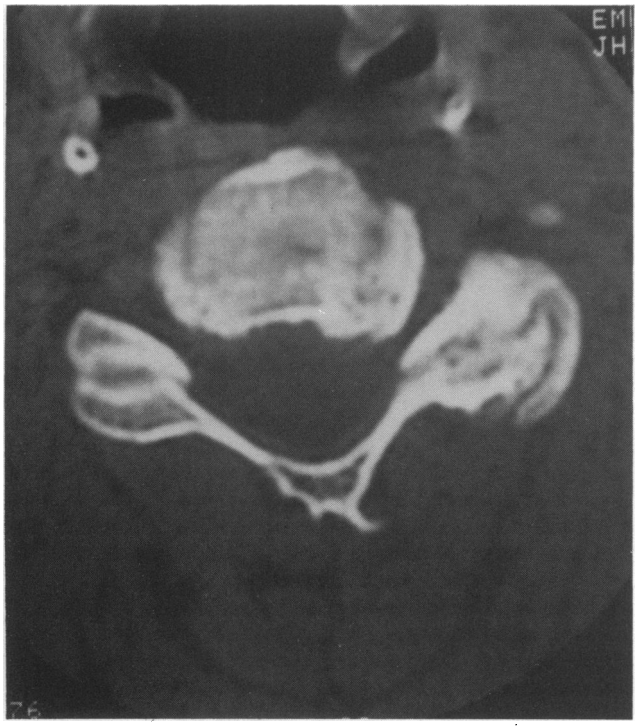

FIG. 4 CT scan of cervical spine at the C4–5 facet joint 3.5 years later.

previously reported, we are confident that it will be seen more in the future.

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Reference

1 Feldman F. Soft tissue mineralization: roentgen analysis. Curr Probl Diagn Radiol 1986;15:204–21.

Intra-operative air testing: an audit on rectal anastomosis

The idea behind this article (*Annals*, November 1988, vol 70, p345) has been well conceived. This simple innovation can go a long way to reduce morbidity and an occasional mortality. It is unfortunate that such procedures do not get wider publicity; and worse still, they are ignored.

Cocks and Desmond *(1)* have instilled saline to test the integrity of their pyloroplasty suture line. I *(2)* have used air for the same purpose, which, of course, is identical in principle and very similar in detail to what has been described in this article.

The authors are too modest when they claim that their procedure is justified. Simple and safe, as it is this technique should be mandatory to ascertain the safety of suture lines, one has doubt about, or if the situation is otherwise notorious for leak. It must be conceded that mechanical integrity of the suture line is only one of the major factors that prevent leakage.

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References

1 Cocks JR, Desmond AM. Pyloroplasty. Br J Surg 1963;56: 116.
2 Kuruvilla MJ. Pyloroplasty—A modification. J R Coll Surg Edinb 1984;52:115.

Subclavian vein catheterisation for parenteral nutrition

The case of myocardial perforation following central venous catheterisation reported by Reed (*Annals*, November 1988, vol 70, p396) indicates the catheter had been advanced too far. The X-ray showed 'correct placement' in that the catheter lay in the central veins: it also showed almost certainly the tip to be in the right heart.

Central venous catheterisation implies the catheter tip lies within the central veins, an ideal position for parenteral nutrition or for administering drugs. Naturally there is no danger of myocardial perforation. If the tip lies in the heart, the situation is one of cardiac catheterisation which is only indicated if monitoring of the right heart is required.

It is a pity the site of the perforation was not mentioned in the report: presumably it was in the thin-walled right atrium.

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Pancreatic sphincteroplasty: indications and outcome

Dr Mervyn Rosenberg suggested that he was the first to perform the operation of pancreatic ductal sphincteroplasty in 1973 (*Annals*, November 1988, vol 70, p399).

I would like to point out that this procedure was described and illustrated in detail by me in Surgery, Gynecology & Obstetrics in 1960 *(1)*.

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Reference

1 Nardi George L. Technique of sphincteroplasty in recurrent pancreatitis. Surg Gynecol Obstet 1960;110:639–40.

Author's reply

I am, clearly, remiss in missing Professor Nardi's paper in 1960. Perhaps he will at least agree that all good things have to be 'invented' more than once, before they become accepted.

I am loath to stick my head once more above the parapet but may I, at least, claim first British rights to the operation of septal or 'butterfly' sphincteroplasty? I could be taking the third light in a trench but, if so, I am sure that another of your erudite readers will fire the shot to let us know. The next time, possibly, I may not have the opportunity of hearing it.

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Do children need routine preoperative blood tests and blood cross matching in orthopaedic practice?

We read with interest the article by Jones *et al.* (*Annals*, January 1989, vol 71, p1) detailing their cross-match audit for a paediatric orthopaedic unit. We recently completed a similar audit of children undergoing common urological procedures at

Procedure	*< 1 year*	*1–17 years*
Nephrectomy*	2/10	0/6
Ureter reimplant	1/7	1/13
Pyeloplasty	1/10	0/13
Heminephrectomy	0/6	0/2

* Excluding one case of Wilms' tumour