《坎贝尔骨科手术学》

图书基本信息

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书籍目录

章节摘录

 插图： With the patient supine, administer general or regionalanesthesia and apply a thigh tourniquet. Make a skin incision that runs medially and longitudinallyover the first metatarsophalangeal joint, extending fromabout the proximal half of the proximal phalanx to themiddle part of the first metatarsal. Subperiosteally free the dorsal aspects of the proximalphalanx and first metatarsal from the overlying softtissues. To preserve the blood supply to the distal frag-ment, do not detach the soft tissues on the plantar aspectof the first metatarsal. With the medial aspect of the first metatarsal exposed,make a three-cut Z-shaped osteotomy. Begin the longitudinal cut at the level of the metatarsalhead, 5 mm from the joint at the junction between thedorsal third and the plantar two thirds of the metatarsal.Depending on the severity of the deformity to be cor-rected, make this cut longer or shorter, but generallyreaching the proximal part of the diaphysis. In the frontalplane, this cut is parallel to the weight-bearing plane orslightly oblique from dorsomedial to plantar-lateral tobring the metatarsal head more plantar if required. Make the first transverse cut distally and dorsally, perpen-dicular to the long axis of the second metatarsal if thelength of the first metatarsal has to remain equal. Thetransverse cut usually runs parallel to the cartilage line ofthe metatarsal head. To lengthen the metatarsal, orientthe transverse (short) cut in the horizontal plane frommedial-proximal to distal-lateral at an angle that will allowdistal translation. If shortening of the first metatarsal isdesired, orient the transverse cut from medial-distal tolateral-proximal in the horizontal plane; the more obliquethe cut and the larger the lateral shift, the more shortening will occur. Alternatively, shorten the metatarsal by removing asegment of bone of the amount of desired shortening bymaking a second cut just proximal to the first one. Thisis a more predictable method of obtaining shortening. Make the second transverse cut strictly parallel to the firsttransverse cut, plantar at the proximal end of the longi-tudinal cut (Fig. 81-46A). Take care to avoid making thiscut convergent to the first one because this would preventthe shifting of the head fragment (locking effect)(Fig. 81-46B).

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媒体关注与评论

一、出版时间紧随原著：《坎贝尔骨科手术学》第12版的英文原版于2012年12月新近出版，影印版几乎在第一时间同步推出，使中国读者得以率先领略原著风采。二、专业英语原汁原味：《坎贝尔骨科手术学》第12版对于刚开始从事骨科工作的低年资住院医生、年资较高的骨科专家及广大医学院校师生均为一部值得深入研读的高级参考书，影印版更可作为学习专业英语的最佳读物。三、平装版本性价比高：平装版按照骨科学分支将原著分为14个分册出版，内文印刷采用全铜版纸，保持与精装版相同的质量，性价比更高，更方便读者根据需要进行选择。四、最新进展完美呈现：第12版全面进行知识更新，介绍骨科近5年的新技术、新装备，如全髋及全膝关节置换微创入路、骨折固定术的小截面植入物、脊柱手术新设备，深入探讨新型骨移植材料，以及关节镜和内镜技术等。

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编辑推荐

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名人推荐

足和踝分册内容在第12版延续了第11版的编写方式，将踝部运动损伤作为单独的一章加以介绍，并按最新的进展对内容进行了更新和修订。

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精彩短评

1、内容新，与描述一致。铜版纸

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