

Comments and letters, addressed to the editor at the publication office, are welcome.

A CASE OF HOT HIPS

Dear Editors:

I read the "diagnostic challenge" with interest. Heterotopic ossification (HO) would be that term which would be most commonly associated with the proliferation of osteoid in soft tissues with subsequent ossification. This type of problem has been described in four fairly distinct clinical scenarios:

1. As a result of direct trauma to the muscle. This would be the scenario described by Nicholson and Barnes. In addition to this occurring in athlete injuries, there are the phenomena of "gunner's shoulder" and "rider's hip" which have been described over the last 100 years;
2. A rare congenital disorder which produces diffuse involvement of joints;
3. Heterotopic ossification occurring most commonly after spinal cord injury or traumatic brain injury; and,
4. Heterotopic ossification which occurs following total arthroplasty.

The advice regarding passive stretching exercises which the authors state as "should never be permitted" is not appropriate for heterotopic ossification following spinal cord injury (SCI) or traumatic brain injury (TBI). Once the process is identified, passive stretching exercises are mandatory to prevent restriction of range of motion. In this population, avoidance of passive mobilizations will lead to the rapid development of contractures. The functional consequence of this for an individual who will be seated in a wheelchair is devastating as an inability to flex the hips to 90 degrees produces difficulty in seating. I wish to point this out to your readers.

In general, the earliest consideration of surgery in the population of SCI HO individuals is at the 12-18 months range. Most authors advocate waiting until the process "cools down" as indicated by resolution of activity on technetium bonescan. Wharton's work indicates that the length of time for this to occur is a mean of 14 months. Surgical excision is a procedure which is avoided if possible because of the associated risks of significant hemorrhage and the high risk of recurrence. It is thought that the risk of recurrence is greatly increased should this be attempted before the process "cools down." There is some disagreement on this point and other authors (Garland) have reported similar results on attempting excision prior to resolution of the "inflammatory" process. Perhaps in contrast to the "orthopedic experience" with joint arthroplasty, use of antiinflammatory drugs has not been shown to be of benefit in dealing with the HO in SCI and TBI individuals. Sodium etidronate in doses of 10-20 mg per kg for a period of several months (variable between authors) is

the pharmaceutical intervention used in the patient population represented by your case.

As well, the flow diagram regarding management of this problem would obviously be significantly different for someone who was paraplegic, as they certainly would not be able to take part in isometric or resisted exercises. I would suggest that the Figure 1 for management of myositis ossificans traumatica does not apply to individuals who have a spinal cord injury.

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