

References

- Cardinal. E, Braunstein E M, Capello W N, Heck D A. *Candida albicans* infection of prosthetic joints. *Orthopedics* 1996; 19 (3): 247-51.
- Darouiche R O, Hamill R J, Musher D M, Young E J, Harris R L. Periprosthetic candidal infections following arthroplasty. *Rev Infect Dis* 1989; 11 (1): 89-96.
- Evans R P, Nelson C L. Staged reimplantation of a total hip prosthesis after infection with *Candida albicans*. A report of two cases. *J Bone Joint Surg (Am)* 1990; 72 (10): 1551-3.
- Goodman J S, Seibert D G, Reahl G E Jr, Geckler R W. Fungal infection of prosthetic joints: a report of two cases. *J Rheumatol* 1983; 10 (3): 494-5.
- Iskander M K, Khan M A. *Candida albicans* infection of a prosthetic knee replacement. *J Rheumatol* 1988; 15 (10): 1594-5.
- Koch A E. *Candida albicans* infection of a prosthetic knee replacement: a report and review of the literature. *J Rheumatol* 1988; 15 (2): 362-5.
- Lambertus M, Thordarson D, Goetz M B. Fungal prosthetic arthritis: presentation of two cases and review of the literature. *Rev Infect Dis* 1988; 10 (5): 1038-43.
- Levine M, Rehm S J, Wilde A H. Infection with *Candida albicans* of a total knee arthroplasty. Case report and review of the literature. *Clin Orthop* 1988; 226: 235-9.
- Lichtman E A. *Candida* infection of a prosthetic shoulder joint. *Skeletal Radiol* 1983; 10 (3):176-7.
- Lim E V A, Stern P J. *Candida* infection after implant arthroplasty. *J Bone Joint Surg (Am)* 1986; 68: 143-5.
- MacGregor R R, Schimmer B M, Steinberg M E. Result of combined amphotericin B-5-fluorocytosine therapy for prosthetic knee joint infected with *Candida parapsilosis*. *J Rheumatol* 1979; 6: 451-5.
- Morley D C, Patterson A. *Candida parapsilosis* infection of total hip replacement: a case. *Orthop Rev* 1983; 12 (11): 61-4.
- Paul J, White S H, Nicholls K M, Crook D W. Prosthetic joint infection due to *Candida parapsilosis* in the UK: case report and literature review. *Eur J Clin Microbiol Infect Dis* 1992; 11 (9): 847-9.
- Tunkel A R, Thomas C Y, Wispelwey B. *Candida* prosthetic arthritis: report of a case treated with fluconazole and review of the literature. *Am J Med* 1993; 94 (1): 100-3.
- White A, Goetz M B. *Candida parapsilosis* prosthetic joint infection unresponsive to treatment with fluconazole. *Clin Infect Dis* 1995; 20 (4): 1068-9.
- Younkin S, Evarts C M, Steigbigel R T. *Candida parapsilosis* infection of a total hip-joint replacement: successful reimplantation after treatment with amphotericin B and 5-fluorocytosine. *J Bone Joint Surg (Am)* 1984; 66: 142-3.

Congenital absence of fibulae with equinovarus deformity—a case report

Devinder K Khurana and Sataya P Bhargava

Sir Ganga Ram Hospital, New Delhi, India-110060. Correspondence: S.P. Bhargava, Dept. of Orthopaedics, Broomfield Hospital Court Road, Broomfield, Essex CM1 5ET, U.K. Tel +44 1245 51-4010. Fax -4644
Submitted 96-11-01. Accepted 97-01-27

A 2.5-year-old girl presented with deformity of the feet from birth and walked on the dorsolateral aspect of the feet. Clinical assessment showed uncorrectable bilateral equinovarus deformities with callosities over the dorsolateral aspect of the feet. She had symmetrical genu valgum deformity of 10 degrees in both knees, and limited supination and pronation of both forearms. There was no history of similar deformities in her sibs and family. Radiographs revealed complete symmetrical absence of the fibulae (Figure) together with equinovarus deformity and metatarsus varus. Radiographs of the elbows showed bilaterally subluxed radial heads. A full skeletal survey revealed no other abnormality. She was treated by standard posteromedial soft tissue release. This was followed by corrective serial plaster casts for 3 months. A muscle biopsy from the gastrosoleus muscle was normal.

1.5 years after surgery, the feet were plantigrade, although mild metatarsus varus of the forefeet persisted. The ankles were stable, despite the complete absence of fibulae.

Discussion

Congenital absence of the fibula, also known as intercalary paraxial fibular hemimelia, is the commonest long bone deficiency (Harmon and Fahey 1937, Coventry and Johnson 1952, Farmer and Laurin 1960). It is usually associated with equinovarus deformity of the foot and the ankle, with or without tarsal bone abnormalities (Harmon and Fahey 1937, Coventry and Johnson 1952, Thomson et al. 1957, Farmer and Laurin 1960, Westin et al. 1976, Achterman and Kalam-



Absence of fibulae and marked varus deformity. All 5 rays are present.



Marked equinus deformity with talus and calcaneum almost parallel to the longitudinal axis of the tibia.

chi 1979). Bilateral congenital complete absence of the fibulae associated with equinovarus deformity, may be a distinct syndrome not previously reported.

Acknowledgements

We are grateful to Professor L. Klenerman for reading the manuscript and making useful suggestions.

References

Achterman C, Kalamchi A. Congenital deficiency of the fibula. *J. Bone Joint Surg (Br)* 1979; 61: 133-7.

Coventry M B, Johnson E W Jr. Congenital absence of the fibula. *J. Bone Joint Surg (Am)* 1952; 34: 941-5.

Farmer A W, Laurin C A. Congenital absence of the fibula. *J Bone Joint Surg (Am)* 1960; 42: 1-12.

Harmon P J, Fahey J J. The syndrome of congenital absence of the fibula. Report of three cases with special reference to pathogenesis and treatment. *Surg Gynecol Obstet* 1937; 64: 876-8.

Thomson T C, Straub L R, Arnold W D. Congenital absence of the fibula. *J Bone Joint Surg (Am)* 1957; 39: 1229-37.

Westin G W, Sakai D N, Wood W L. Congenital longitudinal deficiency of the fibula. *J Bone Joint Surg (Am)* 1976; 58: 492-6.

Degenerative tear of the tibialis anterior tendon after corticosteroid injection—augmentation with the extensor hallucis longus tendon, case report

Gad J Velan and David Hendel

Department of Orthopedics, Golda campus, Rabin Medical Center, P.O.B 17102, Tel-Aviv 61171, Israel
Tel +972 3-6414388. Fax -9372501. E-mail drvelan@iol.co.il
Submitted 96-08-09. Accepted 97-02-04

A 52-year-old physician, active in recreational sport, suffered pain for 2 months in the dorsum of his left foot. Bethamethasone 7 mg was injected in the anterior tibialis tendon sheath. 4 months later and 2 weeks before his admission, when climbing stairs, his left foot hit the stair's edge, sharply plantiflexing the foot. The pain increased and he could not extend the foot.

The tibialis anterior tendon was tender and a gap was felt. A presumptive diagnosis of tear of the tibialis anterior tendon was suggested and confirmed by MRI.

We decided to repair the lesion. During the operation, it became clear that a direct repair was not feasible due to severe degeneration of both stumps. The extensor hallucis longus tendon was transferred and sutured parallel to the tibialis anterior proximal stump. The conjoint tendon was passed through a tunnel in the medial cuneiform bone and then sutured back to itself. Thus, the extensor hallucis longus bridged the gap, while keeping the important insertion of the tibialis anterior tendon into the medial cuneiform bone. The extensor hallucis brevis was cut