

INTRODUCTION

The necessity for additional bone for certain orthopedic operations has undoubtedly presented itself to surgeons many times. Secondary operations to obtain more bone are the result, thus prolonging the operative time, increasing morbidity and occasionally promoting a complicating factor. In certain patients, especially children, It may be difficult or impossible to obtain enough autogenous bone for the operation, (Bush and Garber; 1948).

The goal of bone banks is to provide safe and efficacious tissues, and to do so on a timely basis with respect to elective reconstructive procedures, (Friedlaender, 1987).

The availability of a variety of allografts in the bone banks allows for the selection, on an anatomic basis, of an allograft best suited for a particular recipient, (Malinin et al., 1985).

The first reliable account of a successful allograft of human bone was that of Macewen, published in 1881. Lexer attempted transplantation of whole joints and parts therefore, with mixed results. However, wide spread enthusiasm of the use of allografts in orthopaedic reconstructive surgery did not become evident until the reports of Inclan in 1942 and Wil-

son in 1951, and the clinical program initiated by Hyatt and Butler at the United States Navy Tissue Bank in 1950, (Friedlaender and Sell, 1984).

The banking of bone is not a simple task. It requires a conducive legal environment for both donors and physicians, as well as cooperation among individuals with the wide variety of skills involved in tissue procurement. Reliable facilities for tissue storage and a meticulous approach to methodology and record keeping are imperative, (Tomford et al., 1983).

The banking of bone is neither simple nor inexpensive. Numerous procedures and high costs are involved in the transplantation of an orthopaedic allograft, (Doppelt et al., 1981).

The purpose of this article is to highlight the aspects of bone-banking which should be strongly considered to establish a safe and cost-effective bone bank.