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Authors’ reply
The use of sutures as Kirschner wire and tension-band wire for olecranon fractures avoids the risk of complications associated with metal fixation such as implant cut-out, irritation of the surrounding soft tissues, and migration with secondary skin breakdown. No immediate clinical and biomechanical differences were noted between the different fixation techniques.1,2 Nonetheless, displacement of the olecranon fracture was noted if the load increased over 100 N.3 Therefore, elderly patients were instructed to use the arm for daily activities such as drinking and eating only. Multiple low-load tasks were allowed. A compression bandage instead of a cast was applied for 2 weeks, and early mobilisation of the elbow was recommended. Although suture cut-through in osteoporotic bone is feasible, we did not observe this. We do not recommend this technique for adults. Further study is necessary to evaluate this technique in elderly people before extending its indication to adults.

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Proximal femoral locking compression plate for proximal femoral fractures

To the Editor:
We read the article by Lee et al.1 with great interest. We have a few concerns regarding the choice of implant and prolonged time to bone union. Treatment of proximal femoral fractures is clinically challenging and multiple factors are responsible for the successful outcome such as bone quality, choice of implant, and surgical technique.2 Dynamic hip screws are the mainstay of treatment for stable intertrochanteric femoral fractures (AO/OTA 31A1 and many 31A2 fractures), and intramedullary implants are the best for unstable intertrochanteric femoral fractures (A3 and some A2 fractures) due to improved biomechanics (shortened lever arm), decreased blood loss, smaller
incision, and decreased femoral neck shortening. Subtrochanteric fractures are mainly treated with intramedullary nailing, whereas the best indication for the proximal femoral locking compression plate (PF-LCP) is subtrochanteric femoral fractures with proximal extension that compromises the integrity of the starting portal.3–5 What is the authors’ opinion regarding their high complication rate (27%)? Could these unstable intertrochanteric fractures be successfully treated with intramedullary implant?

Open reduction and internal fixation for comminuted intertrochanteric fractures are usually supplemented with bone grafting to fill voids and enhance fracture healing. What is the authors’ comment on bone grafting in cases of multifragmentary pertrochanteric fractures? A study reported a union rate of 95% at 3 months in 108 patients with pertrochanteric fractures treated with a PF-LCP.6 What is the authors’ opinion regarding the prolonged mean time to fracture union (9.4 to 11 months) in their series?

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Authors’ reply
The high complication rate in our series is consistent with other studies using the proximal femoral locking compression plate (PF-LCP).1,2 Factors that led to the high complication rate include patient selection and poor fracture biologics.

This series represented our initial experience with the use of the PF-PCP. Our patient cohort included those with intertrochanteric fractures (AO types 31-A1.1-3, A2.1-2) that, in retrospect, should have been treated with the sliding hip screw. Use of the PF-LCP in such fracture configurations increases the risk of the screw backing out.7

Non-union is a common complication. The surgical approach (open versus minimally invasive), patient health status, fracture configuration, use of bone graft, and choice of fixation all affect the biologics of fracture healing to varying degrees.

The use of bone grafts to promote bone union for comminuted pertrochanteric fractures remains variable in our practice. Generally, we avoid the use of bone substitutes and prefer to perform bone grafting when needed. The exact date of bone union was difficult to determine, especially when the patients had variable follow-up periods. We defined bone union as evidence of bone continuity in at least 3 cortices on 2 orthogonal views of the proximal femur. This was a poor estimate compared with using computed tomography.

Both PF-PCP fixation and intramedullary nailing are viable options for the treatment of unstable intertrochanteric fractures. Superiority of one option over the other remains undetermined.4 It is my opinion that intramedullary nailing is more favourable, as it avoids extensive periosteal stripping.

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Hospital mortality after arthroplasty using a cemented stem for displaced femoral neck fractures

To the Editor:
We read with interest the article by Ginsel et al.1
1. Could the authors clarify how they concluded that cemented hemiarthroplasty or total hip replacement for displaced femoral neck fractures had a low mortality rate with no control group?
2. In a study including 64,979 patients,2 cemented hemiarthroplasty was associated with a significantly higher mortality rate on day 0 and up to day 1, compared with uncemented hemiarthroplasty, after adjustment for confounding factors. The 30-day mortality rate was similar in both groups.
3. Could the authors clarify out of the 16 patients who died how many belonged to the hemiarthroplasty versus the total hip replacement group?

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