Retrograde locked intramedullary nailing for aseptic supracondylar femoral nonunion following failed locked plating

To the Editor:
I read with interest the article by Wu.1
1. The authors did not mention why the fractures went into non-union in the first place. What made them chose intramedullary nailing to involve the knee instead of another locked plating after recanalisation of bone?
2. To maintain a dynamic mode, only one distal oblique locked screw was inserted, and the 2 upper nail holes were left vacant. However, the construct was rotationally unstable in 8 patients, and ancillary fixation with a humeral buttress plate was required. Using a plate to provide rotational stability nullifies the reason for which the authors did not insert the screws to lock the nail. Using a long nail with an isthmic support and/or proximal locking bolt above the lesser trochanter averts the need for a plate.2–4 Although the zone is considered unsafe, no vascular injury has been reported.5,6 In my personal experience, this zone is safe for screw insertion.
3. The authors did not mention the length of the nail. A long retrograde nail is crucial for stabilisation of such fractures. Longer nails provide better initial fracture stability than shorter nails, owing to a more stable mechanical interaction between the femoral diaphysis and the nail.3,4
4. Retrograde nailing involves dynamisation.7–9 Dynamisation of the nail is necessary in 19% of patients to achieve union.8 The authors should mention whether they resorted to dynamisation in any patients.
5. Mild knee pain is common after retrograde nailing, with the incidence being 13% to 60%.7,8 The authors should mention how many patients developed postoperative knee pain.

Paritosh Gogna
Pt B.D Sharma, Post Graduate Institute of Medical Sciences, Rohtak, India

REFERENCES
Authors’ reply

1. All patients were referred from other hospitals and both open and closed reduction methods were performed initially. A large gap, over rigidity, and vascular compromise were the probable cause. Locked plates are expensive (US$3000) and not covered by Taiwan’s National Health Insurance. A retrograde traditional locked femoral nail is covered by the National Health Insurance and costs US$30 per patient.

2. Inserting proximal locked screws in the hip area usually requires image intensification, which complicates the operation. Not all retrograde locked nails required plate augmentation for rotational instability; only one third of patients needed augmented plates.

3. A long locked nail was used because it increases mechanical stability (3-point fixation) and decreases the risk of stress fracture in the shaft.

4. All retrograde locked nails were in dynamic mode (without inserting proximal screws).

5. Although mild knee pain has been reported, no intolerable pain was noted in our patients.

Chi-Chuan Wu
Department of Orthopedic Surgery, Chang Gung Memorial Hospital, Chang Gung University, Taoyuan, Taiwan

Local infiltration analgesia versus standard analgesia in total knee arthroplasty

To the Editor:
We read with interest the article by Suthersan et al.1 We would like to discuss our experience:

1. Patients with severe varus/valgus deformity should be excluded, because of their increased analgesic requirement and thus delayed rehabilitation. This could lead to a selection bias and hamper the interpretation of results.

2. There is likely to be an additional reporting bias owing to the inability to blind the 2 groups, as continuous infusion of local infiltration analgesia (LIA) through a catheter would have been clearly differentiable from the other group.

3. The authors used a femoral nerve block (FNB) in 17 of 22 patients in the non-LIA group. 2% of patients who undergo FNB have quadriceps weakness.2 Use of FNB may delay rehabilitation (straight leg raising, range of motion) secondary to quadriceps weakness and confound the results.

4. The mode and number of medications used in the LIA group ranged from a buprenorphine patch, regular paracetamol, codeine, oral celecoxib to oral oxycodone (if required). Moreover, these patients received another injection of bupivacaine, adrenaline, and ketorolac if pain persisted. The rescue medicine for pain in the general group was only oral endone. The variety of drugs used in the LIA groups can confound the results, as the relief of pain may not be solely due to LIA but also the use of a better multi-modal approach than in the general group.

Vipul Vijay, Raju Vaishya, Amit Kumar Agarwal
Indraprastha Apollo Hospital, New Delhi, India

REFERENCES
