To the Editor:

We read with interest the article by Leung and Chow.\(^1\) We consider that the use of a conventional screw as a temporary hold on to the plate is not justified. Instead, locking plates are known to be stabilised (after reduction) with 2 threaded plate holders provided with the AO locking plate system. These holders and drill sleeves can be used to hold the plate across the 2 fracture ends and then the plate can be fixed, drilling across one of the holders.

Bridging plates can be positioned with threaded holders and can be secured more easily by inserting the first locking screw in one fracture end and the second in the other fragment followed by other locking screws. Using a conventional screw to secure the bridging plate after reduction may be difficult in some comminuted fractures. Implants from the upper extremity should be removed after 12 to 18 months.\(^2\) As refracture usually occurs at the old screw tracks, we routinely give external support (plaster of Paris slab) for 2 to 3 weeks.

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To the Editor:

I read with interest the article by Tezeren et al.\(^1\) They concluded that one-stage combined surgery without preoperative traction is effective in the treatment of developmental dislocation of the hip in older children, by virtue of a lower complication rate. However, the method of traction was not described. Divarication traction has been reported to increase the risk of avascular necrosis because of the extreme abduction.\(^2\) The authors further suggested a prospective randomised trial to include a larger number of patients. Is this necessary in view of the current literature reporting favourable outcomes after surgery without preoperative traction?\(^3,4\)

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Acute compression and lengthening by the Ilizarov technique for infected nonunion of the tibia with large bone defects

To the Editor:
I read with pleasure the article by Magadum et al.1 who treated infected nonunion and large bone defects of the tibia with acute compression and lengthening in 27 men. The largest resection was 17 cm. Functional results were excellent in 19 patients and good in 5. Nonetheless, they should have reported the patients’ subjective functional outcomes such as SF-36 scores. Shortening should be evaluated as a percentage of the total length of the tibia. What were the percentage of shortening and the functional outcome of the patient with the largest resection (17 cm)?

We reported 6 patients with type IIIB open tibial fractures treated with primary shortening and limb lengthening.2 The mean shortening was 7.4 (range, 4.5–10.3) cm, which was 18.7% (range, 12.3–29.7%) of the tibia. Functional outcomes according to Puno et al.3 were good in 3 patients, fair in 2, and poor in one. The percentage of shortening in the 2 fair cases was >25%. The median score of physical health summary, mental health summary, and total general health summary based on the SF-36 quality of life questionnaire4 was lower than the standard score in age-matched individuals. We consider that it is difficult to achieve an excellent function and quality of life, especially in patients with shortening of >25% of the tibia.

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