Letter to the Editor
Massive calcaneal enthesopathy in a non-healing leg ulcer: a case report

To the Editor:

The case report by Amaravati et al.[1] is insufficient in many ways. The authors postulated that long-standing infection in the vicinity of the involved ankle is the likely cause of massive spur formation. However, spur formation can be present even in the uninvolved foot, refuting such a hypothesis. Histological examinations have revealed different local factors to be responsible for the formation of these spurs: infracalcaneal spurs may form due to mechanical causes and degeneration in the plantar fascia enthesis. This is akin to peripheral osteophytes around an osteoarthritic joint. Obesity is an additional factor that contributes to an increase in the size of these spurs. Another mechanism of subcalcaneal spur formation in rheumatoid arthritis and spondyloarthropathies is 'reactive ossification' triggered by inflammatory bony erosions. However, the most likely cause of retrocalcaneal spur formation is traction of the Achilles tendon.[2] Diffused idiopathic skeletal hyperostosis could have been strongly considered as a systemic cause of massive spur formation if the authors had specifically looked for the presence of pelvic enthesopathy and calcification and ossification of the anterior longitudinal ligaments.

In addition, the radiograph of the right ankle shows destruction of the ankle and subtalar joints, and there is an osteosclerotic lesion in the body of calcaneum, neither of which were mentioned in the article. It would be interesting to know the cause of destruction and the clinical presentation of the ankle and subtalar joints, the aetiology of the ulcer and, the mobility of the patient. The article does not elaborate the clinical implications, management, or outcome of finding large calcaneal spurs.

Finally, the radiograph also shows fracture of the infracalcaneal spur, which was also omitted by the authors. These fractures are known to heal well with conservative management.[3] In this patient, however, this is likely to be immaterial as he might not be walking with full weight-bearing considering the present status of his ankle and subtalar joints.

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Letter to the Editor
Distal radial fracture treated with minimally invasive procedure

To the Editor:

I read with great pleasure the article by KK Wong et al.[1] Operative treatment is mandatory for distal radial fractures, especially if closed reduction has failed or is inadequate and the treatment goal is to achieve full functional recovery of the wrist. Open reduction and internal fixation is one of the treatment options but has certain disadvantages that affect healing such as infection, nonunion, plate removal, and loss of fracture haematoma. A minimally invasive procedure is a good alternative for the treatment of distal radial fracture. Closed reduction and percutaneous placement of Kirschner wires is a very easy procedure and has the advantages of no blood loss, minimal infection risk, short hospital stay, no loss of fracture haematoma, and no implant removal.

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