Letter to the Editor: Staged Reconstruction of Post-traumatic Medial Malleolus Bone Defects Using Fibular Head Osteochondral Graft: A Report of Two Cases

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To the Editor,

The article by Ramanujapuram and Parameswaran[1] regarding the novel technique for reconstruction of post-traumatic medial malleolar bone defect using fibular head osteochondral graft holds great value in the current management of medial malleolar fractures with bone loss as severe open ankle injuries with soft tissue, as well as bone loss, are a challenging entity for surgeons.

The two case reports included patients with medial malleolar bone loss, initially undergoing plastic intervention and external fixation, eventually undergoing the described operative technique. We request the authors to clarify if any remaining medial malleolar bony fragment is retained or if the whole fragment is excised in the first stage and replaced by the fibular head osteochondral graft in the second stage. Is it advisable to retain any viable fragment, and if any provisional temporary fixation should be done during the course of external fixation?

We would further like the authors to clarify regarding the novel technique. If any special tips can be given for the appropriate excision of the fibular head without damaging the common peroneal nerve and other viable structures during dissection, yet maintaining the integrity of the graft. The authors fail to mention the adequate size of the fibular head to be taken for the adequate outcome and if further graft preparation can be elaborated.

It is mentioned in the article regarding the fixation of the graft with a small fragment cannulated cancellous screw along with a 1.5 mm K-wire. We would ask the authors to clarify if there is any particular rationale behind using the K-wire for the fixation and any particular fixation technique for the graft. It is mentioned in the article that in both cases, the implants were retained till 2 years and then removed after the union. We request the authors to mention if there was any particular rationale regarding this management and if the implants can be removed as soon as the union is achieved.

The first case mentions a diabetic patient and we would like to ask the authors if any specific measures were taken to prevent infection in this high-risk patient during subsequent surgeries, and as mentioned in the first stage, an external fixator along with soft tissue coverage was done; however, is it advisable to carry out simultaneous soft tissue coverage in the first stage in open fracture of a high-risk diabetic patient.

The second case report mentions a patient of neurovascular injury undergoing orthopedic operative management for bone loss in the third stage after 6 months. Are such patients appropriate candidates for such a procedure due to previous neurovascular damage and repetitive operations? The authors have not provided with the skin condition of the patient at the time of follow-up and if any implant prominence in the course of management.

We would like to thank the authors for sharing their novel techniques and experience in the field of open high-velocity ankle injuries, which was worthy of discussion. We eagerly wait for their response in view of a healthy discussion.

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Reference

1. Ramanujapuram S, Parameswaran A. Staged reconstruction of post-traumatic medial malleolus bone defects using fibular head osteochondral graft: a report of two cases. J Foot Ankle Surg Asia-Pacific 2023;10(1):33–37. DOI: 10.5005/jp-journals-10040-1244