Authors' reply

Sir,

Thank you for reading our article with interest.[1] We appreciate your efforts in bringing out certain details[2] which probably would help the readers to understand the article in a more scientific way. However, we would clarify the points which have been raised by you.

In a randomized control trial, prior power analysis is not mandatory to start with. At the start of study, usually it is kept at minimum 80% to calculate the size of samples. But if the sample size seems to be inadequate, power analysis can be done at the end. When this study was planned, more and more patients were opting for hamstring graft rather than bone patellar tendon bonegraft (BTB), so we were not very sure as to how long and what sample size it would take to complete this study. Hence an initial sample size calculation was not performed. Patients who underwent primary anterior cruciate ligament (ACL) reconstruction using BTB were considered in the group. Those who underwent ACL reconstruction by quadrupled hamstring graft were excluded which is understood. The numbers of males and females in the study have been mentioned. Randomization was done approximately for 20 months and not for 4 years. After that point, more patients were demanding hamstring reconstruction, so we had to stop randomization as well as the study. Also, that is why, we have 41 in each group which is not the number calculated by power analysis but by availability of the patients. So, 4 years is the period of study and not the period of randomization. For follow-up, we maintain an excellent electronic arthroscopy database of all patients including their address, phone numbers and e-mail (if any), wherein each patient is followed on regular intervals. The primary purpose of this study was to assess the divergence and not complications of the ACL reconstruction. So, the article was kept brief and it was not mentioned as it would lead to complicated conclusions. We accept that there have been editing mistakes by us at certain places.[3] 6 mm offset should have been 7 mm, as we have mentioned that the femoral tunnel was drilled 7 mm anterior to the posterior wall and drilled upto 9 mm to keep 2-mm-thick wall.[4] There was only one patient and not two who had grade 4 divergence who had IKDC grade B. As far as measurement of laxity is considered, the final IKDC scores are calculated only after anterior drawer and Lachman is measured. It was manually measured in our cases as we did not had KT arthrometer while doing the study, though we have it now. Hence, reporting individual laxity would have been quite subjective and a matter of undue debate. Also, reporting a function is of more value than individual

laxity. Hence, we decided to report final IKDC and Lysholm score than individual laxity. The make of screw was not mentioned; though the diameter was constant, a few times we had to put screws of different companies due to financial constraints of the patients. As rightly pointed, the cadaveric study had been done by Hackl in 2000, but there is no study published in the English literature comparing these two portals on patients. Also, we have reported in our discussion that according to Lemos *et al*.,[4] divergence more than 15° can compromise the fixation, whereas Fulkerson *et al*.[3] reported loss of fixation only if divergence is more than 30°. As most of the time significant divergence happens in saggital plane, we carried out this study to compare the saggital divergence and we ourselves have pointed out this as a major limitation of our study. Though tunnel widening can be seen on anteroposterior X-ray after several months, we did not do this as we had analyzed only immediate postoperative X-rays. For the last comment, this article only compared the screw divergence using anteromedial (AM) or central patellar (CP) portal. We had not taken accessory AM portal into consideration which is indeed a technique used especially when hamstring graft is fixed in femoral tunnel by an interference screw and where there is no patellar tendon defect or making a central patellar portal is not possible. So, we felt it was not worth mentioning the accessory AM portal in our discussion when we were comparing the results of AM and CP portals. We absolutely agree with your comment that drilling from low AM portal and passing screw into femoral tunnel would minimize the divergence, but that was not the aim of article, hence it was not discussed. The article was kept brief, hence missed certain details, so as to keep in focus the real discussion. Finally, we appreciate all your efforts and sincerity in bringing out certain deficiencies in the article.

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