Author's reply

Sir,

We thank the readers[1] for their interest in our article on "Classification of relapse pattern after Ponseti technique".[2]

The most common relapse pattern observed in our series was "dynamic supination" or "grade IB" (30 children) and not grade IIA as stated by the reader.[1] Next, was the loss of ankle dorsiflexion "grade IA" (28 children). This difference is not significant and probably reflects our sample size. Furthermore, our post cast removal protocol included the use of ankle foot orthosis and straight last shoes, which perhaps maintains the ankle in plantigrade position and thus less chance of recurrence of an equinus contracture. Again the numbers are small to confirm this fact. In Ponseti's[3] own series, the role of tibialis anterior tendon transfer in about 65% because of dynamic muscle imbalance indicating that the forefoot supination/inversion remains a problem despite adequate casting.

Second, the reader quoted a paper by Tabrizi *et al.*[4] on "Limited dorsiflexion predisposes to injuries of the ankle in children". The mean age of children in that study was 10.8 and 12 years in two groups respectively. Furthermore, the authors of that paper mentioned in the introduction that "Infants and children have greater flexibility and in neonates the foot can be sometimes dorsiflexed up to the tibia". We are not aware of any studies that have looked at normal range of motion at the ankle in children, but certainly feel that in infants and children the ankle can be dorsiflexed beyond 25°. There may be a natural decrease in dorsiflexion with growth, but we didn't have a control group to study this.

Lastly, the reader mentions the role of casting in relapse cases. We did reintroduce casting in some of our cases, but since most children require some form of sedation to achieve the correction, we preferred to go ahead with surgical correction. We do appreciate that some centers persist with repeated casting and rely on surgery only as the last resort.

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