

Author's reply

Sir,

We appreciate taking interest in our article¹ and raising concerns by Puri and Gulia.² Most of the issues raised are discussed in discussion section.

It is well addressed that the risk of postoperative fracture was more when the lesion had more side to side diameter with more circumferential destruction and endosteal scalloping of the bone; instead of the lesions, which were more longitudinally placed with good thick cortices to tolerate the load and bending forces. We observed that at least two cortices must be preserved to prevent iatrogenic fracture. Whenever more than two cortices in two views are involved, support in the form of plaster slab or brace must be given for 6-8 weeks and delayed weight bearing. If these cortices are thinned out due to curettage one should perform prophylactic internal fixation to prevent the postoperative fracture. Furthermore, the lesions with very little (<5 mm) subchondral bone are not suitable for this procedure as there are chances of joint collapse and intraarticular fracture. Further, we have observed that in the event of peroperative fracture in tumor like lesions (cysts), we have performed the intramedullary fixation and the cavity filled and healed well even without grafting.¹

We fully agree with your observation in regard to the

treatment of giant cell tumor (GCT).³ However, the size and the volume of the lesion do matter as far as the postoperative fracture is concerned. Hirn *et al.* found a strong correlation between risk of postoperative fracture and both the size and volume of the cyst. In their study, the average size of the cysts that fractured postoperatively was 108 cm as compared with 58 cm for the cysts that did not fracture. The risk of fracture was 5% in patients with cysts <60 cm as compared with 17% for those with cysts >60 cm. The risk was 3% when the maximum diameter of the cyst was ≤5 cm, but 15% when the diameter was >5 cm.⁴

In the end, we clarify that it is correct that there should be at least 5 mm (not 5 cm, a typographical/inadvertent mistake) of subchondral bone so that there is no joint collapse and intraarticular fracture.

**Zile Singh Kundu, Vinay Gupta,
Sukhbir Singh Sangwan, Parveen Rana¹**

*Department of Orthopaedics, PGIMS, Rohtak,
1Department of Pathology, Government Medical College for Women,
Khanpur Kalan, Sonapat, Haryana, India*

Address for correspondence: Dr. Zile Singh Kundu,
Department of Orthopaedics, 9J/31, Medical Campus,
PGIMS, Rohtak, Haryana, India.
E-mail: zskundu2003@rediffmail.com

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