Author's reply

Sir,

We are grateful to Vaishya *et al*.[1] for showing keen interest in our article.[2] The response to your comments is as follows:

The results were assessed by parameters as outlined by Rauschning and Lindgren.[3] As all patients did not undergo postoperative magnetic resonance imaging (MRI) due to financial constraints, MRI findings were not used to evaluate the results.

Various studies[4-6] have shown that most of the cases of popliteal cyst are associated with intraarticular pathologies.

Ahn *et al*.[7] have elaborated that the first step in treating a symptomatic popliteal cyst is performing arthroscopic treatment of combined intraarticular lesions causing chronic synovitis. We believe that management of popliteal cyst cannot be done in isolation.

Those cases who had failure of conservative management for 3 months associated with functional compromise (Grade 2 and 3 as per Rauschning and Lindgren[3]) were offered surgical intervention. Grade 1 popliteal cysts and those cases with history of previous surgical intervention in knee were not included in the study.

As this was a retrospective case series, no comparison with the control group was done. We also believe that a prospective, randomized control trial is needed further to validate the results. We agree that a 70° arthroscope is better for visualization of such lesions.

Posteromedial portal was utilized to decompress the opening of cyst; as cysts did not have any septae or loculations, complete evacuation was possible without additional posteromedial cystic portal. However, in cases with intracystic septations, an additional posteromedial cystic portal is often required.[5]

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Conflicts of interest

There are no conflicts of interest.

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