

Author's reply

Sir,

We would like to thank the authors¹ for showing keen interest in our article.² The following explanations will be helpful to clarify their concerns.

Definitely, with the described osteotomy, there will not be injury to the posterior capsule because it is deficient at the lateral third of neck. Lateral ascending cervical artery, which traverses the capsule at posterior trochanteric fossa, usually has more space in adults. It is not adherent to bone at this level of neck. We remove the extra fibrous tissue from the opened up tensile femoral neck surfaces using spine disk forceps, and then, a small wedge of bone is removed from within the trochanter to close the gap and maintain neck shaft realignment. Doing osteotomy in an intact bone may cause damage to the blood vessel, but as the tensile surface is already opened up and the vessels are already stretched, removing the fibrous tissue and a wedge of cancellous bone will reduce stretch and permit enough space to prevent any damage to the blood vessel. None of the patients developed avascular necrosis in this case series, which indicates that probably we could preserve the lateral ascending artery.

This osteotomy will not lead to shortening of the femoral neck and the abductor lever arm. Due to gradually developing varus deformity, the length had already increased. By the osteotomy procedure described, we restore the neck shaft angle by removal of only a triangular wedge of bone from the opened up tensile surface. By keeping the inferomedial trabeculae intact, we maintain the neck length and triangular wedge bone resection from the upper portion of basal neck and trochanter, restoring the neck shaft angle. The figures in the article do not show femur neck length shortening or shortening of abductor lever arm.

The figures (preoperative X-rays) clearly show opening of fracture on the tensile surface of femur neck while there is evidence of union on the inferior side with varus deformity. By removing the fibrous tissue from the opened up femoral neck surface and after removing a small wedge of bone, the bleeding cancellous bone surfaces are exposed. The inferomedial bone is not osteotomized and is kept intact; multiple linear drilling over this bony hinge allows abduction movement to close the opened up femur neck fracture surface.

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