

# **Avoidance of Reamer Breakage During ACL Reconstruction With Flexible Reamer System: Letter to the Editor**

**Dear Editor:**

I read with great attentiveness the article titled “Anterior Cruciate Ligament Reconstruction Using a Flexible Reamer System: Technique and Pitfalls” by Fitzgerald et al,<sup>1</sup> published in July 2015.

It is a perfectly timed article, as surgeons are actually looking to PubMed to know the tips, tricks, and results of the “flexible drilling system for anatomical ACL reconstruction” owing to recent promotion of the Clancy System by Smith & Nephew and the VersiTomc System by Stryker. The authors have rightly described the need to flex the knee to 110°. The article also precisely highlights the potential pitfall of the system: reamer breakage.

However, I differ with this view of the authors: “Using an initial 4.5-mm reamer is often advantageous as it allows for button fixation passage out over the lateral wall of the femur and for accurately measuring the femoral tunnel length. Using a 4.5-mm reamer also allows mobility of the nitinol guide wire and can position the final reamer slightly superior or more toward the [posterolateral] bundle footprint; this is useful if the nitinol guide wire is initially positioned slightly inferior or too close to the [anteromedial] bundle footprint.”<sup>1(p4)</sup>

The 4.5-mm reamer must not be used before the reaming of the proposed femoral tunnel to the desired dimension and desired length, usually by an 8- or 9-mm reamer. To elaborate, the flexible guide wire remains in the femoral

tunnel, binded by the cortex of the lateral femoral condyle and by lateral femoral condylar bone. The initial reamer that we use is determined by the diameter of the graft, usually 8 or 9 mm. This reamer is not blown through and through the lateral femoral condyle, and we usually leave 5 to 10 mm of lateral wall so that the guide wire does not leave its purchase in the bone and does not move with the reamers. This, in turn, allows a reasonable length of flexible guide wire coming out of the medial portal. As well, this leads to a long contact between the flexible guide wire and flexible reamer, thereby decreasing the possibility of reamer breakage. After this step, the 4.5-mm reamer is used so as to allow flipping of the suspensory fixation system that we intend to use.

Additionally, I also differ with the authors’ view of using a fixed 55° tibial guide. The entry point of the tibial guide wire on the anteromedial tibial surface must be the determinant to the tibial guide angle and not vice versa.

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The author declared there are no conflicts of interest in the authorship and publication of this contribution.

## **REFERENCE**

1. Fitzgerald J, Saluan P, Richter DL, Huff N, Schenck RC. Anterior cruciate ligament reconstruction using a flexible reamer system: technique and pitfalls. *Orthop J Sports Med.* 2015;3:2325967115592875.