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LETTER TO THE EDITOR

Reply to "Megaprosthesis in distal femur nonunions in elderly patients—experience from twenty-four cases: a letter to editor"

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Dear Editor,

We read with great interest and appreciate the comments made by Vaishya and Vaish in "Megaprosthesis in distal femur nonunions in elderly patients—experience from twenty-four cases: a letter to editor" with relation to our article [1]. We agree with the authors that orthopaedic surgery has seen a quantum leap in the use of endoprosthesis for non-neoplastic conditions [2, 3]. In elderly patients with distal femur non-union, megaprosthesis has proven to be a useful single-stage solution with favourable outcomes [3, 4].

Nonetheless, we would like to clarify the following points. With reference to the emphasis on this being a major surgical procedure requiring vast surgical expertise and excellent operative facilities, we concur with them that these procedures done in especially elderly patients with multiple co-morbidities would need skilled anaesthetists and also experienced surgeons to minimise intra-operative complications. All cases were performed in our institution which is a level-1 tertiary orthopaedic centre with experienced anaesthetists and also equipped with a critical care unit. We recommend all such surgeries to be performed in highly equipped centres by experienced teams to achieve favourable outcomes.

The authors have differed with us on using megaprosthesis as the management option for patients with one previous failed surgery. The decision to use megaprosthesis was taken on multiple factors. One of the key factors of importance is the amount of distal femoral bone stock available to achieve a stable fixation during revision surgery [5, 6]. This assessment was made pre-operatively and in those cases where bone stock was inadequate, we used megaprosthesis as the treatment option as doing another revision osteosynthesis surgery had higher chances of failure. Using megaprosthesis in elderly patients helped them to weight bear immediately and restored most patients to an acceptable functional status.

Another query raised by the authors was with the rationale behind using different types of prosthesis in our series. We used rotating hinged prosthesis in 21 patients and non-rotating hinged prosthesis in 3 patients. The decision to use this was made mainly in concurrence with the financial affordability of the patient as the non-rotating hinged prosthesis which was indigenously manufactured was significantly cheaper. Literature has shown rotating hinges to perform better [7] when used in such surgery, and wherever possible, we suggest the use of rotating hinged implants.

Compliance with ethical standards The study was performed in accordance with the ethical standards in the 1964 Declaration of Helsinki.

Conflict of interest The authors declare that they have no conflict of interest.

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