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Reply to Ulfin Rethnam's Letter to the Editor entitled "Floating knee injuries: more than meets the eye"

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Dear Editor:

We would like to thank Ulfin Rethnam for appreciating the difficulties involved in the management of the floating knee injury, especially in developing countries where it is further compounded by financial and resource constraints.

Blake and McBryde's [3] classification includes intra-articular fractures. Since all intra-articular fractures were excluded from this study, Bansal et al.'s [2] classification was found to be most appropriate. Bansal et al.'s [2] classification is for "true floating knees" and it brings out the difference in the treatment and prognosis between fractures that involve the shaft and those that are juxta-articular.

We do realise the frequency of ligament injury to the knee [6, 7] with this injury and did assess it both pre- and postoperatively. We documented in our article that there were 10 out of 60 patients with ligament injury to the knee and they were treated accordingly. All patients were monitored for clinical signs of fat embolism; however, none of the patients in this in this series presented with these.

We agree that the best treatment option is intramedullary nailing of both fractures (femur and tibia) as has been reported previously [1, 4–6]. However, when faced with

Bansal [2] Type 1 injury (which involves fractures of the shaft of both the femur and the tibia) in an environment poor in resources, one may consider a combined approach with intramedullary nailing of the femur and functional cast bracing for the tibial shaft fracture, as this provided similar and comparable results to intramedullary nailing of both the femur and the tibia in our study. We suggest the use of internal fixation of both fractures in Bansal [2] Type II and III injuries that include juxta-articular fractures, since cast bracing did not give the desired results, while internal fixation with early joint mobilisation did.

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