Reply to Letter to the Editor

Surgical Technique: Medial Column Arthrodesis in Rigid Spastic Planovalgus Feet

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We thank Dr Fang for his careful review and consideration of our manuscript [1]. For the benefit of patients every debate is welcome in the development of surgical techniques.

Dr Fang questioned whether the technique addresses the hindfoot. The technique we describe reduces from the subtalar joint to the medial cuneiform first metatarsal joint. Therefore, the hindfoot also is corrected. As described in the article, the hindfoot of these patients was in valgus preoperatively and was corrected by the technique. We showed the AP and lateral views of the cases so the reader could view the correction we obtained. We have data for the measurements of all patients (data were not shown). Lateral measurements are much more a reflection of the correction with this technique than the AP angles. If the subtalar joint appears corrected on the lateral view, it will be corrected on the AP view and we reported the subtalar joint was adequately corrected.

The second concern regarding degeneration of the adjacent joints also deserves our attention. Wünschel [2] suggested degenerative disease would occur in adjacent

joints whenever there is a limitation of movement produced by an arthrodesis (although he did not report on such occurrence in his full article) and we agree. Our patients are being followed every 6 months and none has had complaints of pain or any sign of arthritis up to the last followup (ranging from 2.5 to 7.5 years). The transference of pain to the forefoot also was not observed. A study on the followup of our patients in which the issue of arthritic lesions will be addressed is underway.

The third observation regarding hardware points out a “too long screw” observed on the lateral radiograph. As described in our paper, no local complications occurred including skin problems. The long screw observed on the image was observed by our team, but we believed it unnecessary to remove as the patient had no complaints. A second intervention to correct the length of a screw can be a bigger problem in an aligned and pain-free foot. One patient had pain in the plantar surface of the foot, in that case bilaterally, and had the plates removed with resolution of the pain (and a corrected deformity). However, we cannot attribute this pain solely to presumed impingement with soft tissues.

Regarding the insertions of the tendons, the description of the technique shows that the periosteum was retracted together with the tendon insertions. Clearly, the insertions of the plantar tendons are contiguous with the periosteum and they are replaced after the plates are fixed and the wound is closed. Therefore, tendon function is not impaired by the procedure. In this deformity the posterior tibial tendon usually is not working properly. The details regarding function, such as balance, will be discussed in a followup report of these patients.

We are pleased to have the opportunity to further describe details regarding the surgical technique we proposed.

(Re: de Moraes Barros Fucs PM, Svartman C, de Assumpção RM, Yamada HH, Simis SD. Surgical technique: medial column arthrodesis in rigid spastic planovalgus feet. *Clin Orthop Relat Res*. 2011 November 19 [Epub ahead of print])

All ICMJE Conflict of Interest Forms for authors and *Clinical Orthopaedics and Related Research* editors and board members are on file with the publication and can be viewed on request.

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2. Wünschel M. [Arthrodesis of the foot and ankle] [in German]. *Orthopade*. 2011;40:407–414.