REVIEWER'S COMMENT

The authors discuss flexion tear-drop fractures, and describe an innovative way to reduce such fractures. The authors have been successful in reducing seven such cases with this new technique, although it is disappointing that the example of displacement of bone into the canal (Fig. 7) shows only minimal displacement. Overall, however, they report that the average posterior displacement of the inferior corner of the fracture was $4.8 \text{ mm} \pm 1.6 \text{ mm}$. A very specific fracture pattern must be recognised on the CT in order to perform this procedure. An MRI must also be undertaken to identify if there is disc protrusion into the canal. Severe soft tissue disruption of the posterior complex must also be recognised and is a contraindication.

The authors also imply that laminectomy can be performed for neurologically impaired patients. I mention

this only to condemn it as the vast majority of such patients only have anterior cord compression and should not have a laminectomy.

The application of a plate is across two motion segments without the application of a fusion. I presume, therefore, the plate will need to be removed at some stage.

This is an interesting technique but its application is clearly limited to a very specific pattern of a flexion tear-drop type fracture.

Posterior surgery is extensive and uncomfortable for the patient. I am concerned that extruded bone compressing the spinal cord may not be removed by this technique. Anterior corpectomy is well described in this fracture pattern and is relatively easy to undertake with the ability to expose the dura to ensure that bone and soft tissue compression of the dura is obtained. Stabilisation is a relatively easy undertaking.

I am concerned that this paper describes a "technique over reason". The group need to enlarge the number of cases and report on their neurological outcome before this technique is encompassed and accepted by the spinal community.

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