Letter to the Editor

Surgical Technique: Unicondylar Osteoallograft Prosthesis Composite in Tumor Limb Salvage Surgery

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To the Editor:

We read with great interest the article, “Surgical Technique: Unicondylar Osteoallograft Prosthesis Composite in Tumor Limb Salvage Surgery” by Fan et al. [4]. We thank them for sharing their experience; however, we have some concerns.

The method using an osteoarticular allograft with a prosthetic composite is not new and has been discussed in a much larger series before [3]. We agree with Fan et al. that the described technique using a unicondylar osteoallograft prosthesis composite has not been described before. However, even if their article [4] is only a technical note, we think that the success of this method is not proven by the published short-term results. To exclude intermediate- and long-term complications (such as mechanical failure), a larger patient number with a longer followup is necessary.

We also are concerned about the high number of local recurrences in this case series. Analyzing the subgroups,

there is a local recurrence rate of 33% in patients with high-grade sarcoma (osteosarcoma and Ewing sarcoma). This is unacceptably high if a wide tumor resection, as described by Fan et al., was performed. This should have been discussed. Furthermore, we question the treatment of patients with recurrent Ewing sarcoma as shown in Fig. 1 in their article [4]. From our point of view, the knee was contaminated owing to the previous transarticular curettage of the tumor. Accordingly, we would recommend an extraarticular knee resection in this case or at least adjuvant radiotherapy. It should have been stated clearly in the Discussion section of the article that the described method is not a standard treatment option. Fan et al. should have explained why this method was used instead of using more standard treatment approaches (... all potentially contaminated tissues... should be removed en bloc with the specimen.”).

Moreover, the grading of the one chondrosarcoma in the series is missing. If this was a Grade 1 chondrosarcoma, the preferred treatment would have been curettage and cementation, especially in a small tumor that is confined to one femur condyle [6]. Therefore, Fan et al. should have explained why the current method was used.

Finally, we are surprised regarding the high number of giant cell tumors (GCT, n = 5) they treated by wide or marginal resection. We do not believe that patients with GCT, even with a pathologic fracture, have to be treated in such an aggressive way. Large studies have shown that curettage and cementation is the preferred treatment [2, 5], and even in recurrent disease additional curettage and cementation should be performed [1, 7]. Extensive surgery for the primary tumor in an attempt to obtain wide margins is not the preferred method, as it leaves the patient with higher morbidity with no significant gain with respect to cure of the disease. We believe, in particular, that the

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patient whose tumor was shown in Fig. 5A and B should not have been treated with the approach advocated by the authors, as this could result in others using this approach for such a tumor, with possible fatal consequences for the patient

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