Letter to the Editor

Prophylactic Stabilization For Bone Metastases, Myeloma, or Lymphoma: Do We Need to Protect the Entire Bone?

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To the Editor:

We read the article by Alvi and Damron regarding the need for prophylactic stabilization of the whole bone in bone metastases, myeloma and lymphoma [1] with interest. It has long been stated that the whole bone should be protected, although there is unease regarding the cardiopulmonary risks of prophylactic intramedullary fixation [2, 4, 5].

We believe the article raises some important points that the main feature was not required to emphasize.

We previously reported on two patients who had new metastases develop at the tip of an intramedullary nail. The nail subsequently fractured, resulting in complex revision surgery [3]. These would represent Type 3 lesions in the classification by Alvi and Damron.

(Re: Alvi HM, Damron TA. Prophylactic stabilization for bone metastases, myeloma, or lymphoma: do we need to protect the entire bone? *Clin Orthop Relat Res.* 2013;471:706–714.)

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We believe there are two points that require additional emphasis. First, the article only briefly mentioned the role of radiotherapy. We strongly believe that patients with a tumor not removed en bloc should have radiotherapy, especially in radiosensitive tumors such as lymphoma and myeloma. Preoperative irradiation of a lesion is sufficient, unless there is clear evidence that the tumor is growing despite radiotherapy. If the radiotherapy is postoperative, the whole bone should be irradiated, as there would be seeding throughout the medullary cavity.

Second, an orthopaedic surgeon followed up clinically and radiographically all patients, enabling detection of disease progression or impending implant failure. This allowed for early intervention, which hopefully reduces morbidity. This approach is essential to the management of metastatic lesions, although it often is neglected.

We congratulate Alvi and Damron on their thought-provoking paper.

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