Reply to the Letter to the Editor

Mid-America Orthopaedic Association Physician in Training Award: Surgical Technique: Pediatric Supracondylar Humerus Fractures: A Technique to Aid Closed Reduction

Mary A. Herzog MD, Shelley M. Oliver MD,
James R. Ringler MD, Clifford B. Jones MD, FACS,
Debra L. Sietsema PhD

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To the Editor:

I appreciate the exuberant and detailed response by Ozkaya and colleagues. Additionally, I appreciate the reference to their prior published “joy-stick” technique [3]. Finding more options and techniques to improve supracondylar humeral fracture care is to be encouraged [1].

First, the authors claim that the lateral to medial K-wire insertion below the level of the deltoid insertion is safer than our posterior to anterior Schantz pin distal triceps insertion. We believe that our technique is actually safer than theirs. Since the radial nerve courses from proximal to distal and ulnar, to radial distal, to the deltoid muscle, and anterior to the triceps muscle, their technique could jeopardize injury to

the radial nerve more than our technique, which does not jeopardize any potential neural structures [2]. Posteriorly, we have the least risky pin insertion site. We had no clinical injury to the triceps integrity or function. In fact, percutaneous insertion of a pin through the deltoid or triceps has the same effect. We agree that more distal pin insertion allows for greater control of the diaphyseal segment and overall reduction quality. We disagree that these fractures do not require “tremendous effort,” since some fractures require extensive control of translation, rotation, flexion/extension, and length.

Secondly, we had not experienced any problems utilizing 2.5 mm terminally threaded Schantz pins. In fact, the 2.5 mm size is perfectly situated between the 2 mm and 3 mm pins utilized by Parmaksizoglu and colleagues [3]. Additionally, the terminal thread prevents translation and anterior protrusion versus a smooth pin. We have not had any problems such as iatrogenic fractures, ectopic bone, or callus formation from our 2.5 mm pin technique.

The one patient that had an open technique had impalement of distal humerus within the brachialis that did not get “milked out” or disengaged. We are sorry that we did not elaborate further with this example in the original article.

Again, we would like to thank the *CORR*® journal for publishing our technique and Ozkaya et al. for continuing an important dialogue regarding treatment of the patients whom we treat.

(Re: Herzog MA, Oliver SM, Ringler JR, Jones CB, Sietsema DL. Mid-America Orthopaedic Association Physician in Training Award: Surgical Technique: Pediatric Supracondylar Humerus Fractures: A Technique to Aid Closed Reduction. *Clin Orthop Relat Res*. 2013;471:1419–1426.)

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M. A. Herzog, S. M. Oliver
Grand Rapids Medical Education Partners/Michigan State
University Orthopaedic Surgery, Grand Rapids, MI, USA

J. R. Ringler, C. B. Jones, D. L. Sietsema (✉)
Orthopaedic Associates of Michigan, Michigan State University,
230 Michigan St. NE, Grand Rapids, MI 49503, USA
e-mail: debra.sietsema@oamichigan.com

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