inferior parts (diamond-shaped cross section). Considering the neck cross section as roughly circular, the probability of neck perforation is same for both screw configurations. As pointed out in our earlier reply to the editor's letter, DC screw fixation may require more orientation and three-dimensional conceptualization of the neck as three screws will be always seen in AP and lateral image intensifier images (i.e., overcrowding of screws in two-dimensional pictures).

In our case series of 64 patients, 14 patients had posterior comminution. Many comminutions were not visualized in the initial routine radiographs, but were seen in the image intensifier lateral view at the time of surgery. A preoperative CT scan may help to identify the comminuted fractures and make a better plan. However, we have not done CT scan in our patients. The surgical management of FNF with comminution does not differ significantly as we do four screw fixation in all cases irrespective of the comminution. However, few precautions need to be taken in those cases.

Since generally surgeons consider screw fixation as the first choice for FNFs in younger patients, we have not included them in our study. The study has included patients aged 50 years or more to specifically emphasize the point that screw fixation can be successful in this age group also. Nevertheless, FQPP can be done in younger patients with good outcome.

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Author's reply

Sir,

We thank the readers¹ for showing interest in our article titled "Four quadrant parallel peripheral screw fixation for displaced femoral neck fractures in elderly patients".²

Four screw parallel fixation, done either in rectangular or diamond configuration (DC), theoretically occupies same area inside the head and neck of femur. Hence, it should provide same degree of stability in a given case of femoral neck fracture (FNF). We presume the authors have used the term "skimming the calcar" for "compression" at the fracture site. In four quadrant parallel peripheral (FQPP) screw fixation, maximal compression is achieved by the first inferior screw which is placed either anteriorly or posteriorly depending on the opening at the fracture site. Other screws will subsequently provide more fixation and close the fracture gap. We presume the term "perforation of neck" means inadvertent entry of screw through the neck cortices. The chances of neck perforation may be more with FQPP than with DC if the neck has a wider cross section in the central part and narrower superior and

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