Authors' reply

Sir,

We thank the authors of the letter¹ for the interest shown in our paper.² I would like to address the issues raised. After the proximal broken nail segment is removed, the intramedullary canal is widened with a rigid reamer. The guide wire is passed through this rigid reamer with better manual control to aim the wire into the distal broken segment. The rigid reamer can also function as a joy stick either to align to the broken metal piece or to push the piece down till it reaches the subchondral bone.

The presence of an intramedullary nail, albeit a broken one, prevents excessive angulations at the non-union site. If they are present, these displacements need to be corrected by manipulation aided with axial traction, after the proximal broken nail is extracted, before attempting to ream across.

The illustration in the published article is not about the broken nail, but is about a broken intramedullary reamer, a complication that occasionally surfaces. Unfortunately, the reaming procedure was being performed over a plain guide wire instead of a conventional ball-tipped guide wire. This illustration was chosen as we felt that the images best served to demonstrate the technique described. However, the authors have resubmitted more images which show the technique in application for a broken nail segment [Figure 1].

The study was prospective. This new technique was devised when a few other techniques described in the literature failed to retrieve the broken nail. The technique was then implemented in the rest of the cases electively and the results were analyzed. The procedure is only an alternative to the various other described techniques for extraction of broken intramedullary nail, and hence ethical committee approval was not deemed necessary for

Figure 1: Fluoroscopy image showing (a) the broken nail segment and guide wire exiting in the knee joint at the desired point (b) picture of broken nail segment and 5 mm cannulated drill passed over the guide wire (c) the broken nail segment and the ball-tipped guide wire passed up from below

describing a technique that is only a part of the exchange nailing procedure. However, the patients consented for the additional intervention that may be required in the initial part of the exchange nailing.

As clearly mentioned in the paper, only a subjective knee disability assessment monitoring the knee pain and range of motion was used. Objective validated scoring systems were not used to assess the knee function. With such a small series of eight patients, relevant statistical analysis would not be meaningful and would only add to the mathematical content of the paper. Hence, this was not attempted.

The 5 mm cannulated drill bit from ACL reconstruction set was used to create the tibial tunnel over a guide wire. It is marketed as "Endoscopic Cannulated Reamer," product Code 1405, HIB Company, Mumbai, India. The standard long, plain, interlocking nail guide wire is 2.5 mm in diameter and is manufactured by Sharma Surgical and Engg. (P) Ltd.

We are thankful for the interest shown in our paper.

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