Author's reply

Sir,

We thank the authors¹ for showing keen interest in our paper.² We would like to address the issues raised.

Condyle fracture of femur starts from trochlear condylar groove at the junction between trochlea and the medial and the lateral condyles (type B1 and B2 – AO classification).³ Starting from this site fracture line may be frontal, sagittal or oblique.³ Hence, critical point for diagnosing condyle fracture is extension of fracture line to trochlear condylar groove. Hoffa fracture is coronally oriented fracture of femoral condyle where trochlear condylar groove is intact. In our case, we found fracture in an oblique plane in which trochlear condylar groove was found intact and fracture separated patellofemoral joint from tibiofemoral joint (type B3 fractures – AO classification).⁴ Hence, we considered it as a Hoffa's fracture. Present literature offers paucity of information regarding such type of oblique fracture of femoral condyle.

Rigid fixation of the fracture can be achieved by optimally positioning the screw perpendicular to fracture line.⁴ Hoffa's fracture in our case (oblique fracture line) was in an oblique plane extending from anterolateral to posteromedial. Hence, to achieve rigid fixation screws were fixed perpendicular to fracture line. Present literature supports various methods of fixation for Hoffa fracture.⁵ Jarit *et al.* showed fixation with 6.5 mm partially threaded screws from posterior to anterior was more stable.⁶ In our case, we fixed fracture posterior to anterior with 6.5 mm partially threaded screws.

Vertical patellar dislocations even in isolation are difficult to reduce by closed maneuvers. Our case had Hoffa's fracture

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with incarceration of patella hence we did not attempt any closed reduction. Avulsion fracture was not seen in preoperative radiographs and computed tomography scan. Hence, we believe that it could be calcification at quadriceps attachment to patella.

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