Classification of relapse pattern in clubfoot treated with Ponseti technique

Sir,

We read with interest the article "Classification of relapse pattern in clubfoot treated with Ponseti technique".[1] We congratulate the authors for the simplified and useful classification of relapses and its management protocol.[1] However, these are the few issues we want to discuss.

First of all, the most common pattern noted in this series was grade IIA or dynamic supination.[1] This is in contrast to Ponseti, who noted hind foot relapse or limitation of ankle dorsiflexion as the most common relapse pattern.[2] Secondly, authors have considered ankle dorsiflexion <15° with knee in extension as grade IA relapse, whereas Ponseti aimed at 15° ankle dorsiflexion with the knee in flexion as the correction.[2] Furthermore, in an evaluation of 85 normal feet in children, Tabrizi *et al*. found that, the mean ankle dorsiflexion was 12.8° with knees in extension and 21.5° with knees in flexion.[3] Hence, it is practically difficult to achieve >15° ankle dorsiflexion with the knee extended in a previously treated clubfoot.

Thirdly, authors have discussed surgical options for grades IB, IIA, IIB, and III relapses, but have failed to mention the role of repeat serial casting in the treatment of relapse after Ponseti correction. Serial manipulation and casting has been a very effective method in relapses, especially in supple feet. It can also be useful in relapse with rigid feet where it can help by increasing the flexibility of the foot, thus minimizing the amount of soft tissue release needed during the surgical correction of the deformity.[2,4]

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