In Reply:

We thank the authors1 for their interest in our recently reported article2 although we believe that their judgment of our diagnosis as inaccurate is both extreme and unfair.

We agree with the authors that terrible triad injury of the elbow is described as a posterior dislocation of the joint with fractures of the radial head and coronoid process.3 Concerning the first case, we emphasized that the child underwent a terrible triad injury combined with an olecranon fracture. This case cannot be classified as a transolecranon fracture dislocation as the authors suggest, for the simple reason that the entity of transolecranon fracture dislocation consists of an olecranon fracture and an anterior elbow dislocation,4–6 in contrast to the posterior dislocation of our first patient.

Regarding our second case, the initial radiographs depicting elbow dislocation that were obtained in the emergency department by mini c-arm fluoroscopy were not saved, and additional imaging with magnetic resonance was not performed. Although we agree with the authors that the postreduction preoperative radiograph does not depict dislocation, the coronoid fracture cannot be definitely excluded. Obviously, owing to the large cartilaginous component of the coronoid process these fractures are not clearly visible. The coronoid process looked similar in the preoperative lateral radiographs of both our cases, although in our first case a much larger, type 2 fracture was found and depicted intraoperatively whereas a smaller, type 1 fracture was found in the second case and fixed with pullout sutures. Thus, the concomitant presence of posterior dislocation of the elbow with fractures of the radial head and coronoid process in our second case also allows the classification of this injury as a terrible triad elbow fracture dislocation.

Finally, although we agree that avulsion fractures are expected injuries in children, the presence of avulsed ligaments in both of our cases and in other series in the literature7 suggests that elbow fracture-dislocations with concomitant ligamentous injuries are also possible in children.

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REFERENCES


Avoiding the V-V Flap When Performing an Atasoy V-Y Flap

To the Editor:

We read with interest the excellent review article on “Local and regional flaps for hand coverage” by Biswas et al.1 The authors described the use of the Atasoy V-Y flap for transverse amputations of the fingertip. This flap provides durable skin coverage to exposed distal phalanx and preserves digital length. However, sometimes little advancement can be gained with the Atasoy flap, and in many cases when patients are followed up in a clinic, a V-V scar is noted on the fingertip rather than a V-Y scar. This makes many surgeons reluctant to perform this local flap, as they feel substantial advancement is not feasible.

We would like to make a comment about dividing the fibrous septa. Although the authors have discussed the division of fibrous septa, there is potential for incomplete division of the septa and the inability to distinguish between small vessels and fibrous septa.

To perform a sufficient division of the septa, the spreading action of tenotomy scissors can delineate these


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We would like to make a comment about dividing the fibrous septa. Although the authors have discussed the division of fibrous septa, there is potential for incomplete division of the septa and the inability to distinguish between small vessels and fibrous septa.

To perform a sufficient division of the septa, the spreading action of tenotomy scissors can delineate these
structures. The 2 structures differ in consistency when stretched. The fine vessels are elastic and relatively robust when responding to stretch and can be readily identified under 2.5× loupe magnification. Once all the septa are divided, substantial “give” can be achieved that allows sufficient advancement of the flap and its elevation and release from the flexor tendon sheath. We also sometimes allow the donor site to heal by secondary intention and do not close with multiple sutures.2

We believe that sutures should be kept to a minimum and tight repair should be avoided to prevent flap ischemia. We found that these flaps can be advanced safely up to 10 mm following these steps while maintaining flap vascularity.

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REFERENCES

In Reply:

We thank the authors for the technical points about division of the fibrous septa. We agree that, with a gentle spread, a palpable difference in tautness can be appreciated between the septa and the neurovascular structures. We would also emphasize their point that release of the flap dorsally from the distal phalanx and flexor tendon sheath is critical in achieving advancement.

We also agree with leaving the donor site, or the vertical limb of the Y, open for healing by secondary intention. This limits the risk of compromising the blood supply to the flap, which typically heals rapidly by secondary intention.

Patients must be aware that, even with all attempts at preserving the neurovascular attachments to the flap, many will have slightly altered 2-point discrimination. Hypersensitivity and cold intolerance are also not uncommon.1–3

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REFERENCES

Letter Regarding “The Relationship of the Superficial Radial Nerve and Its Branch to the Thumb to the First Extensor Compartment”

To the Editor:

I have reviewed the article by Gurses et al1 with great interest, and I duly note the importance of the atomic relationships. However, I am concerned that this article might perpetuate a response that I frequently hear as I interact with fellows and residents concerning innervation along the radial aspect of the forearm, wrist, and dorsal hand. Specifically, there is an absence of reference to the lateral antebrachial cutaneous nerve and the potential for involvement of this nerve during approaches in the areas that the authors discuss.

In their 1985 article in the Journal of Hand Surgery, Mackinnon and Dellen2 noted significant overlap of the lateral antebrachial cutaneous nerve and the superficial branch of the radial nerve. As I point out to the residents, in the distal third of the forearm the dorsal sensory nerve does not emerge until approximately 8 cm proximal to the radial styloid, where it begins a superficial course after exiting between the brachioradialis and the extensor carpi radialis longus. Therefore, the lateral antebrachial cutaneous nerve can overlap and be more superficial than the dorsal radial sensory nerve.

I do not want to minimize the importance of the article by Gurses et al1 but I believe that the presence of the lateral antebrachial cutaneous nerve and its potential involvement in incisions should be acknowledged because it needs to be respected during surgical procedures. Thank you for your time and attention.