LETTER TO THE EDITOR


We were very interested by the article by Fouilleron et al. The authors demonstrated that, in case of strong lateral tibial torsion, tibial derotation osteotomy almost systematically relieves painful patella-femoral disorder.

The osteotomy action mechanism they suggested is that ‘’derotation corrects the bayonet shaped malalignment by recentering the patella, so that the tuberosity is anatomically repositioned, thereby improving the Q angle’’. It is unfortunate that postoperative AT-TG, which could have objectively assessed tibial tuberosity repositioning, was not measured and correlated to the trochlear opening angle and degree of trochlear edge protrusion: we thought that the quality of results at 4 years’ FU (2—6 years) for simple medial anterior tibial tuberosity transposition depended on these correlations [1].

It is moreover not sure that tibial derotation underlies the improvement in painful patella-femoral disorder seen at 4.5 years: para-articular osteotomies improve arthropathic pain even when they do not correct the mechanical disorder. This is true of the hip (MacMurray osteotomy), the shoulder and the knee (Benjamin double osteotomy). In the knee, para-articular double femoral-tibial Benjamin osteotomy relieves the pain associated with osteoarthritis of the knee in four cases out of five, and even that associated with rheumatoid arthritis, over a 4—8-year period [2]. Likewise, tibial valgus osteotomies that have failed to fulfill the biomechanical prerequisites still obtain pain relief in medial knee osteoarthritis for an average of 7 years [3].

Finally, the possibility of associating derotation to frontal realignment to prevent osteoarthritic medial tibiofemoral degradation due to the medialization of the tibial tuberosity in varus knee, may not be a sufficient argument for tibial osteotomy in young adult patients. Moreover, it is not sure that the frontal normalization advocated by the authors is in fact the ideal correction: post-osteotomy stability in medial knee osteoarthritis seemed to us to depend on the twin factors of tibiofemoral torsion index and postoperative frontal mechanical axis. With the mean postoperative tibiofemoral index of −10.8° reported in the series presented here, the ideal frontal axis to ensure radiologic knee joint stability and prolonged functional lifetime for the operated knee should be 174° rather than 179° [4].

It would, therefore, be especially interesting to know the functionality, radiologic tibiofemoral and femoropatellar evolution and AT-TG values for the operated knees at a minimum of 10 years’ follow-up.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

References


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