Letter to the editor

- the diagnosis of aseptic arthritis was made by elimination. It was not possible to confirm this diagnosis based on histological results, except for the appearance and contents of the intraarticular fluid. The appearance of the joint during arthroscopy corresponded exactly to the cases of aseptic arthritis described in the literature;
- the diagnosis of septic arthritis was excluded based on the absence of specific germs, the complete cure and the lack of recurrence following lavage, arthroscopic synovectomy and the associated discontinuation of antibiotic treatment. The search for rare, slow growing germs was systematically performed and was negative;
- this was indeed our hypothesis because it was the only point where the foreign body can theoretically be in prolonged contact with the knee joint cavity. However, all perioperative measures to prevent contact are clearly explained in the surgical technique, and we must insist upon the importance of rigorously applying these measures;
- because there is no classification for foreign body induced aseptic arthritis, this was recommended by the reviewers;
- you are correct to emphasize this point again as it is the main unknown element in this report. Indeed, the physiopathology and the natural history of aseptic arthritis due to a foreign body such as PET but also Dacron or others has not been clearly explained clinically, biologically in the literature. Nevertheless, it seems to be cured by lavage and arthroscopic anterior synovectomy, with no recurrence. Hypotheses to explain this phenomenon include as you suggested, initial physical rehabilitation that is too intensive or insufficient lavage at the end of the surgical procedure. On the other hand we do not believe that impingement with the lateral femoral notch, which is more prone to result in painful flexion contracture, could cause this type of inflammatory reaction because only the native part of the graft can be found in this part. The PET strip is totally buried in the bone, except at the extracortical end of the femoral tunnel, which may be in contact with the synovial membrane if the tunnel is too anterior and distal and if the strip is not cut absolutely flush with the femur.

In conclusion, we would like to thank you for your remarks, which have allowed us to confirm the following points of our case report:

- the diagnosis of aseptic arthritis is based on elimination in the absence of identifiable germs and when a complete cure can be obtained by arthroscopic anterior synovectomy. Management sometimes requires empirical antibiotic treatment while waiting for results of bacteriological tests;
- although the role of PET could not be absolutely confirmed, it is our main hypothesis based on prior publications, and can in any case be prevented by closely following the surgical technique. In particular, the correct implantation and direction of the tunnels is essential (especially the femoral tunnel) the extra-articular strips must be carefully cut on the extracortical end of the femoral tunnel (arthroscopic control can provide assistance with this), and thorough lavage must be performed at the end of the procedure to remove potential articular debris;
- by following these measures we have not had any other cases since, and we continue to use the TLS technique for ACL reconstruction, which, it should be remembered, has biological and mechanical advantages (preservation of tendon stock, quality of primary fixation and secondary integration "all inside").

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