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Letter to Editor

Ashraf Ahmad Khanfour

Professor Orthopaedic Surgeon

Chairman of Trauma & Orthopaedic Surgery; Chief of Limb Lengthening & Reconstruction and Paediatric Orthopaedics; Damanhour Medical National Institute (DMNI), Egypt.

Dear Professor Marc Swiontkowski; Chief editor of JBJS, Greetings and happy new year.

I have read a recently published paper entitled [Original and Modified Lapidus Procedures Proposals for a New Terminology] in December 3, 2020 in this great journal.

It is a very interesting paper that touched & try to herald solving a very big problem in medicine in general and Orthopaedics in particular, which is “Misnomers & fostering eponyms”

The preciousness of this paper together with its smart idea let me eager to postulate a commentary on it that may be of value increasing its informative content:

Great thanks for the authors who sufficiently declaring the eponyms of “Lapidus procedure” subcategories regarding its:

1. The extend of the arthrodesis at the 1st TMT.
2. The addition of an adjunctive distal lateral ST Procedures.

But unfortunately, they missed addressing important issues which became nowadays a break through revolution in TMT fusion in Hallux valgus surgical correction. These are (1-7) :

1. The most important revolution was 3-D correction of the 1st metatarsal [Where the 1st ray pronation rotational deformity is considered now as the basic deformity element that must be addressed] in addition to the known transverse & sagittal plan deformities. This was not considered at all in the old literature and became now an essential consideration that must not be ignored.
2. +/- Adjunctive medial excistectomy & medial capsular reefing.
3. +/- Grafting (to avoid 1st ray shortening)

4. Schematic classification of hardware fixations.

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Article Author Response

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Article Author(s) to Letter Writer(s)

Dear Editor,

We would like to thank Professor Khanfour for his interest in our study and useful comments. The author has raised some valid points, which need to be addressed.

Indeed, the evolution of our understanding in hallux valgus pathology has led to an increased awareness of the rotational element of the deformity. Among other techniques, the arthrodesis of the first tarsometatarsal (TMT) joint offers the surgeon the option to correct the rotational deformity intraoperatively. The impact of this on the clinical outcome is expected to be demonstrated in future

studies.

With regards to exostectomy and capsular reefing, most authors would include it to a standard first TMT fusion in the correction of a hallux valgus deformity. Therefore, its inclusion to a classification scheme may prove to be redundant.

On the other hand, grafting has not been a constant part of the procedure by all surgeons, according to its description in previous publications. Therefore, a detailed terminology which would incorporate all subtypes of the procedure would also include the variant of grafting use.

Nevertheless, the success and widespread use of any given classification system lies in both its clarity and its simplicity. Hopefully, the recently described new terminology for TMT arthrodesis procedures fulfills both these tasks. In the future, researchers may agree to add a capital “R” in each type, denoting the derotational element of the technique. Again, a capital “G” could refer to the use of bone graft and, if deemed useful, a capital “E” for exostectomy and capsular reefing. For the time being though, we feel that such complexity would not add to the value and general acceptance of our proposed classification.

Finally, as clarified in our figure legends, the lines do not represent the only, or the suggested means of internal fixation. The wide spectrum of the implants in use, including screws, staples, and plates, along with their different design and mechanical properties, renders it difficult to incorporate them in a meaningful, yet simple, schematic classification. Besides, such an incorporation may not even be necessary as long as all hardware essentially serves the same task, namely to provide adequate mechanical stability.

We hope that this response addresses all issues raised by Professor Khanfour. Once again, we would like to thank him for his contribution.

Yours sincerely,

Panos Symeonidis