Correspondence

We welcome letters to the Editor concerning articles which have recently been published. Such letters will be subject to the usual stages of selection and editing; where appropriate the authors of the original article will be offered the opportunity to reply.

Letters should normally be under 300 words in length, *double-spaced throughout,* signed by all authors and fully referenced. The edited version will be returned for approval before publication.

Fractures of the distal radius treated by internal fixation and early function

Sir,

We read with interest the article by Jakob, Rikli and Regazzoni[1] in the April 2000 issue entitled 'Fractures of the distal radius treated by internal fixation and early function'.

This is a promising technique based on the three-column concept of the distal radius and ulna affording stable fixation and allowing early function. It is rather disturbing to note, however, that further surgery was undertaken in 21 wrists (almost 30%) for various reasons which include rupture of the extensor tendon, extensor tendonitis and secondary displacement of the fracture. This is a high percentage and we would like to know how the authors can justify the use of this technique especially in the elderly patient.

Despite what is described as stable fixation, a loss of radial length of up to 4 mm and an increase in palmar tilt of up to 14° are reported. Carter, Frederick and Loseter[2] reported a loss of radial length of less than 3 mm and an increase in palmar tilt of less than 10° with the use of a single low-profile plate in a multicentre study. It would seem that the double-plating technique offers no advantage in terms of stability and adds more complications.

Finally, we would have liked to see a correlation between the outcome at one year and the corresponding type of fracture (Müller classification).

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1. **Jakob M, Rikli DA, Regazzoni P.** Fractures of the distal radius treated by internal fixation and early function: a prospective study of 73 consecutive patients. *J Bone Joint Surg [Br]* 2000;82-B:340-4.
2. **Carter PC, Frederick HA, Loseter GF.** Open reduction and internal fixation of unstable distal radius fractures with a low profile plate: a multicentre study of 73 fractures. *J Hand Surg* 1998;23-A:300-7.

Author's reply:

Sir,

We introduced the double-plating technique for internal fixation of distal fractures of the radius in 1993 and published a preliminary report on a small series in 1996.[1] The technique has undergone biomechanical testing, which confirms the mechanical stability of the construct.[2] Encouraged by the promising results, we used the technique more widely in patients in a prospective protocol, which is the subject of this paper. During the course of the series we encountered major complications because of technical errors (i.e., cut plate ends and incorrect placement of the dorsoradial plate). We felt a strong obligation to describe these complications in order to avoid repetition of these errors.

Of the 21 reoperations, five were due to cut plate edges and four to incorrect placement of the dorsoradial plate. Four revisions were caused by extreme distal placement of the dorso-ulnar plate because of the configuration of the fracture, which is probably encountered in other techniques. Five patients requested removal of the plate without specific symptoms; only three removals were due to irritation of the tendon. If we do not count the technical errors and the removal of the plates, we had a total of seven revisions which compares favourably with other reports.[3,4]

We observed a mean loss of radial length of 1 mm and an increase in palmar tilt of 1.7°, which is in accordance with the experience of Carter et al.[3] We therefore modified our design of plate and are now using one with locked distal screws to avoid this complication.

We do not claim that our technique is the sole solution to an unsolved clinical problem, but we have found it to be reliable in the management of these difficult fractures.

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1. **Rikli DA, Regazzoni P.** Fractures of the distal end of the radius treated by internal fixation and early function: a preliminary report of 20 cases. *J Bone Joint Surg [Br]* 1996;78-B:588-92.
2. **Peine R, Rikli D, Hoffmann R, Duda G, Regazzoni P.** Compression of three different plating techniques for the dorsum of the distal radius. *J Hand Surg [Am]* 2000;25-A:29-33.
3. **Carter PC, Frederick HA, Loseter GF.** Open reduction and internal fixation of unstable distal radius fractures with a low profile plate: a multicenter study of 73 fractures. *J Hand Surg* 1998;23-A:300-7.
4. **Ring D, Jupiter JB, Brennwald J, Büchler U, Hastings HII.** Prospective multicenter trial of a plate for dorsal fixation of distal radius fractures. *J Hand Surg [Am]* 1997;22-A:777-84.

The Stanmore total hip replacement

Sir,

I read with interest the paper by Gerritsma-Bleeker et al.[1] entitled 'The Stanmore total hip replacement' in the January 2000 issue.

In their discussion the authors state that "The longer the observation time, the more important the amount of polyethylene wear becomes", but they do not quantify the wear in their series, simply commenting that "At 22 years, eight of the 20 prostheses (40%) showed signs of wear".

The legend accompanying Figure 3b states that "no wear is seen", but there does appear to be obvious radiological penetration. The legend accompanying Figure 5b also states that "there are no signs of wear," but the actual radiological projection of the cup in this particular case makes accurate assessment of wear impossible.

0301-620X/00/811636 $2.00
J Bone Joint Surg [Br] 2000;82-B:1204-7.