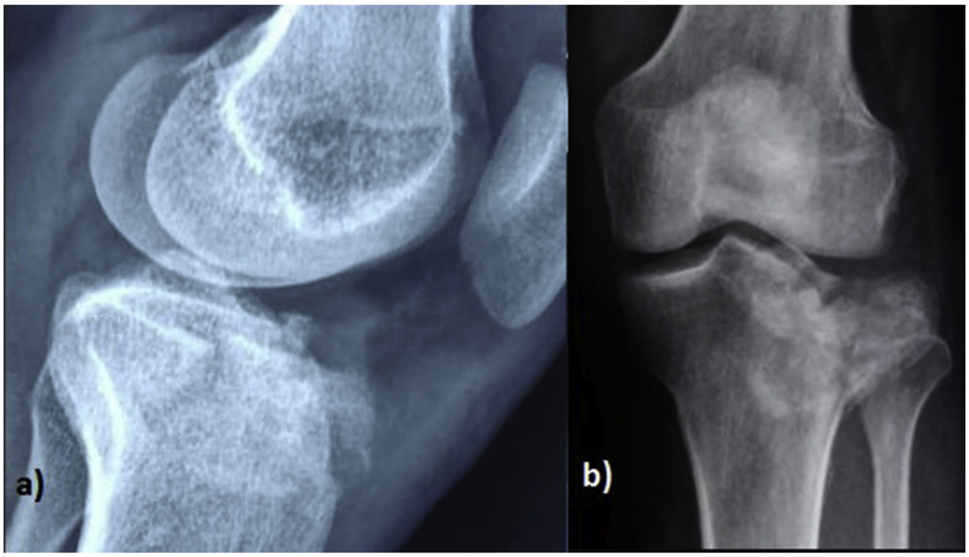

Fig. 2. Two visibly different injuries with regard to the extent of comminution, affecting medial condyle on right and lateral condyle on left. Beacuse of lack of comminution related data both will be called as "mildly comminuted" with TPII = 3 (2 points for 2 segments and 1 point for one column).

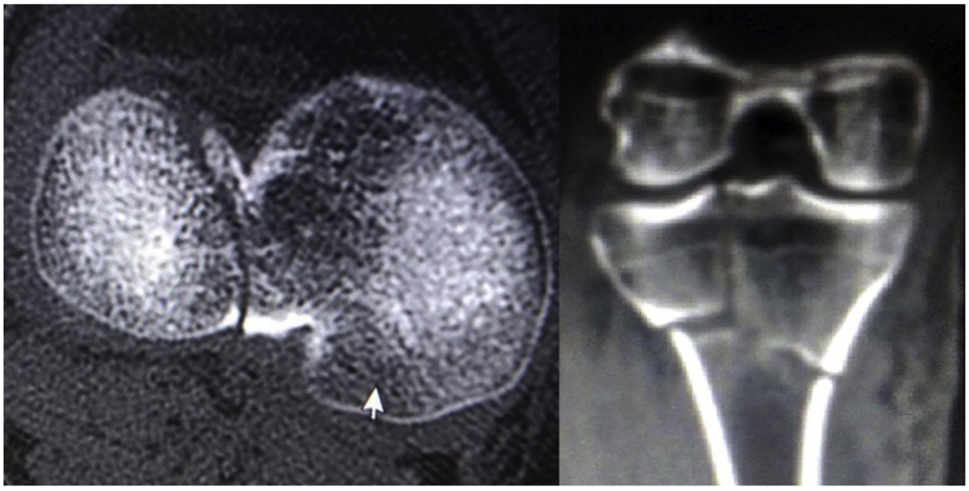

Fig. 3. Coronal and axial CT scan cuts showing bicondylar tibial plateau fracture with minimal displacement. The fracture line spans whole of the intermediate column and exits through medial and lateral cotices without breaching the cartiage bearing areas of medial and lateral colum. The columnar as well as the segmental classification for such a fracture would be difficult.

Conflict of interest

None of the authors have any conflict of interest to declare.

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Letter to the Editor

Letter to the Editor regarding "Proposal for the classification of peri-implant femoral fractures: Retrospective cohort study"

We read with keen interest the recent article by VIdela-Ces et al. [1] and wholeheartedly agree that a distinction between periprosthetic and peri-implant fractures should be made. In addition, we agree that current classifications for periprosthetic fractures are not fully applicable to peri-implant fractures and have inherent deficiencies.

We would like to draw the authors' attention to a similar article by the Singapore Orthopaedic Research Collaborative (SORCE)

group [2]. In it, we describe a classification system for Non-Prosthetic Peri-Implant Fractures, or NPPIFs, based on a similar retrospective cohort methodology, and would like to highlight the similarities and differences.

Both classification systems recognize the importance of the nail (N) or plate (P) as the primary fixation device. Similarly, these fractures are also subclassified according to the location of the fracture in relation to the implant (at the end, or distant to it).

Whilst the current article addressed peri-implant fractures specific to the femur, our classification system is generalisable to all long bones. We also identify the healing status of the original fracture, as well as the integrity of the primary fixation, as important factors to be highlighted as subclasses of our system. In particular, we believe the identification of the healing status to have a significant bearing on the decision to retain or remove the primary implant, which in turn influences the fixation options for addressing the second fracture. Based on our series, our paper recommends management strategies for specific subtypes of peri-implant femoral fractures.

We congratulate the authors on amassing a large number of cases in their series, and the incorporation of the AO-OTA classification which will extend the applicability of their system. However, we suggest to enhance the comprehensiveness of their proposed classification system by integrating the healing status of the primary fracture.

Conflict of interest

The authors of this manuscript have no conflict of interest to declare.

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Letter to the Editor

Authors' reply to letter to editor "Surgical approaches for open reduction and internal fixation of intra-articular distal humerus fractures in adults: a systematic review and meta-analysis"

Dear Dr Vijay,

We thank you for your comments [1] on our recently published study [2]. We agree and are well aware that capitellar and trochlear fractures are an important subset of intra-articular distal humerus fractures (IDH), however non-inclusion of such studies in our study was not by oversight. Our combined search results did yield studies looking at these injuries, but these were excluded due to our well-defined study objectives and strict inclusion criteria. The study by Singh et al [3] was excluded as it looked at primarily at the fixation modality rather than the approach, which was one of the exclusion criteria for our study.

We congratulate you on your excellent case series describing the anterolateral approach for fixation of capitellar fractures [4]. Our search strategy was comprehensive and designed to identify as relevant many studies as possible, but as is the case with all search strategies, it is not without its limitations. Although we were very meticulous in including all studies that met the inclusion criteria, studies that were in the pre-publication stage or that had not been indexed by our search sources might have been excluded inadvertently.

Since our meta-analyses included only comparative studies, we disagree that exclusion of your study [4], which is essentially a non-comparative, prospective case series, would skew the results of the quantitative analysis.

The primary aim of our study was to determine which surgical approach for open reduction and internal fixation (ORIF) of intra-articular distal humerus (IDH) fractures is superior, in terms of functional outcomes and complication rates. The study was not meant to be an exhaustive listing of the numerous surgical approaches that have been well described in the literature. We also reiterate the main finding of our study: the evidence to determine which surgical approach is superior for ORIF of IDH fractures is limited. As is evident from our study, this is primarily due to the abundance of case series, many of which do not report on important outcome measures, and lack of well-designed controlled trials.

Finally, we are pleased to note that He et al. [5] have recently published a systematic review looking exclusively at corornal shear fractures of the distal humerus, which will add to our understanding of these rare, nevertheless, important injuries.

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The authors declare that they have no conflicts of interest.

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