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Letter to the Editor

Dear Editor,

My keen interest in Orthopaedic oncology made me read an article "A case report on partial Scapulectomy with glenoid preservation for Chondromyxoid fibroma of scapula" by N. P. Chetia et al.[1]

Partial Scapulectomy is a well-known treatment option for low grade sarcomas and benign lesions of scapular body, especially the portion inferior to scapular spine, with good functional results.[2]

As stated by the authors, the tumor arose from the supra-scapular portion of the scapula with infiltration into the supra-spinatus. Despite being at an unfavorable site the outcome has been good, however details regarding the surgical steps have not been elaborated.

Following points are not clear to the reader after going through the article:

1) Which all muscles were excised and which were preserved during the procedure?
2) What method of soft tissue reconstruction was used after tumor removal?

Conflict of interest statement

Authors have following declarations to be made:

1 This paper is not under consideration elsewhere.
2 No part of this paper's contents has been published previously.
3 All the Authors have read and approved the manuscript.

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References

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2. Malawar M, Wittig JC, Rubert CK. Scapulectomy. In: Malawar MM, Sugaraker PH, eds. *Musculoskeletal cancer surgery: treatment of sarcomas and allied diseases*. Dordrecht: Kluwer Academic Pulishers; 2001:551–566.

Author's Reply

We approached the lesion using Das Gupta technique that is described for subtotal resection of the scapula to achieve wide margin clearance. Intraoperatively the tumour was found to be well marginated. The bony cortex were expanded but there was no cortical breach and surrounding soft tissue extension. As such, no muscle was sacrificed in toto. The soft tissue reconstruction was done taking a clue from Phelps technique described for partial resection of scapula. Trapezius and deltoid were approximated. Subscapularis sutured to teres major at its lateral border and to serratus anterior at its medial border. Infraspinatous at its lateral border to teres minor and its medial border to serratus anterior and combined attachments of these muscles to the rhomboids. Both these approaches are described in the chapter of "General principles of Tumors" in Campbell's operative Orthopaedics. The good functional result obtained in our case may be due to 1) preservation of glenoid and thus not violating intregity of gleno-humeral joint 2) muscle repair as recommended in described approaches and 3) early aggressive physiotherapy as soon as post operative pain allowed.

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