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Author's Reply

When we submitted our cover photograph, taken in 2007, the concept was already out of date. The thought behind submitting this picture was just for it to be on the cover of *Arthroscopy*; however, obeying the "on the cover" instructions, we sent a summary of the patient history. We have to agree with the comments of Fu et al., especially when they say that phrases such as "we placed the tunnels in an ideal position," "we performed an anatomic anterior cruciate ligament (ACL) reconstruction," or "we performed surgery in a routine fashion" should no longer be used in the modern literature.

Another important point is the imprecise position of the femoral tunnel compared with a clock-face location; however, once again, because we only submitted one picture, this seemed to be the fastest and most practical way to define this position. To be honest, it is important to state that this patient had an intact meniscus and an intact secondary restraint, and for this reason, we did not see a need to perform a more complex procedure to correct the issue.

At the end of this athlete's rehabilitation process, he was given an International Knee Documentation Committee rating of "A", and he resumed his activities with the same intensity and frequency as before he was injured.[1] He also presented with a 3-mm difference on KT-2000 evaluation (MEDmetric, San Diego, CA), which justifies his stability for anterior translation and external rotation.[2]

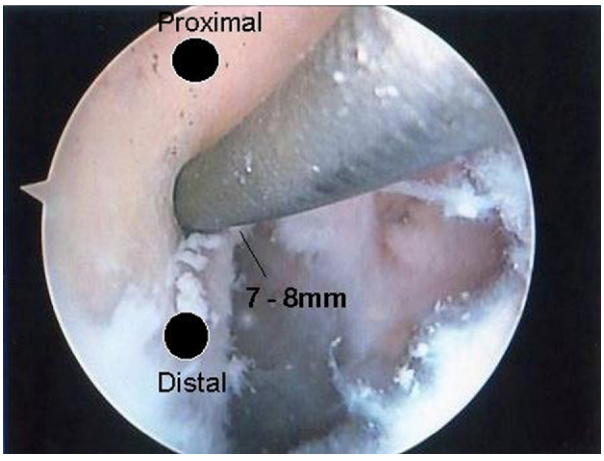

Figure 1. Femoral pin.

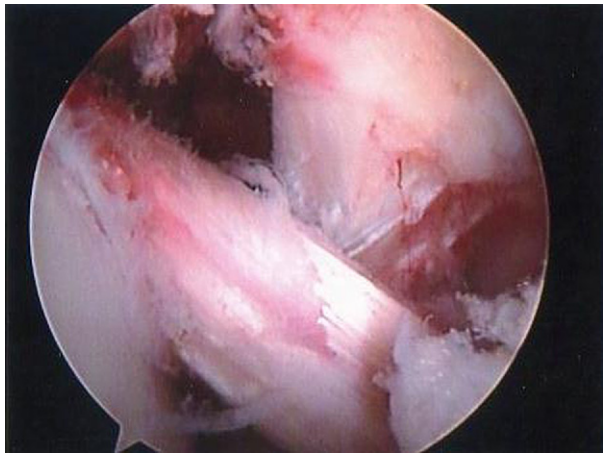

Figure 2. Graft positioned.

Once again, the idea was just to show this picture and not to compare techniques. At the time, we did not submit a description of our present anatomic and biomechanical approach. With the Editor's permission, we would like to make some important points. First, we would like to describe technically how we positioned the graft in the femur: we used a single-bundle graft and anatomic ACL placement. The guide pin was placed on the lateral notch at the midpoint of the proximal to distal length of the ACL attachment, just above this location (Fig 1) and about 7 to 8 mm from the posterior cortex. To achieve this, we have been using a special guide and flexible drill system through the anterior medial portal and with the knee in flexion.[2] After this standard selection, we inserted our graft (Fig 2).

With regard to the literature, it is also necessary to point out that when we talk about double-bundle reconstruction, we still lack conclusive data on where to place the tunnels during surgery, and we still cannot conclude that we have a better result when we compare both techniques. From the biomechanical point of view[3-7] and also from the clinical benefits,

double-bundle reconstruction is questionable.[6] In a meta-analysis comparison of single-bundle versus double-bundle reconstruction, there were no significant differences.[5] It is important to point out that, in various comparative studies, the patients with a single bundle had their grafts positioned on the roofs of the intercondylar notch, which surely affects the control of rotation.[8-11]

We are not against double-bundle reconstruction, but currently, there are still many controversies that need to be clarified before we decide to use a more complex surgery routinely in our practice, especially in cases in which future revision may be necessary. This does not mean that after the publishing of good objective and subjective results, the double-bundle reconstruction cannot be used to treat ACL tears, unless there are indications that a single-bundle reconstruction is superior. We understand that the concerns of Fu et al. are pertinent, especially for future publications involving ACL reconstruction, with better-described landmarks. Once again, we could not have described all of these details with a single cover image.

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Concerns About Management of Septic Arthritis After ACL Reconstruction

To the Editor:

I have serious concerns about the article "Septic Arthritis After Arthroscopic Anterior Cruciate Ligament Reconstruction: A Retrospective Analysis of Incidence, Presentation, Treatment, and Cause" by Wang et al.[1] They report on 21 patients with a postoperative infection, and yet only 16 patients had positive cultures. Of the 21 patients, 6 were treated by simple arthrocentesis and irrigation. I think this is very worrisome to present as a potential treatment for an infected ACL reconstruction. In my opinion, this would clearly be below the standard of care. The authors also state that IV antibiotics were only continued for a mean period of 19.4 days. For some of these serious infections with serious potential complications, this seems like an inordinately short period of time for the IV antibiotics. The authors state that patients were changed to oral antibiotics as soon as the C-reactive protein level was normalized, but this seems like a very rapid time to normalize, particularly in the face of patients who potentially only had an aspiration of their knee. The authors state that the symptoms of infection stabilized at a mean of 3.8 days. These data are highly contrary to almost all published cases of ACL infection where, many times, multiple procedures, and lengthy hospitalizations, are required to stabilize symptoms of infection. In fact, the authors state that the symptoms of infection stabilized within a range of 0 to 22 days. It seems hard to imagine that symptoms of infection could stabilize on day 0. Lastly, the authors, in their title, discuss their treatment for this septic arthritis. However, there are no results in the article on postoperative range of motion, some sort of standardized knee score, radiographic follow-up, and so on. How can judgments be made that treat-