

loss of correction after open-wedge HTO, but in the Discussion section, there was no explanation of that finding. Could it be possible that they used nonlocking screws and not the TomoFix plate but a different plate? If so, their observation is understandable. The stability of the fixation depends on the implant. Different biomechanical studies describe how important the fixation system is for stability.^{2,3} Brinkman et al.⁴ described in a radiostereometric analysis that early full weight bearing is possible with the TomoFix plate without loss of correction. For nonlocking plates with less stability, a biplanar technique would be an advantage.⁵

Therefore we do not agree with the conclusion. We suggest that the following statement would be more correct: "The WBL shifts after open-wedge HTO in a single-plane technique using nonlocking screws and bone graft in the first year medially."

We recommend the use of a locking compression plate (TomoFix, Solothurn, Switzerland) in conjunction with 5.0 locking screws with the modified technique described by Staubli et al. (Fig 2).⁶ The biplanar ascending cut should be at an angle of 110° to the transverse cut without bone graft.

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Author's Reply

We read the letter to the editor by Schröter and Ateschrang with great interest and thanks for their thoughtful consideration and questions about our article "Serial assessment of weight-bearing lower extremity alignment radiographs after open-wedge high tibial osteotomy." They mentioned the TomoFix plate in relation to our figures and methods. First, we are in agreement with them about the TomoFix: 6.5-mm screws cannot be used in holes A through C and holes 3 and 4. Second, the materials for this study were collected retrospectively and from multiple centers from 2007 to 2011. All surgeons performed the osteotomy using a similar technique in relation to the pes anserinus and medial collateral ligament, osteotomy method, and osteotomy level. However, the fixation materials and graft materials were chosen according to the surgeons' preferences. The figures we used in our report were chosen to show and to maximize the phenomenon of weight-bearing line shift after high tibial osteotomy (HTO). In this series, the bony correction loss was minimal and has been reported.¹ The only remarkable changes were loss of valgus instability at the last follow-up compared with the instability immediately after surgery. Therefore we thought that the correction loss was not due to bony collapse but to reduced medial instability, which made us disagree with the late progression of valgus alignment after HTO.² Third, we agree with the authors' statement about the nonlocking plates. The results of our study may be derived from the data collected from multiple centers with different plates. Because we are aware of the characteristics of the TomoFix plate, we will keep collecting data to evaluate whether the result differs when only TomoFix with biplanar osteotomy is performed. Fourth, regarding our conclusion, because the results of this study include locking and nonlocking plates from different hospitals, we think the authors' suggestions about the conclusion may not comply with our results. The ongoing studies we are working on may provide evidence for these questions in the future.

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Letter to the Editor Regarding Our Article "Properties of Biologic Scaffolds and Their Response to Mesenchymal Stem Cells"

To the Editor:

We are writing in regard to our article "Properties of Biologic Scaffolds and Their Response to Mesenchymal Stem Cells" published in the March 2014 issue of *Arthroscopy*.¹ Throughout the article, we refer to the 2 collagen scaffolds tested as being "highly and non-cross-linked." These terms were meant to describe the histologic structure of the scaffold; they were not meant to indicate anything else, such as the chemical processes by which some biologic scaffolds are manufactured.² In our study the porcine collagen scaffold has a loose fibrous infrastructure compared with the human dermal scaffold that is more tightly packed.

We have received feedback from clinicians that this nomenclature could be misleading, and this was not our intent. The purpose of our study was to accurately report the response of mesenchymal stem cells to different biologic scaffolds and not compare the structure of the grafts. Our only intent in using this terminology was as a way to differentiate between grafts.

Furthermore, in the "Discussion" section, "Flexigraft" was written in error; it should have said "Arthroflex." We apologize if there has been any confusion about this terminology, and we sincerely hope that we have cleared up any misunderstandings.

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Regarding "Intraoperative Hoffa Fracture During Primary ACL Reconstruction: Can Hamstring Graft and Tunnel Diameter Be Too Large?"

To the Editor:

I read with interest the case report by Werner and Miller¹ in the May 2014 issue of *Arthroscopy*. As the patient in the case report, I appreciate the publication and hope that increased awareness of the importance of tailoring graft size to the size of the patient will result in more nuanced surgical repair plans to prevent similar adverse events.

However, as the patient in question, I would like to correct one significant detail regarding the outcome of the case. The authors wrote that "knee stability one year postoperatively remained excellent and she had returned to full activities." This statement is inaccurate because 15 months postoperatively, I am unable to run or participate in activities that involve significant valgus or varus stresses to the knee. Simple activities such as descending stairs remain painful. I am motivated to correct this statement so as to further emphasize the goal of the article: urging more individualized approaches to graft size selection in ACL repairs to hopefully further prevent future similar complications. There is limited research on the correlation between graft size and patient gender and BMI.^{2,3} While recent studies have suggested lower overall failure rates with grafts of greater than 8 mm, it may be prudent to avoid generalization when treating patients at either end of the spectrum.

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