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Author Reply to "Regarding 'No Difference in Complication Rates or Patient-Reported Outcomes Between Bone-Patellar Tendon-Bone and Quadriceps Tendon Autograft for Anterior Cruciate Ligament Reconstruction"'

We would like to thank Dr. Joseph Lamplot for his interest, appreciation, and critical review of our article. We agree with his expanded discussion, commentary, and cautious optimism that surrounds the use of all-soft tissue quadriceps autograft (ASTQT) for ACL reconstruction. We feel there are potential benefits of ASTQT in certain patient subsets but agree that we must resist the temptation for a one-size-fits-all approach. Additionally, we fully acknowledge the limitations of our study, namely selection bias for graft choice and relatively short follow-up duration.

We would be remiss if we did not acknowledge that there is always some innate surgeon bias in graft selection based on personal preferences, training biases, our interpretation of the literature, or other factors, particularly, in contact athletes or high-demand individuals. We also acknowledge that our selection criteria for each graft type could have been more

specific or better controlled. In this cohort study, graft selection was determined through a joint decision-making process between the surgeon and patient/family. On the basis of these discussions, contact athletes more often chose the "gold standard" BPTB autograft. In contrast, our youngest athletes more often selected ASTQT autograft. Bone-patellar tendon-bone (BPTB) autograft is often contraindicated in skeletally immature individuals due to concerns of growth arrest. ASTQT has grown in popularity as a favorable graft option in the skeletally immature population.[1] As such, there was a predilection for using BPTB in the skeletally mature contact athletes and ASTQT in the skeletally immature and/or noncontact athletes. However, our graft choice selection continues to evolve with emerging evidence and remains a "hot topic" overall. Future studies must do a better job defining specific selection criteria for each graft type and/or randomizing patients to appropriately compare BPTB and ASTQT.

Our mean follow-up duration was 22.4 months for ASTQT and 28.5 months for BPTB. We would agree that this more accurately represents short-term follow up in the context of ACL reconstruction. In addition, several patients were lost to follow-up in both groups, which we should have delineated more clearly. To answer the specific query, we did continue to perform both BPTB and ASTQT reconstructions during the entire study period. BPTB autograft ACLR was performed from October 2011 to April 2019, while ASTQT autograft ACLR was performed from March 2014 to April 2019. Lastly, considering our short-term follow-up and low failure numbers, we were limited in the conclusions that could be drawn from these data. However, the similar early failure rates between BPTB and ASTQT suggest that initial graft fixation is sufficient using modern ASTQT techniques in this challenging active patient population.

In conclusion, we recognize the limitations of our study and hope that we have clarified our data to help better inform the readership. We were encouraged by the early results, specifically that our single surgeon series demonstrated no outcome differences between ASTQT and BPTB in a young, at-risk population at relatively short-term follow-up. We remain optimistic about the potential to expand indications for ASTQT as a graft choice for ACL reconstruction. We thank other drivers of ACLR innovation, including Dr. Lamplot,[2] who encourage data-driven advancement of our knowledge in sports medicine.

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Platelet-Rich Plasma Injections Versus Surgery for Treating Lateral Epicondylitis, Placebo Versus Placebo?

The conclusion of Hardy et al. that platelet-rich plasma (PRP) injections are an alternative to surgery for enthesopathy of the origin of the extensor carpi radialis brevis (eECRB; lateral epicondylitis) is misleading.[1] Enthesopathy of the eECRB is a self-limited condition.[2] You could treat it with anything or nothing and people will feel better. There are other nonspecific effects, such as regression to the mean and placebo effects. Comparisons of surgery to simulated surgery (placebo) or to treatments have shown to be no better than placebo.[3–5]

Two recent meta-analyses concluded that PRP injections were no better than placebo.[6,7]

On the basis of the available evidence, the more accurate conclusion may be that neither PRP treatment nor surgery are superior to placebo.

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