Letter to the Editor

Dear Dr. Thodarson,

We enjoyed reading the article of Cottom et al.\textsuperscript{1} They report on the promising results of Arthrex\textsuperscript{®} tightrope distal tibiofibular syndesmotic stabilization. As the authors correctly state is the main advantage of this technique is that in contrary to many other techniques there is no need for routine hardware removal in this minimal invasive technique.\textsuperscript{2} They used very relevant outcome measures in their group of 25 patients.

The authors mention some limitations of their study, most of these are indeed not avoidable and inherent to retrospective studies. The average follow-up was only 10.8 months and the authors did not discuss this as a shortcoming of the study. In our opinion the follow up is too short to conclude that the tightrope is a good option in the treatment of syndesmotic diastases.

After a longer follow up some removals may become necessary and eventually the tightrope will fail because there is a continuing movement over the implant. As one can expect, the fiberwire of the tightrope can fail or even the button can pull through the bone. You can see an example of the last complication for a patient treated for symptomatic AC luxation (Figure 1). It is not possible to observe whether the syndesmotic ligaments have healed or if there is enough fibrous union to obtain a stable congruent ankle mortise. Initially the ankle mortise is stable because of the implant and not due to ligament healing. If the healing process was not sufficient after failure or removal of the implant the results will be late syndesmotic instability and widening. This is difficult to treat with less favourable outcomes as compared to properly treated acute injuries.\textsuperscript{3}

We suggest that these authors continue to follow their patients and report on the long-term results in a few years.

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\textbf{Fig. 1:} Failed tightrope.
REFERENCES


Thank you for your letter on our study regarding the use of Tight Rope in syndesmotic ligament injuries of the ankle.

This was an observational study with the primary endpoint being syndesmotic stability. Hardware removal is a potential complication that does warrant longer-term evaluation.

We feel that the syndesmotic ligament is healed by 10 months. The traditional technique of screw fixation provides reliable healing in 4 months and the senior surgeon routinely removes the screws at 4 months. We selected 6 months as the minimal followup because of this favorable experience with screws and feel that 10 months (2.5 X routine screw removal) is adequate to assess late-term syndesmotic instability.

Although it is regrettable that the author had a complication with use of the Tight Rope in the AC joint, we do not feel this experience translates well to the ankle. We have not seen the reported complications in our patient series.

Sincerely yours,

GCB

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