Author's response to reviews

Title: Acromioclavicular joint reconstruction with coracoacromial ligament transfer using the docking technique

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Version: 4 Date: 19 November 2008

Author's response to reviews:

November 17, 2008

Melissa Norton, MD
BMC Musculoskeletal Disorders
www.biomedcentral.com/

RE: Manuscript: Acromioclavicular joint reconstruction with coracoacromial ligament transfer using the docking technique

Manuscript ID 3391390561810411

Dear Dr. Norton,

We are submitting a revised manuscript on “Acromioclavicular joint reconstruction with coracoacromial ligament transfer using the docking technique online with BMC Musculoskeletal Disorders“.

Acromioclavicular joint reconstruction with coracoacromial ligament transfer using the docking technique

Author’s response to reviewer’s comments

Reviewer In-Ho Jeon

We appreciate the reviewer’s comments to our manuscript.

As requested we changed AC to CC ligament in the second line of the background paragraph in the abstract.

We agree with the reviewer, that the presented docking technique does
reconstruct the CC ligaments rather than the AC joint. By reducing the clavicle, the presented technique does restore the anatomic position of the clavicle. It does not reconstruct the acromioclavicular joint itself, but it’s function for shoulder positioning. Surgical techniques for treatment of AC separations are often combined with resection of the lateral clavicle to prevent early osteoarthritis of the AC joint. The Weaver-Dunn technique is maybe the best know of these procedures. In the literature these are all called techniques for “AC joint reconstruction” (see references). We point this out in the manuscript in the second sentence of the background section.

Guy et al. (40) indeed published a longer follow-up in their series. They found complications (broken screws) and one cranial subluxation at the time of hardware removal and none after that. The hardware was removed as an outpatient procedure 12 to 16 weeks after the initial surgery. The difference in our series is augmentation with an absorbable braid of PDS sutures instead of using a screw that needs to be removed in a second procedure. We can assume that our presented procedure and the technique published by Guy et al. are comparable for the time after hardware removal, although we do not have the same long term follow up yet. We commented on this in the manuscript’s discussion.

We thank the reviewer for the comment on the lateral clavicle’s anatomy. Andermahr et al. show that the medullary canal at the lateral end of the clavicle is 15mm wide in average at 85% of the overall length of the clavicle, which appears to be approximately the line of resection for the presented procedure. This study therefore supports our findings in surgery, that the medullary canal allows a docking technique as described in this study. In our series we drilled a 15-20mm tunnel for transfer of the ligaments. This conforms to Andermahr’s measurements of the medullary canal.

All future correspondence should be addressed to Dr. Peter Millett, Attn: Clinical Research, 181 W. Meadow Dr. Ste 1000, Vail, CO 81657. The phone number is 970-479-5876 and the fax number is 970-479-9753. Email: drmillett@steadman-hawkins.com. Thank you in advance for your consideration in reviewing this manuscript and please let us know if there is any other information that you may need.

Sincerely,

Peter J. Millett MD, MSc Sepp Braun, MD