Author's response to reviews

**Title:** Unilateral, trifocal, diaphyseal fracture of the radius with ipsilateral mid-shaft ulna fracture in an adult: a case report

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**Author's response to reviews:** see over
Dear Sir/Madam

Thank you for your review and comments regarding our case report.

Following your response we have addressed the reviewers’ concerns and have revised our case report to include “tracked changes”.

The following is a point – by- point response to the concerns elicited by the reviewers:

**Title:** We have changed the title to the following:

*Unilateral, trifocal, diaphyseal fracture of the radius with ipsilateral mid-shaft ulna fracture in an adult: a case report*

The word “trifocal” now replaces the words “complex (four parts)”.

**First referee comments:**

**General comments:**

1- We have changed the title of the report as advised

2- The abstract has been changed as requested to include more patient details in the case presentation, and the conclusion has been changed. (please see tracked changes)

**Introduction:**

We have made reference to the published case report as advised.

**Case report:**

1- We have highlighted the necessity for the careful handling of soft tissues during internal fixation.

2- 1mm compression was utilised and we have included this in the report (please see changes).

3- A 9-hole DCP was used rather than a 14-hole DCP (apologies for the error) and this has been amended.

4- The patient follow-up section has been made more concise as requested (please see changes).

**Discussion:**

1) We have discussed the role of Prebent intramedullary nails with interlocking, and this is now included in the text (please see tracked changes).

2) In this case, we also agree with the reviewer that careful preservation of the vascularity of the bone fracture segments obviated the need for bone grafting (included in the text).
3) It is well known that the use of DCP plates causes the phenomenon of “stress-shielding”. In our case, the area of bone between the two radial DCP plates is at potentially higher risk of fracture following another episode of trauma, as a result of “stress shielding”. Hence, one could advocate the removal of the DCP plates after fracture union. We have not made plans to remove the plates. However, if we had decided on this course, then removal of the distal radial DCP plate would be easier to achieve, with a lower risk of nerve injury, and the proximal plate could remain. Removal of the proximal plate would be associated with a higher risk of nerve injury (this has been added to the discussion).

4) We felt that Locked Compression Plates were not necessary, in view of the patient’s good bone quality. They would play a useful role in elderly patients, who have poorer bone stock (added to the discussion).

Second referee comments:

1) Lateral view of figure 3 has been added to the case report as requested

2) We have included in our revised case report that we have made no plans to remove plates unless they cause any problem (added to the discussion).

We would be most grateful for your kind consideration

Yours faithfully,

Mazin Ibrahim, Jenny Cwilewicz, Osman Khan and Anthony Gibbon