Author's response to reviews

**Title:** Proximal plastic deformity in the paediatric Monteggia fracture: a case report

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

Concerning our manuscript *Proximal plastic deformity in the paediatric Monteggia fracture: a case report*

We are immensely grateful to your reviewers for their remarks and suggestions for improvement, which we have sought to address, by modifying the text with two additional components:

Firstly, in the introduction para 1 line 8 onwards we have inserted a remark << In our centre, a review of Monteggia fracture-dislocations between 1992 and 2001 showed that ~20% (8 out of 39) were initially missed [5].>> concerning the high miss rate of Monteggia fractures, with evidence showing a 20% miss rate in our own unit in the years 1992-2001. We are grateful to the reviewer for notifying us of this, and agree it is an important point which deserves to be emphasised. the reference has been added and the references throughout appropriately numerically altered.

We are also grateful to the second reviewer for asking us to expand our discussion of whether this technique might have a role in other Bado types eg type IV. Of course this is a good question, if a little difficult to answer succinctly. First off, I (JSH) have no experience of it being used in a type 4, which are rare, and when I have seen them have not been associated with proximal plastic ulna bowing - I think the answer really depends on the character and influence of the ulna fracture, and therefore the Letts classification is potentially more useful than Bado's in children's Monteggias, albeit his original paper doesn't really make this point! I've sought to discuss this in the Conclusion section - by splitting the original para 1 in 2, and then adding to the new second para: << Although successful here in the combined Bado type I and III fracture, we have no experience of using this technique in other Bado types (eg the rare type IV in which there is an associated radial shaft fracture). However, in accordance with the Letts classification [7], we suggest that it is largely the character of the ulna fracture that determines the strategy for reduction and/or fixation ie whatever the direction of the radiocapitellar dislocation, and whatever associated injuries there are, if there is proximal plastic deformity of the ulna that does not yield to manipulation, then this technique may be useful.>>
Again, we are most grateful to the reviewers for their comments, and hope that you find we have addressed them satisfactorily.

Faithfully
Jim S Huntley
Jason Lim