

## Author's reply

Sir,

We thank the authors<sup>1</sup> for showing keen interest in our paper.<sup>2</sup> We would like to address the issues raised.

Condyle fracture of femur starts from trochlear condylar groove at the junction between trochlea and the medial and the lateral condyles (type B1 and B2 – AO classification).<sup>3</sup> Starting from this site fracture line may be frontal, sagittal or oblique.<sup>3</sup> Hence, critical point for diagnosing condyle fracture is extension of fracture line to trochlear condylar groove. Hoffa fracture is coronally oriented fracture of femoral condyle where trochlear condylar groove is intact. In our case, we found fracture in an oblique plane in which trochlear condylar groove was found intact and fracture separated patellofemoral joint from tibiofemoral joint (type B3 fractures – AO classification).<sup>4</sup> Hence, we considered it as a Hoffa's fracture. Present literature offers paucity of information regarding such type of oblique fracture of femoral condyle.

Rigid fixation of the fracture can be achieved by optimally positioning the screw perpendicular to fracture line.<sup>4</sup> Hoffa's fracture in our case (oblique fracture line) was in an oblique plane extending from anterolateral to posteromedial. Hence, to achieve rigid fixation screws were fixed perpendicular to fracture line. Present literature supports various methods of fixation for Hoffa fracture.<sup>5</sup> Jarit *et al.* showed fixation with 6.5 mm partially threaded screws from posterior to anterior was more stable.<sup>6</sup> In our case, we fixed fracture posterior to anterior with 6.5 mm partially threaded screws.

Vertical patellar dislocations even in isolation are difficult to reduce by closed maneuvers. Our case had Hoffa's fracture

with incarceration of patella hence we did not attempt any closed reduction. Avulsion fracture was not seen in preoperative radiographs and computed tomography scan. Hence, we believe that it could be calcification at quadriceps attachment to patella.

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## REFERENCES

1. Chauhan A. Irreducible, incarcerated vertical dislocation of patella into a Hoffa fracture. *Indian J Orthop* 2015;49:369.
2. Soraganvi PC, Narayan Gowda B, Rajagopalakrishnan R, Gavaskar AS. Irreducible, incarcerated vertical dislocation of patella into a Hoffa fracture. *Indian J Orthop* 2014;48:525-8.
3. Manfredini M, Gildone A, Ferrante R, Bernasconi S, Massari L. Unicondylar femoral fractures: Therapeutic strategy and long term results. A review of 23 patients. *Acta Orthop Belg* 2001;67:132-8.
4. Sahu RL, Gupta P. Operative management of Hoffa fracture of the femoral condyle. *Acta Med Iran* 2014;52:443-7.
5. Arastu MH, Kokke MC, Duffy PJ, Korley RE, Buckley RE. Coronal plane partial articular fractures of the distal femoral condyle: Current concepts in management. *Bone Joint J* 2013;95-B:1165-71.
6. Jarit GJ, Kummer FJ, Gibber MJ, Egol KA. A mechanical evaluation of two fixation methods using cancellous screws for coronal fractures of the lateral condyle of the distal femur (OTA type 33B). *J Orthop Trauma* 2006;20:273-6.

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