
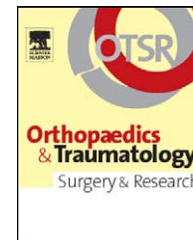




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## LETTER TO THE EDITOR

### Comments on: "Osteochondral lesions of the talus: Current concept" by O. Laffenêtre published in *Orthop Traumatol Surg Res* 2010;96: 554-66

Dear Editor,

We read with interest Dr. Laffenêtre [1] current concept review article, "Osteochondral lesions of the talus: Current concept" (Epub ahead of print, 2010 July 14). It provides a detailed and useful description of treatment options for osteochondral talar lesions, with considerations for decision making.

The author states that "arthroscopy appears to be the most effective procedure for lesions smaller than 1 cm<sup>2</sup>", referring to articles in which no distinction is made between lesion size and outcome [2–5]. Furthermore, the author states that "larger lesions (> 1 cm) should be filled, either with cancellous bone or with an osteochondral graft or using autogenous chondrocyte implantation". We disagree with the author concerning the cutoff point of 1 cm<sup>2</sup>.

Zengerink et al. [6], in 2010, reported in a systematic review of treatment strategies for osteochondral talar lesions, a mean success rate of 85% after debridement and bone marrow stimulation including lesions up to 1.5 cm in size. For autogenous chondrocyte implantation, cancellous bone graft, and osteochondral graft for large lesions, a mean success rate of 76%, 61%, and 87% was reported, respectively [6]. In different current concepts reviews [7–9], debridement and bone marrow stimulation is recommended for primary lesions with a diameter less than 1.5 cm or a surface area less than 1.5 cm [10]. A cancellous bone graft, osteochondral graft or autogenous chondrocyte implantation is recommended for secondary lesions or lesions with a diameter greater than 1.5 cm. Han et al. [11], in 2006, confirmed that good clinical and radiographic results are obtained after arthroscopic debridement and bone marrow stimulation for lesions up to 1.5 cm in size, also in the presence of sub-

chondral cysts. Recently, a cutoff point of a defect area of approximately 1.5 cm<sup>2</sup> was determined on 120 ankles as a risk of clinical failure of the arthroscopic bone marrow stimulation techniques [12].

Looking at the currently best available evidence [6,10–12], it is clear that treatment with debridement and bone marrow stimulation for isolated talar lesions is the primary treatment of choice for lesions of up to 15 mm in diameter. At this time, alternative treatment options are mainly indicated for secondary and large lesions. Their effectiveness needs to be evaluated in larger series with long-term results.

### Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

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