

Osteochondroma of the Proximal Fibula-Revisited

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Keywords: Giant cell tumours, Malignant, Neurovascular deficit

It was interesting to read the case report by Kumar et al., [1]. "Osteochondroma arising from the proximal fibula: a rare presentation", where the authors mentioned about a case of a giant osteochondroma arising from the proximal fibula in an 18-year-old male without the complications of distal neurovascular deficit or a sarcomatous change. We congratulate the authors for such a nice presentation of this common tumour with various case scenarios.

The authors mentioned in the title 'Osteochondroma arising from the proximal fibula: a rare presentation' which in fact contradicts the statement written in the discussion 'the most common tumours found in the proximal fibula are osteochondromas, giant cell tumours, osteosarcomas and ewing's sarcomas' [1]. Literature gives identical statistics and concludes that the proximal fibula is a common site for symptomatic Osteochondroma [2].

Involvement of the tibia in a case of solitary osteochondroma of proximal fibula is rare and coalescence of kissing osteochondromata (facing osteochondromas of both tibia and fibula may show an interlocking growth at the abutting parts) in patients with multiple cartilaginous exostoses (MCE) may result in tibiofibular synostosis. Hence, the tibial involvement as mentioned by the authors could actually be the scalloping of the proximal tibia due to erosion on the contiguous surface adjacent to the giant proximal fibular lesion. Though there were no symptoms of neurovascular involvement in the case reported by the authors, knowledge of the possible complications from the neurovascular involvement as mentioned by the authors should be born in mind especially in cases of a giant tumours at such a notorious anatomical site [1,3,4]. Preoperative nerve conduction studies and the angiography or colour doppler ultrasonography would be invaluable in planning definitive treatment.

The authors did an en block resection of the lesion leaving a very small portion of the head of fibula where the lateral collateral ligament (LCL) was attached. In the one year follow-up they did not mention about the status of the knee joint laxity which could have judged the requirement of a LCL repair or reconstruction. Type 1 en block resection of proximal fibula is indicated for aggressive or epiphyseally located tumours where LCL repair and reconstruction is necessary to address the knee instability. Abdel Matthew et al., [5], in their study did en block resection of tumours at proximal fibula followed by LCL and biceps femoris repair or reconstruction. They found no functional knee instability.

Last but not the least, further follow-up of the case is required keeping in mind the possibility of recurrence or the malignant transformation.

The purpose of this letter is to highlight the key points regarding such an important entity. In the end, we wish to thank the authors for presenting such a difficult to treat case to the readers.

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FINANCIAL OR OTHER COMPETING INTERESTS: None.

Date of Submission: **Aug 19, 2014**
Date of Peer Review: **Dec 22, 2014**
Date of Acceptance: **Jan 27, 2015**
Date of Publishing: **Jul 01, 2015**