

Dear Editor:

In a recent article, "An Anatomic and Autologous Lateral Ankle Stabilization," *Journal of Foot and Ankle Surgery* 48(6):700–705, 2009, the author, Dr Jack Schuberth, discusses a new approach for the stabilization of lateral ankle sprains using the peroneus longus tendon. Although I found this a well-written article, I must take issue with the technique being presented as new and for not crediting the original source. Drs Schoenhaus and Jay originally published the anatomy, pathomechanics, diagnosis, rationale, purpose, and operative procedure using a portion of the peroneus longus tendon in the original article, which appeared in *Current Therapy in Podiatric Surgery*, pp 283–285, B.C. Decker, Philadelphia, 1989.

The purpose of using the peroneus longus tendon is not limited to the available length or the preservation of the evertor effect of the peroneus brevis. Most importantly, ankle stabilization with the peroneus longus tendon weakens one of the major deforming forces in recurrent ankle instability (forefoot valgus) without jeopardizing the stabilizing effect of that muscle.

The peroneus longus is a stance phase muscle that begins to fire in late contact phase and continues into late propulsion. It transfers weight to the medial side of the foot and stabilizes the first ray in late midstance and propulsion. The stabilization of the first ray follows the locking mechanism of the calcaneo-cuboid attained during midstance by the soleus muscle and resupination of the foot. When an imbalance from antagonist muscle exists, the biomechanical function of the peroneus longus can cause a pathomechanical deformity.

In the normal foot, the lateral aspect of the forefoot contacts the ground in the beginning of stance phase. When the forefoot is fixed in valgus, the medial aspect is first to contact the ground, placing a retrograde force on the foot and causing supination of the subtalar and midtarsal joints. The force is transmitted to the leg segment, causing an abrupt cessation of the normal internal rotation, and forces external rotation of the limb. These abrupt changes in motion apply supinatory forces into the ankle, a "supinatory rock," which may cause an acute inversion ankle injury with subsequent lateral ankle instability. A rearfoot varus is often associated with a forefoot valgus.

Drs Schoenhaus and Jay's approach of the peroneus longus stabilization was also credited in *McGlamry's Comprehensive Textbook of Foot and Ankle Surgery*, Volumes 1 to 2, Chapter 35, Chronic ankle conditions, page 1120, Lippincott Williams and Wilkins, Philadelphia.

Thank you.

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Dear Editor:

We have had the opportunity to review the correspondence from Richard Jay, DPM, regarding our recent contribution to the

Journal. In this letter, Dr Jay opines that our manuscript did not credit the original source and, as such, suggests that our technique is not new. First of all, we would like to thank Dr Jay for sending us a copy of his publication in order to comment on the issues brought forth in his letter, as we were unable to locate or retrieve it with the common electronic databases and search engines that are available in modern literary convention. We might have discovered their article and referenced it therein, if it had been published in indexed publications.

We agree that the use of peroneus longus for lateral ankle stabilization procedures is not "new." In fact, the use of that particular tendon has been described numerous times in the past. There are references dating back to 1945, 1954, and 1977 (1–3), well before the 1989 publication from Drs Schoenhaus and Jay (4). Subsequently, other authors have also discussed the use of peroneus longus for lateral ankle stabilization (5).

The fundamental tenet of our manuscript is clearly articulated within, and is predicated on a precise anatomic course of the reconstructed ligaments, in contradistinction to the course of the peroneus longus in the article by Drs Schoenhaus and Jay. Although there are no pictures or diagrams, the course of the transferred peroneus longus tendon described by Drs Schoenhaus and Jay is clearly not an anatomic one. Primarily, this is because the peroneus longus is not anchored to the talus and calcaneus, a prerequisite and obligate condition for an anatomic repair. As Dr Jay points out in his letter, their article was included in *McGlamry's Textbook*, but is listed under "non-anatomic repairs" (6). Further, our manuscript discusses the ease of modulation and capture of the tension of the transferred tendon with the use of interference screws. Upon comparison of Drs Schoenhaus and Jay's publication with ours, it is clear that the only synchronous feature is indeed use of the peroneus longus. Our intention was not to slight Drs Jay and Schoenhaus or any of the authors who used peroneus longus either before or after their article. Yet no prior publication discusses an anatomic route of the peroneus longus for re-creation of the lateral ligament complex.

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