

Letter to the Editor

Dear Editor:

We would like to thank Drs. Spinner and Amrami for their commentary regarding our recent article describing the case involving an intraneural peroneal ganglion of the superficial nerve and its branches (1).

We are glad that our article has triggered such an academic discussion and we are keen to further comment on this topic.

We acknowledge that Drs. Spinner and Amrami have done tremendous work during the past decade putting forth reasonable evidence trying to elucidate the pathogenesis of these peculiar ganglionic cysts at the level of the proximal tibiofibular joint. But, on the other hand, an effort to extrapolate it to other sites and other nerves may not be always safe.

Drs. Spinner and Amrami, in trying to reinterpret our published MRI images (Fig. 1 in their commentary), demonstrate with arrowheads what they consider as “a connection of the anterior aspect of the ITFJ with the nerve”—the ascending branch according to their theory. Careful re-interpretation of their figure clearly shows that the indicated connecting branch invades the most posterior branch, namely the intermediate dorsal cutaneous (IDC) branch. This is, though, not compatible with what they demonstrate in the reinterpreted intraoperative photograph (Fig. 2 in their commentary), where they clearly indicate that the connecting branch invades and ascends across the anterior branch—namely the medial dorsal cutaneous (MDC) branch.

Additionally, our intraoperative photograph demonstrates in a rather adamant way that the trunk of the superficial nerve, along with its branches, was meticulously exposed under magnification, preserving the surrounding anatomy. It is really

unexplainable how we could “miss” a connecting branch, which would be expected to be rather enlarged and recognizable, taking into account that only a nerve conduit of significant size could potentially relieve the increased intra-articular pressure of the ITFJ, producing such an enlargement of the dorsal medial cutaneous branch as seen in the intraoperative photograph.

We do agree that the treatment of choice for an intraneural ganglionic cyst would be cyst resection and ligation of a possible connecting branch, especially in a case where a nerve with motor function would be involved. But for our case, preservation of the nerve was impossible because of the inability to resect the cysts without jeopardizing the fascicles, which were intimately intertwined with them.

Finally, we would like to state that although our comments seem to challenge the theory by Drs. Spinner and Amrami, our purposes, as stated in the article, are just to alert foot and ankle surgeons of such a clinical possibility and to rely solely on strong evidence and not extrapolation.

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Reference

1. Stamatis ED, Manidakis NE, Patouras PP. Intraneural ganglion of the superficial peroneal nerve: a case report. *J Foot Ankle Surg* 49:400.e1–e4, 2010.