

Management of Maternofetal Emergency in Shock with Fracture of Femur

Sir,

We read with great interest, the manuscript by Singh *et al.* 'Management of maternofetal emergency in shock with fracture of femur'.^[1] We must congratulate the authors for this case report and highlighting this uncommon issue. However, we would like to draw the attention of the authors and readers to the following:

1. The authors did not mention the mechanism of injury and the time elapsed from injury to presentation. The mechanism of injury is an important aspect of the history that may suggest the fracture location, fracture configuration, and associated soft tissue injury. The time from injury to presentation gives valuable information regarding the potential for extensive blood loss into the thigh, the overall condition of the patient, and the possibility of significant associated soft tissue injury such as substantial muscle crush that is occasionally seen with a prolonged extrication
2. Although isolated femur fractures are associated with blood loss requiring transfusion, their association with hypotensive shock is less clear. Ostrum *et al.* found that patients with femoral shaft fractures frequently exhibited hemodynamic changes with blood loss; however, hypotension was not observed. As a result, they recommended that in patients with an isolated closed femoral shaft fracture with associated hypotensive shock, alternative sources of blood loss

should be investigated^[2]

3. According to the authors, the fracture was comminuted but Figure 1 shows a simple oblique fracture. The pre-operative and post-operative radiograph shows different fracture patterns. It seems that the fracture was converted into a segmental pattern while being operated. No mention of it was made in the manuscript
4. The fracture was at the level of the isthmus and was amenable to retrograde nailing. All fractures of the femoral shaft that are distal to the lesser

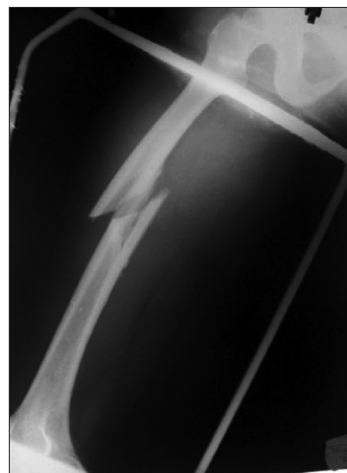


Figure 1: Preoperative radiograph of the patient showing a simple oblique fracture of femur

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trochanter are amenable to retrograde fixation.^[3] In pregnant patients, retrograde nails may be easier to place and have the advantage of minimizing the amount of radiation exposure. In pregnant patients, osseous landmarks are difficult to palpate, and femoral adduction is usually somewhat limited. This frequently leads to the need for a large surgical approach to simply identify the osseous anatomy proximally. In addition, it also has the advantage of minimizing the amount of radiation exposure. There are plethora of articles available in the literature recommending retrograde nailing in pregnant patients with fracture shaft of femur.

With warm regards, and once again, congratulations for the research.

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