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Compared with nonfunded or peer-reviewed funded projects, industry-sponsored clinical trials have traditionally been associated with more positive results. This relationship has been extensively studied in the nonsurgical literature. Although a few authors have addressed specialties, little has been reported on orthopedic clinical trials and their association with funding, study outcome, and efforts to reduce bias after randomization across journals of multiple subspecialties.

For the study reported here, we selected 5 major orthopedic subspecialty journals: *Journal of Bone and Joint Surgery (American Volume)*, *Spine*, *Journal of Arthroplasty*, *Journal of Orthopaedic Trauma*, and *American Journal of Sports Medicine*. We chose a 2-year limit for investigation (2002–2004); included all original randomized clinical trials reported in these 5 journals; and examined these trials for their study design, funding source, outcome, bias potential, and conclusion reached.

Support for the 100 eligible orthopedic clinical trials was stated as coming from industry (26 trials, 26%), nonprofit sources (19 trials, 19%), and mixed sources (5 trials, 5%); no support was stated in 46 trials (46%), and support was not reported in 4 trials (4%). Of the 26 trials reporting industry support, 22 (85%) were graded as indicating an outcome favorable to the new treatment. The association between industry funding and favorable outcome was strong and significant ($P < .001$). In almost half of the studies reported in *Journal of Bone and Joint Surgery* and *Spine*, measures taken to reduce bias were not documented.

Our results indicate that there is a significant positive association between reported clinical trial outcome and funding source

in the orthopedic surgery literature across subspecialties. There appears to be poor recording for bias reduction in the selected journals.

CASE REPORTS & LITERATURE REVIEW[†]

Spontaneous Tibialis Anterior Tendon Rupture: Delayed Repair With Free-Sliding Tibialis Anterior Tendon Graft

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Rupture of the tibialis anterior (TA) tendon is rare.^{1,2} A spontaneous rupture is even rarer.³ The rarity of the condition and the subtle physical signs⁴ make the diagnosis difficult. A high level of suspicion and meticulous clinical evaluation are required. We report on a case of spontaneous TA rupture in a 51-year-old man with diabetes. The tendon defect was 8 cm long, and reconstruction was performed with a free-sliding TA tendon ipsilateral autograft.

LETTERS TO THE EDITOR

SYNDESMOTIC SCREW PLACEMENT

I am writing in regard to an article by Dr. Robert Rupp published in the May 2008 issue of *The American Journal of Orthopedics* (Rupp RE. Overcompression of the Syndesmosis During Ankle Fracture Fixation: A Case Report. *Am J Orthop.* 2008;37(5):259-261).

I thought the case report noted by Dr. Rupp was interesting. The injuries to the syndesmosis remain a controversial topic. However, I would like to note that there is also a little controversy regarding syndesmotomic screw placement in a nonarticular portion of the distal tibia fibula syndesmosis—that is, not through the distal tibiofibular joint. In the case shown within the article, the syndesmotomic screw was clearly placed directly through the joint. In addition, it is unclear whether, at the time of this patient's initial surgical intervention, noted to not have been under Dr. Rupp's direction, the syndesmotomic screw was placed as a position or compression screw. Neither of these issues was mentioned in the published article, but each is a critical technical point.

David F. Beigler, MD
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AUTHOR'S RESPONSE

I appreciate Dr. Beigler's comments concerning my case report. I agree that there is some controversy about the position of syndesmotomic screw placement relative to the distal tibiofibular joint. It is my experience that different surgeons use various techniques to place the syndesmotomic screw. Some attempt to achieve compression, and others try to avoid any compression. My reason for reporting this case was the finding that the syndesmosis can be overcompressed by internal fixation and that this can be corrected with screw removal after the syndesmosis injury has healed. I was unable to determine in this case whether the initial surgeon purposely compressed the syndesmosis.

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