

Article information: <https://dx.doi.org/10.21037/aoj-22-15>

Reviewer A

Comment 1: To keep ratios consistent, numbers and percentages to be included for clarity

Reply 1: Thank you for your review and comments. We agree that this would give more consistency and clarity. The appropriate changes have been made in the text.

Changes in the text: We added percentages for all relevant data including: percentage of patients who had nonunions that underwent revisions (see Page 1, line 22 and Page 7, line 139); percentages for causes of injury (see Page 4, line 74, 75); percentages of patients who were smokers, obese, diabetic (see Page 4, line 75, 76); percentages for revision techniques (see Page 7 line 144, 146-149; percentages for reasons revision was not attempted (see Page 7, line 149, 150 and Page 8, line 151, 152); percentages for fracture types (see Page 8, line 156-158); percentages of infections and other complications (see Page 8, line 168-172 and Page 9, line 173, 174).

Comment 2: In final paragraphs of results - clarity required as to whether infected cases were linked to non-union etc

Reply 2: Thanks for this great question. Yes, the five infected cases were linked to non-union.

Changes in the text: The five infected cases were linked to non-union.

Reviewer B

Comment 1: With the increasing number of elderly patients, I think it is important to report on the ORIF of distal femur fractures in elderly women. The high rate of nonunion with lateral locking plate surgery is also an issue to be overcome in the future, in my opinion.

Reply 1: Thank you for your review and comments. We agree with this statement and that is why we think publication of this paper will contribute to research and clinical practice on this topic.

Changes in the text: N/A

Comment 2: A few important modifications are necessary: AO/OTA 33A1 type is an avulsion fracture. It is not appropriate to compare A1 with A3 or C types.

Reply 2: Thank you for your insight on the different fracture types. We present this

information merely as a method of further classification and additional preoperative data. There is no direct comparison of the outcomes of each fracture type and our intention is not to state that one has better outcomes than another.

Changes in the text: We have included an explanation of this in the Discussion section, paragraph 2 (see Page 9, line 187-191).

Comment 3: Next, you conclude that obesity is a risk, but didn't you just compare two groups of obese and non-obese patients? To claim that obesity is a risk in distal femur fractures treated with lateral locking plate, you need to do a prospective study or do a multivariate analysis with an increase number of patients.

Reply 3: Our study involved patients who were both obese and non-obese. It was found that obese patients had a higher rate of nonunion than non-obese patients ($p = 0.008$). Our conclusion states that those with obesity have an increased risk of developing nonunion, which our data shows. However, we do not mean to state that obesity alone is definitively the risk in distal femur fractures treated with lateral locking plate and we understand that more research needs to be done to definitively make this conclusion and we have adjusted the manuscript accordingly.

Changes in the text: We have revised the abstract conclusion and Conclusion section to reflect this concern (see Page 2, line 31-33 and Page 11, line 223-226).