Evidence-based medicine integrates the best available evidence of clinical expertise and patient preference in making the best decisions about patient care. This concept represents excellence and is firmly established in the pursuit of best medical practice. It has been applied to almost all subspecialties in medicine including orthopaedics. It is the focus in peer-reviewed journals and discussed in consensus statements of medical societies.1,2

Studies that eliminate the most bias and control for most confounding factors are ranked high, with randomised controlled trials being highest, and case reports and expert opinions being lowest. A proposed treatment is likely to be accepted if the risk-to-benefit ratio is clearly shown.3,4 Even in the absence of high-level scientific studies, a collection of lower-grade studies can provide some guidance for clinical decision making. Many journals state the level of evidence of each article to assist readers in determining the strength of the information presented.

For patients undergoing hip fracture surgery, it is important to mitigate against the risk of venous thromboembolism, while minimising the risk of bleeding due to pharmacologic prophylaxis. In this issue, Leonidou et al.5 emphasise the need for early intervention in elderly patients with hip fractures who are in receipt of anticoagulation. Although the study was retrospective and the sample size was small, the groups being compared were well defined. However, the complications encountered needed further elucidation. Poh and Lingaraj6 followed up 294 patients who underwent hip fracture surgery to evaluate various postoperative complications and risk factors. The study method was in line with evidence-based medicine, but the duration of follow-up was not reported. Al Khudairy et al.7 reported that withholding clopidogrel for <7 days before hip fracture surgery had no discernible effect on patients, although the sample size was small.

Few would debate the need to balance between maximal antithrombotic efficacy and minimal bleeding in choosing a thromboprophylactic strategy, but there is less agreement as to how best to accomplish this task. The American Academy of Orthopaedic Surgeons and the American College of Chest Physicians have published their own guidelines, which entail subtle differences.8 This further illustrates the difficulty in evaluating the best evidence available. Practising surgeons should study these guidelines, evaluate the evidence, and come up with the best solutions for their own patients.

REFERENCES