Letters to the Editor

Long-term outcome of total hip replacement in patients with or without femoral head contamination

To the Editor:
We read with interest the article by Ibrahim et al. The authors have not mentioned whether a cemented or uncemented total hip arthroplasty (THA) was performed in the primary setting. This factor is pivotal, as uncemented THA even in elderly patients leads to better biological integration owing to the microlock mechanism, reduced duration of surgery, no tissue damage by cement polymerisation and reduced intra-operative embolisms. The overall outcome with regard to infection and revision may therefore be affected.

The authors also failed to mention whether the procedures were performed by one or multiple surgeons (as the surgical technique and soft tissue dissection could affect the outcome) and whether any preoperative screenings for infection in the form of blood culture or serum markers (erythrocyte sedimentation rate or C-reactive protein) were performed.

The current practice for active Koch’s hips is to perform THA after 2 weeks of anti-tuberculosis treatment, followed by 6 months of postoperative treatment. Would the authors administer a different postoperative protocol if the swab or culture was positive. In India, tuberculosis is a common cause of indolent or latent infections in hip or knee arthroplasties. Would a similar model have worked in cases for primary knee arthroplasty as well? Would the site of biopsy in cases of knee arthroplasty affect the screening for infection?

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Authors’ reply
In our series, most primary THAs were cemented; the few uncemented THAs were for younger patients. Data were obtained from the regional arthroplasty register, with the procedures having been carried out by multiple surgeons of different grades. At the time of primary THA, our policy was not to screen patients preoperatively for infection. Since the late 1990s, all preoperative joint arthroplasty patients are screened for infection using serum C-reactive protein as a marker. With regard to latent tuberculosis infections in hip or knee arthroplasties, we have very limited experience with this complication and are not able to comment.

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Autologous blood reinfusion in patients undergoing bilateral total hip arthroplasty

To the Editor:
I read with interest the article by Gee et al, which concluded that autologous blood reinfusion reduced the rate and units of allogeneic blood transfusion in patients undergoing one-stage bilateral total hip arthroplasty. The authors failed to blind against the transfusion in theatre; recovery among the autologous transfusion group introduces bias against further transfusion during the
postoperative period, which could lead to type I error. The authors also failed to address the cost implications of autologous blood transfusion. In orthopaedic surgery, alternative methods to postoperative allogeneic blood transfusion have shown cost-effectiveness, whereas autologous blood transfusion has not.246 Was the cost implication considered during the study period?

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Authors’ reply
Our study was a retrospective review of patients undergoing simultaneous bilateral total hip arthroplasty. As per our hospital protocol, all patients were asked to predonate autologous blood prior to surgery. For logistic reasons, nearly half of the study group were not able to predonate blood, thus creating these 2 comparative groups. Although the demographics and intraoperative data were similar, there was no doubt that a prospective randomised study would have minimised the chance of confounding variables and errors.

We did not evaluate the cost-effectiveness of this strategy of blood conservation. Your point of being cost-conscious and taking treatment costs into account is valid and sensible, particularly in our current health care environment. However, the aim of this study was to evaluate whether preoperative donation could decrease the rate of allogeneic blood transfusions, given that this technique has been proven non-effective in the setting of unilateral hip and knee replacements. We recognise the pitfalls of autologous donation, and acknowledge that blood conservation should be multimodal and with a patient-specific approach.

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Breakage of an intramedullary rod after bone union in congenital pseudoarthrosis of the tibia: a report of two cases

To the Editor: I read with interest the article by Sulaiman et al.1 Although the 2 patients achieved bone union, the breakage of the 2 Rush rods in the ankle joints may lead to further articular damage. The authors stated that “…the Rush rod anchor in the calcaneum transfixes the ankle joint permanently until its removal after skeletal maturity.”

In our institution and others,2 a smooth Steinmann pin is used as an intramedullary rod to treat congenital pseudoarthrosis of the tibia. This does not transfix the ankle and subtalar joints permanently, as growth of the distal tibia especially in a young child eventually results in freeing of the ankle and subtalar joints from the Steinmann pin.

I would recommend Steinmann pins as an alternative to Rush rods to treat congenital pseudoarthrosis of the tibia, as these are inexpensive and easily available.

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