ABSTRACT

Objective: To identify anatomical changes and skeletal maturity through radiographic analysis, allowing more accuracy for indication of surgical management of non-slipped hips in patients with epiphysiolysis. Methods: A retrospective study of the radiographs of 61 patients followed until the end of skeletal growth, assigned to two groups: 37 patients with unilateral epiphysiolysis, and 24 patients with contralateral epiphysiolysis diagnosed during follow-up. The skeletal maturity was evaluated using pelvis radiographs (Oxford method) and compared between the groups for patients of the same gender. In addition, the Southwick angle (in anteroposterior and in Lauenstein view), physeal sloping angle and physeal posterior sloping angle were compared as well.

Results: Skeletal maturity showed a statistically significant difference between the two groups for both genders. It was observed that the lateral view of the Southwick angle is mathematically equal to the physeal posterior sloping angle, and were the only ones to show relevant differences between the groups. Conclusion: The Oxford method and the Southwick angle in Lauenstein view can be utilized as parameters to help the physician to better indicate the prophylactic surgical treatment of the contralateral hip, in patients with slipped capital femoral epiphysis (SCFE).

Level of Evidence III, Diagnostic Study.

Keywords: Epiphyses, slipped. Hip joint/radiography. Femur head. Age determination by skeleton. Child. Adolescent. Humans. Male. Female.
The inclusion criteria were unilateral epiphysiolysis without any radiographic signs of impairment of the opposite side and with follow-up until complete physeal closure. Cases with unsatisfactory follow-up and documentation were excluded. Group 1 (37 patients) was of patients with unilateral epiphysiolysis and group 2 (24 patients) of patients with bilateral impairment (contralateral epiphysiolysis during outpatient follow-up). None of the patients had undergone prophylactic fixation. As regards the sex, 33 of the patients were male (54.1%) and 28 female (45.9%). In group 1, 20 patients (54.1%) were male and 17 (45.9%) female. In group 2, 13 patients (54.2%) were male and 11 (45.8%) female. Age at the time of epiphysiolysis ranged from 120 to 199 months (averaging 155.97), while in group 1 the average age was 158.86 and in group 2, 151.50 months. The radiographic views analyzed were anteroposterior (AP) of the pelvis with internal rotation of the hips of 15° (lateral view of lesser trochanter) and Lauenstein (lateral view of the hips in “frog position”- flexion of 90° and abduction of 45°). Only the initial radiographs (at the time of the first epiphysiolysis event) were used, and the parameters were evaluated on the normal side, without any sign of slipping or pre-slipping. The parameters of comparison between the groups were: skeletal maturity, based on the situation of the ossification centers of the pelvis and of the proximal femoral region (Oxford method);18 Southwick angle (AP and Lauenstein);6,7 and posterior sloping angle of the proximal physis of the femur (or physeal angle, in the AP view)9 and posterior sloping angle of the proximal physis of the femur (Lauenstein).15 The Oxford method18 consists of a numerical score that can range from 0 (neonatal hip) to 45 (adult hip). This numerical value is found by adding up the score found in nine variables. (Figure 1) The Southwick angle is measured equally in the AP and Lauenstein views by the intersection of the straight line parallel to the long axis of the femur with the straight line that passes through the two ends of the epiphysis. In AP it is considered the greater angle and in the lateral view it is considered the lesser angle.6,7 (Figures 2A and 2B) The sloping angle of the proximal physis is obtained in AP by the intersection of the line that crosses the “teardrop” bilaterally with another that passes through the ends of the epiphysis (as in the Southwick angle).16 (Figure 2C) The posterior sloping angle, in the Lauenstein view, is determined by the intersection of a line perpendicular to the long axis of the diaphysis which passes through the ends of the epiphysis.20 (Figure 2D) All the parameters described were checked by two third-year residents from the Department of Orthopedics and Traumatology, assisted by two scholars from the Faculdade de Ciências Médicas da Santa Casa de São Paulo (School of Medical Sciences), all properly trained in the application of the methods. The values obtained were sent for statistical analysis for a comparison between groups 1 and 2, applying the Student’s t-test to each one of them.

RESULTS
Initially, due to the differences in the growth and maturation process between the two sexes, the Oxford method was compared among patients of the same sex. Accordingly, the groups were subdivided into male and female for the performance of the statistical analysis. The graphs present in this study are of the boxplot type, where the gray rectangle represents 50% of the studied sample,
while the other values are contained on the rest of the black line (distribution in quartiles). The small black band inside the rectangle represents the mean value. The values that fall outside standard deviation in each case are shown as isolated numbers, off the line.

Table 1 and Figures 3A and 3B show the values obtained for skeletal maturity, using the Oxford method, and their distribution. The statistical analysis demonstrated that there was a statistically significant difference (p<0.001) between groups 1 and 2, divided into male and female sex, in relation to skeletal maturity. In relation to the angles assessed, Table 2 and Figures 4A and 4B show the results obtained.

| Table 1. Comparison of skeletal maturity between groups 1 and 2, according to sex. |
|---------------------------------|---------------|----------------|----------------|----------------|
| Oxford                          | Sex (number) | Sex (number) | Sex (number) | Sex (number) |
|                                 | Mean          | Standard      | Confidence    | p              |
|                                 | Deviation     | Intervals 95% |               |               |
| Group 1                         | Male (20)     | 34.45         | 1.605         | 32.845 - 36.055 | p<0.001        |
|                                 | Female (17)   | 35.24         | 2.047         | 33.193 - 37.287 |
| Group 2                         | Male (13)     | 31.00         | 2.225         | 28.775 - 33.225 |
|                                 | Female (11)   | 29.73         | 2.054         | 27.676 - 31.784 |

Table 2. Values of the measured angles (minimum – maximum, mean and CI – confidence interval of 95%), showing the p-value after statistical comparison between the two groups.

| Angles (in degrees) | Group 1 | Group 2 | p  |
|---------------------|---------|---------|----|
|                     | Min – Max | Mean | CI 95% | Min – Max | Mean | CI 95% |   |
| AP Southwick        | 138 - 168 | 152.11 | 149.15 - 155.07 | 132 - 168 | 150.92 | 147.74 - 154.09 | 0.589 |
| L Southwick         | 0 - 28   | 12.43  | 10.45 - 14.42  | 5 - 34   | 16.58  | 13.29 - 19.88  | 0.032 |
| Physeal angle       | 10 - 41  | 26.97  | 24.26 - 29.59  | 5 - 42   | 25.96  | 22.05 - 29.87  | 0.654 |
| Posterior sloping   | 0 - 28   | 12.43  | 10.45 - 14.42  | 5 - 34   | 16.58  | 13.29 - 19.88  | 0.032 |

DISCUSSION

The performance of this study was based on two hypotheses: the first, that patients with epiphysiolysis, who have the disease in both hips or have a greater risk of developing it bilaterally, are skeletally immature when compared with the children in the
same age bracket with the unilateral disease, and even more so when compared to the normal children. As the physeal tissue of these predisposed patients is still very immature, it would have less resistance to mechanical loads and would have to bear these loads for a longer period of time, which would invariably predispose to physeal slipping. The second hypothesis is that the patients have hips with slight anatomical alterations, which can increase the risk of epiphysiolysis, and these alterations can be detected by measuring angles in simple radiographs.

Prophylactic surgical treatment in the contralateral femur, when the patient presents unilateral epiphysiolysis, remains a controversial subject. Although the procedure is relatively simple, it implies possible complications, inherent to any surgery, which may produce more harm than good. The current indication implies possible complications, inherent to any surgery, which may produce more harm than good. The current indication of such a procedure is based on the chronological age, yet the idea of making a decision using other parameters in conjunction appears reasonable to us given that the chronological age is not always consistent with the degree of skeletal maturity of the individual. Evaluating the results obtained in this study, we observed that there is a clear and considerable difference between the skeletal maturity of the patients from group 1 and those from group 2. The results corroborate the hypothesis that patients with bilateral epiphysiolysis have a more immature skeleton. The radiographs required for the evaluation according to the Oxford method are the same already used in the diagnosis and follow-up of patients with epiphysiolysis, which facilitates their use in the clinical practice, allowing the performance of retrospective studies like this one.

Among the angles assessed, we were surprised by the fact that the Southwick angle in the lateral view and the posterior slope of the proximal femur in the coronal plane are the same already used in the diagnosis and follow-up of patients with epiphysiolysis. These radiographic parameters can be used as complementary tools in the clinical practice, as predictors of bilateral involvement, to the effect of assisting in the choice of the prophylactic, conservative or surgical treatment, for the contralateral hip of a patient with epiphysiolysis.

CONCLUSION

The data and the statistical analysis present in this study allow us to conclude that the Southwick angles in the lateral view and the posterior sloping angles (mathematically equal) showed important correlation with the risk of appearance of bilateral epiphysiolysis ($p<0.05$). Skeletal maturity between the groups of patients with unilateral and bilateral epiphysiolysis, estimated by the Oxford method, presented important differences, with considerable statistical reliability ($p<0.001$). These radiographic parameters can be used as complementary tools in the clinical practice, as predictors of bilateral involvement, to the effect of assisting in the choice of the prophylactic, conservative or surgical treatment, for the contralateral hip of a patient with epiphysiolysis.

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