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Seasonal variation in adult hip disease secondary to osteoarthritis and developmental dysplasia of the hip

Tatsuya Sueyoshi, Merrill A Ritter, Kenneth E Davis, Randall T Loder

AIM
To determine if there was a seasonal variation in adults undergoing total hip arthroplasty for end stage hip disease due to osteoarthritis (OA) or sequelae of developmental dysplasia of the hip (DDH).

METHODS
The total hip registry from the author’s institution for the years 1969 to 2013 was reviewed. The month of birth, age, gender, and ethnicity was recorded. Differences between number of births observed and expected in the winter months (October through February) and non-winter months (March through September) were analyzed with the $\chi^2$ test. Detailed temporal variation was mathematically assessed using cosinor analysis.

RESULTS
There were 7792 OA patients and 60 DDH patients who underwent total hip arthroplasty. There were more births than expected in the winter months for both the DDH ($P < 0.0001$) and OA ($P = 0.0052$) groups. Cosinor analyses demonstrated a peak date of birth on 1st October.

CONCLUSION
These data demonstrate an increased prevalence of DDH and OA in those patients born in winter.
Core tip: The purpose of this study was to determine if there was a seasonal variation underlying total hip arthroplasty for osteoarthritis (OA) or developmental dysplasia of the hip (DDH). Differences between number of births observed and expected in the winter months and non-winter months were analyzed with the χ² test. There were 7792 OA and 60 DDH, and more births than expected in the winter months for both the DDH (P < 0.0001) and the OA (P = 0.0052) cohorts. These data clearly demonstrated an increased prevalence of DDH and OA in those patients born during the winter months.

INTRODUCTION

Total hip arthroplasty (THA) is a standard, successful treatment for end stage hip disease. The etiology of such disease is frequently due to osteoarthritis (OA), osteonecrosis/vascular necrosis (ON/AVN), rheumatoid arthritis (RA) and developmental dysplasia of the hip (DDH). Studies of hip osteoarthritis suggest that childhood deformities or residuals of childhood hip disease often experience accelerated or premature joint degeneration[1,2]. DDH is a wide spectrum of deformity ranging from mild acetabular dysplasia to complete and fixed dislocation[3]. Many studies have noted that DDH is more frequent in patients born in the colder months[4-6]. DDH with residual acetabular dysplasia is often followed by OA of the hip. OA has also been reported to be more frequent in people born in the winter[7]. The authors wished to determine if there was any seasonal variation in adults who are treated for OA and DDH in the Midwest region of the United States. This will further augment a previous study which noted a seasonal variation in children with DDH in this region[3].

MATERIALS AND METHODS

A retrospective review of all THAs performed from November 1969 through November 2013 at the author’s institution was performed. This review was approved by the local Institutional Review Board. There were 10572 THAs in 8579 patients that met the initial inclusion criteria of primary OA, RA, ON or DDH diagnosis. There were 192 THAs in 157 patients that did not have adequate demographic data and were excluded from any analysis. The diagnosis was OA in 7792 patients, ON/AVN in 523, RA in 204, and DDH in 60. Those with ON/AVN and RA were then excluded, leaving 9671 THAs in 7852 patients for analysis. Date of birth, age, and gender were gathered from the database of total joint surgeries performed at the authors’ institution based on medical records and operation note data at the time of surgery.

The months of the year were divided into winter and non-winter. Winter was defined as October through February, and non-winter as March through September based on local temperatures. The source for the average monthly temperature and precipitation was from the Indiana State Climate Office in Perdue University (https://climate.agry.purdue.edu/climate/facts.asp) (Table 1). Differences by winter and non-winter months were evaluated for both the DDH and OA groups. Temporal variation was analyzed using cosinor analysis (see below).

Statistical analysis

Continuous data are reported as the mean ± standard deviation. Categorical data are reported as frequencies or percentages. Statistical differences between continuous variables were analyzed by the student’s t-test and between categorical variables by the Pearson’s χ² test. Statistical Analysis System (SAS) version 9.2 (Cary, NC) was used for t-tests and categorical analysis where the expected value was set as the null hypothesis. The Statistical Package for Social Sciences (SPSS) version 12.0 for Windows (SPSS Inc., Chicago, IL, United States) was used for further statistical analysis. The data were subjected to cosinor analysis in an effort to mathematically define any seasonal variation when present. Cosinor analysis[8,9] determines the best mathematical fit of the data to an equation defined by F(t) = M + Acos (n(t) + ϕ), where M = the mean level (termed mesor), A = the

Table 1 Month of birth for 7852 patients undergoing total hip arthroplasty for osteoarthritis and sequelae of developmental hip dysplasia

| Month of birth | DDH | OA | Temperature (°F) | Precipitation (ins) |
|----------------|-----|----|-----------------|-------------------|
| January        | 10  | 17 | 745             | 9.6               | 26                | 2.5               |
| February       | 6   | 10 | 622             | 8                 | 30.5              | 2.3               |
| March          | 3   | 5  | 617             | 7.9               | 40.7              | 3.4               |
| April          | 3   | 5  | 585             | 7.5               | 51                | 3.9               |
| May            | 3   | 5  | 582             | 7.5               | 61.4              | 4.5               |
| June           | 4   | 7  | 613             | 7.9               | 70.5              | 4.2               |
| July           | 3   | 5  | 667             | 8.6               | 74.3              | 4.2               |
| August         | 0   | 6  | 675             | 8.7               | 72.2              | 3.9               |
| September      | 3   | 5  | 682             | 8.8               | 65.2              | 3.1               |
| October        | 14  | 23 | 702             | 9                 | 53.6              | 3                 |
| November       | 3   | 5  | 610             | 7.8               | 42.3              | 3.4               |
| December       | 8   | 13 | 692             | 8.9               | 31.2              | 3.1               |
| Total          | 60  | 100| 7792            | 100               | 41.5              |
amplitude of the cosine curve, $\phi =$ acrophase (phase angle of the maximum value), $\omega =$ the frequency (which for monthly analysis is $360^\circ/12 = 30^\circ$), and $t =$ time (which in this case is each month). The overall $P$ and $r^2$ value for the distribution are given for the rhythmic pattern described by the cosinor equation for $M$, $A$, and $\phi$. The data was analyzed for the entire period of 12 mo as well as decreasing increments of 1 mo. A best monthly fit may not be over a period of 12 mo, but a different time span (e.g., 7 or 6 mo periodicity). Cosinor analyses were performed with ChronoLab 3.0™ software (see Acknowledgement). For all statistical analyses the level of significance was set at $P < 0.05$.

RESULTS

The average age at the time of THA was $55.4 \pm 13.6$ years in the DDH group and $67.9 \pm 11.4$ years in the OA group. This age was analyzed for a period of 12 mo as well as decreasing increments of 1 mo. A best monthly fit may not be over a period of 12 mo, but a different time span (e.g., 7 or 6 mo periodicity). Cosinor analyses were performed with ChronoLab 3.0™ software (see Acknowledgement). For all statistical analyses the level of significance was set at $P < 0.05$.

DISCUSSION

This study demonstrates that both adult DDH and OA patients with end stage hip disease are more frequently born in the colder months. This is similar to pediatric DDH in the previous report \cite{3} and adult Japanese OA \cite{7}.

Children with DDH undergoing operative treatment demonstrated a peak birth on 15th October \cite{3}, and is essentially the same as the adult OA patients peak on 1st October. Nagamine et al \cite{7} noted that adult hip osteoarthritis in the Japanese population was more prevalent when the patient was born in the colder months. The authors subjected their data to cosinor analysis and found a peak on 20th January (Figure 2). The Japanese OA peak of 20th January is identical to the 26th January peak in Japanese children with DDH from Kochi, Japan \cite{3,10}.

There are certain limitations to this study. This is a retrospective study and diagnosis of DDH and OA was determined mainly by radiographs and patient history. The diagnosis of OA includes both primary and secondary OA \cite{7}. Patients undergoing THA are usually at the end stage of hip arthritis making it difficult to distinguish primary from secondary OA. Some patients will have shallow acetabulae, but once the joint space disappears at the lateral aspect of the acetabulum, it is impossible to differentiate between primary and secondary OA. The patient’s history may help, but most patients with DDH treated in infancy with a Pavlik harness or other abduction bracing may not be aware of that history; they would not be able to remember it due to their young age at the time of treatment and their parents may not have told them of such treatment. Although the DDH group was small, we still believe that the findings are valid due to the highly significant $P < 0.0001$.

These findings have several possible explanations. First, it is very likely that many of the OA patients had underlying, subtle mild DDH (e.g., minimal acetabular dysplasia). The population of OA, technically the secondary OA, may have just more of DDH than what the authors think. Another possible explanation is that both DDH and OA patients share some common, but as yet unknown, etiology. The possible factors/etiologies that can be invoked are pre-/perinatal maternal factors as well as postnatal environmental factors.

Figure 1  The cosinor fit for Indiana patients with hip osteoarthritis and month of birth. The best fit is represented by the equation: Number of OA births = 646.4 + 55.3 $[\cos(36t - 18) - 324]$, where $t = 1$ is January, 2 is February, 3 is March, etc. This was statistically significant ($r^2 = 0.56, P = 0.025$). The peak is 1st October (solid arrow). The data points are the black triangles and the best fit represented by the bold black line. OA: Osteoarthritis.
Sueyoshi T et al. Seasonal variation of OA and DDH

![Graph showing seasonal variation of OA and DDH](image)

**Figure 2** The cosinor fit for Japanese patients with osteoarthritis and month of birth. Data extracted from the study of [1]. The best fit is represented by the equation: number of OA births = 153.7 + 132.7 (cos30t-15)-21, where t = 1 is January, 2 is February, 3 is March, etc. This was statistically significant ($r^2 = 0.83, P < 0.001$). The peak is 20\(^{th}\) January (solid arrow). The data points are the black triangles and the best fit represented by the bold black line. OA: Osteoarthritis.

Potential pre-/perinatal factors are a breech birth or difficult delivery [12]. First born and high-birth-weight babies are at an increased risk of DDH, but those do not exhibit seasonal trend [6]. Obstetric pelvic insufficiency shows a seasonal variation with a peak in November to December [13]. In the current study, the authors did not investigate the patients’ birth history (pregnancy number or breech/vertex delivery). Since there been no report showing a relationship between osteoarthritis and breech/difficult delivery, it is most likely that residual DDH (minimal acetabular dysplasia) influenced the incidence of OA.

Another potential perinatal factor is relaxin, which stimulates collagenase and alters connective tissue [14,15]. Collagen metabolism is altered in DDH [16] with increased joint laxity [17]. However, the correlation between DDH and relaxin is controversial [18,19]. In addition, no seasonal variation in relaxin levels has been shown leading to the conclusion that relaxin is not a critical factor. Another possible factor is vitamin D, which is well known to have a seasonal variation with peak levels in the summer [20,21]. Low maternal levels of vitamin D result in low birth weight infants and increased levels in heavy infants [22,23]. A report from Norway suggests hip and knee osteoarthritis is more common in those born in the spring months [24], perhaps due to vitamin D issues.

In conclusion, this study demonstrated that patients undergoing THA for end stage hip disease due to OA or the sequelae of DDH are more commonly born in the colder months. This confirms previous reports noting the same phenomenon in both adult OA and childhood DDH. Further research will be needed to understand this association.

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**COMMENTS**

**Background**

Winter birth has been associated with developmental dysplasia of the hip (DDH) and it was reported recently to be related to hip osteoarthritis (OA). This study aims to investigate the epidemiology of DDH and OA according to the registry of total hip arthroplasty in the authors’ institution.

**Research frontiers**

To the authors’ knowledge, this is the first study to present both OA and DDH were associated with winter birth. Reviewing the registry over 40 years, the average age at the surgery was statistically younger in DDH patients than in OA patients. Both DDH and OA patients were more born in winter months than in non-winter months.

**Innovations and breakthroughs**

Several reports have shown DDH is often caused by swaddling during infancy, which was reported to be one reason DDH is associated with winter birth. The study demonstrated OA also was associated with winter birth. The etiology is still unknown why winter birth influences hip OA, but the study will contribute to elucidate the mechanism of OA and the prevention of hip surgery in the future.

**Peer-review**

It is an interesting and well-written article.

**REFERENCES**

1 Harris WH. Etiology of osteoarthritis of the hip. *Clin Orthop Relat Res* 1986; (213): 20-33 [PMID: 3780093]
Cooperman DR, Wallenstein R, Stulberg SD. Acetabular dysplasia in the adult. Clin Orthop Relat Res 1983; (175): 79-85 [PMID: 6839611 DOI: 10.1097/00002061-198305000-00013]

Loder RT, Shaffer C. Seasonal variation in children with developmental dysplasia of the hip. J Child Orthop 2014; 8: 11-22 [PMID: 24590336 DOI: 10.1007/s11832-014-0558-3]

Anand JK, Moden I, Myles JW. Incidence of neonatal hip instability: are there seasonal variations? Acta Orthop Belg 1992; 58: 205-208 [PMID: 1632220]

Record RG, Edwards JH. Environmental influences related to the aetiology of congenital dislocation of the hip. Br J Prev Soc Med 1958; 12: 8-22 [PMID: 13510578 DOI: 10.1136/geb.12.1.8]

Robinson GW. Birth characteristics of children with congenital dislocation of the hip. Am J Epidemiol 1968; 87: 275-284 [PMID: 5647859]

Nagamine S, Sonohata M, Kitajima M, Kawano S, Ogawa K, Mawatari M, Hotokebuchi T. Seasonal trends in the incidence of hip osteoarthritis in Japanese patients. Open Orthop J 2011; 5: 134-137 [PMID: 21584203 DOI: 10.2174/187432501105010134]

Nelson W, Tong YL, Lee JK, Halberg F. Methods for cosinor-rhythmometry. Chronobiologia 1979; 6: 305-323 [PMID: 548245]

Faure A, Nemoz C, Claustres B. A graphical and statistical method for investigation of time series in chronobiology according to the cosinor procedure. Comput Biol Med 1990; 20: 319-329 [PMID: 2257732 DOI: 10.1016/0010-4825(90)90011-D]

Haginomori K. A statistical study of congenital dislocation of the hip in the south-western part of Kochi prefecture. Shikoku Acta Med 1966; 22: 112-125

Hoaglund FT, Steinbach LS. Primary osteoarthritis of the hip: etiology and epidemiology. J Am Acad Orthop Surg 2011; 9: 320-327 [PMID: 11575911 DOI: 10.5435/00124635-201109000-00005]

Fredensborg N. Observations in children with congenital dislocation of the hip. Acta Orthop Scand 1976; 47: 175-180 [PMID: 944988 DOI: 10.3109/17435676708897914]

Berezin D. Pelvic insufficiency during pregnancy and after parturition. Acta Obstet Gynecol Scand Suppl 1950; 30: 170-182 [PMID: 14799179 DOI: 10.3109/00016345009164771]

Forst J, Forst C, Forst R, Heller KD. Pathogenetic relevance of the pregnancy hormone relaxin to inborn hip instability. Arch Orthop Trauma Surg 1997; 116: 209-212 [PMID: 9128773 DOI: 10.1007/BF03059711]

Sau gastad LF. Persistent pelvic pain and pelvic joint instability. Eur J Obstet Gynecol Reprod Biol 1991; 41: 197-201 [PMID: 1936503 DOI: 10.1016/0028-2243(91)90024-F]

Jensen BA, Reimann I, Fredensborg N. Collagen type III predominance in newborns with congenital dislocation of the hip. Acta Orthop Scand 1986; 57: 362-365 [PMID: 3788503 DOI: 10.1136/jon.174.6.53678608994412]

Carr AJ, Jefferson RJ, Benson MK. Joint laxity and hip rotation in normal children and in those with congenital dislocation of the hip. J Bone Joint Surg Br 1993; 75: 76-78 [PMID: 8421041 DOI: 10.1016/0301-6200(93)90043-4]

Hinderaker T, Dalveit AK, Igens LM, Udén A, Reikeras O. The impact of intra-uterine factors on neonatal hip instability. An analysis of 1,059,479 children in Norway. Acta Orthop Scand 1994; 65: 239-242 [PMID: 8042471 DOI: 10.1016/0001-6496(94)90158-0]

Vogel I, Andersson JE, Uldbjerg N. Serum relaxin in the newborn is not a marker of neonatal hip instability. J Pediatr Orthop 1998; 18: 535-537 [PMID: 9661868]

Stryl RP, Gilbertson TJ, Brunden MN. A seasonal variation study of 25-hydroxyvitamin D3 serum levels in normal humans. J Clin Endocrinol Metab 1979; 48: 771-775 [PMID: 429522 DOI: 10.1210/jcem-48-4-771]

Andersen R, Mølgaard C, Skovgaard LT, Broström C, Cashman KD, Chabros E, Charzewiska J, Flynn A, Jakobsen J, Kärkkäinen M, Kiely M, Lambberg-Allardt C, Moreira O, Natri AM, O’Brien M, Rogalska-Niedzwiedz M, Ovesen L. Teenage girls and elderly women living in northern Europe have low winter vitamin D status. Eur J Clin Nutr 2005; 59: 533-541 [PMID: 15714215 DOI: 10.1038/sj.ejcn.1602108]

Aghajafari F, Nagulesapillai T, Ronsley PE, Tough SC, O’Beirne M, Rahi DM. Association between maternal serum 25-hydroxyvitamin D level and pregnancy and neonatal outcomes: systematic review and meta-analysis of observational studies. BMJ 2013; 346: f1169 [PMID: 23533188 DOI: 10.1136/bmj.f1169]

Christensen HT, Elvander C, Lamont RF, Jørgensen JS. The impact of vitamin D in pregnancy on extraskeletal health in children: a systematic review. Acta Obstet Gynecol Scand 2012; 91: 1368-1380 [PMID: 22320535 DOI: 10.1111/aogs.12006]

Funnebo V. Arthritis of the hip and knee: environmental causes in the first year of life? A study of 1405 cases of arthritis in north Norway 1984-1989. Arctic Med Res 1995; 54: 151-154 [PMID: 7669129]

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