Surgery for hip preservation—let the patient decide

I got to thinking the other day. Thinking what might have happened had hip arthroscopy never existed. Around the world I see colleagues being threatened by Governments, insurers, even departmental heads who should know better. The basic tenet of the threats is that impingement is unproven surgery and, as a consequence, should not be undertaken until proof exists. So, my first question is simple—what do we (or they) mean by proof? Readers of JHPS may have read a recent Editorial, which addressed this very issue. There appears to be a view that only the procedure with the most successful result is the one that should be offered. Yet how valid a position is this? It must surely depend on the patient; patients, as many might agree, are at best unpredictable.

For example, if one operation carries a 95% chance of success and another only 65%, does that mean the 65% procedure is contraindicated? Let us look more closely. First, our definition of success, and our derivation of 95%, may not be the same as a patient’s and second, by what right do we discount a lower score? Take osteoarthritis, or for that matter dysplasia, as examples. The party line is that hip arthroscopy should not be undertaken in the presence of osteoarthritis nor, for that matter, in dysplasia. I have seen blood almost spilt at meetings when this matter is debated. And yet there are numerous papers now published that declare symptoms can be improved in both these conditions by the use of hip arthroscopy.

Looking closer still, we know that an arthroplasty undertaken for osteoarthritis of the hip has a probable 95% chance of improving a patient’s symptoms. We also know that a hip arthroscopy has, roughly, a 55% chance of doing the same, albeit for a limited time period. Does that mean hip arthroscopy should be excluded in the presence of osteoarthritis nor, for that matter, in dysplasia. I have seen blood almost spilt at meetings when this matter is debated. And yet there are numerous papers now published that declare symptoms can be improved in both these conditions by the use of hip arthroscopy.

Turning to the last issue (number 3.3) of JHPS, this was again filled with more information than any editorial can reasonably summarize. The review by Bech et al., I admit, went straight to our anaesthetic team, as reassurance that they are not alone in their management of pain after hip arthroscopic surgery. Meanwhile the paper by Hujazi et al. on the normal ischiofemoral distance definitely caught many eyes, as ischiofemoral impingement becomes more widely diagnosed in our various clinical practices.

And as for this issue, number 3.4, where does an Editor-in-Chief begin? I am spoilt for choice. That said, I did especially like the paper by Kivlan et al. on defining the greater

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trochanter-ischial space. Impingement in that area was not a problem I had actually considered and kick myself for not doing so. Thanks to these three very capable authors for bringing the matter to our attention. And while discussing hitherto undescribed phenomena, how about the paper by Schröder et al. on their so-called "hip vacuum sign", a new radiographic finding in FAI? I am straight back to all those frog-leg lateral radiographs to see what I might have missed.

As with earlier issues, JHPS is once again filled to the hilt with pearls and I commend each and every one to you.

My very best wishes to you all.

Richard Villar
Editor-in-Chief, JHPS

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