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Letters to the Editor

Letter to the Editor on “Bilateral Total Hip Arthroplasty has Similar Complication Rates to Unilateral Total Hip Arthroplasty”

To the Editor:

We congratulate the authors of recently published article “Bilateral Total Hip Arthroplasty has Similar Complication Rates to Unilateral Total Hip Arthroplasty” [1] for clearing the doubts amongst the arthroplasty surgeons and their referring physicians regarding the risks and benefits of bilateral THA in selected group of patients. They have analysed a large population of patients retrospectively and found that there was no significant difference in the medical complications in bilateral vs unilateral THA groups, except for higher infection rate in bilateral group.

Firstly, the title of the article should clearly mention the comparison of “simultaneous” bilateral THA with unilateral THA. Also, a look at the sample size which the authors have used shows that the authors have tried to compare the unilateral THA with simultaneous bilateral THA. We believe more meaningful comparison of the groups could have been made if the authors had compared groups comprising simultaneous bilateral THA with staged bilateral THA done early as well as late [2]. The comparison between these groups would have nullified any skew due to the underlying aetiology, which may have a bearing on the functional and other outcome measures. It would be interesting to know the aetiological comparison between the groups undergoing unilateral and simultaneous bilateral THA. It would also be an interesting statistic to know how many of the unilateral THA went on to have the second side THA and after how much time.

The title of this paper is misleading as it has not included any surgical facts and has not discussed the most worrisome immediate complication of THA, i.e., dislocation. The authors have failed to appreciate and document certain important surgical facts related to these THAs. It is not believable that in such a large series comprising 202,986 patients, they could not find any postoperative complications of dislocation in any of these patients, requiring re-manipulation, re-admission and revision hip surgery. Approximately 0.2–10% of primary THAs dislocate per year. These dislocations add to the healthcare costs, further risks to the patient, increased dissatisfaction and inconvenience to the surgeon [3,4]. The incidence of dislocation after THA is multifactorial and is influenced by the approach used by the surgeon. The postero-lateral approach used by many arthroplasty surgeons is associated with highest risk of dislocation as compared to anterior and lateral approaches and its incidence may, theoretically, increase with bilateral THA cases [3]. The present title of this article gives the impression that it has included all the complications following THA, but it has mainly focused on medical complications rather than the surgical ones.

This paper rightly pointed out that the bilateral group patients had less incidence of diabetes, CHF, atherosclerosis, vascular disease,

arrhythmias and COPD as compared to the unilateral group [1]. As mentioned by the authors, this may lead to selection bias and would lead to a “healthy cohort” effect when we try to compare the “comparatively healthy” bilateral THA with the unilateral group.

Lastly, as discussed by the authors, Parvizi et al [5] also mentioned that the patients who had bilateral simultaneous THA had higher blood requirements and lower postoperative haemoglobin at the time of discharge. However, the amount of transfusion required in each group and the blood loss pattern has not been described in this series.

We have the experience of doing bilateral THA in selected group of patients, mainly comprising younger individuals with bilateral problems of avascular necrosis, sickle cell disease, ankylosing spondylitis, rheumatoid arthritis etc. We have found that it is useful to operate these patients in lateral position, using either posterior or lateral approach. Although, it requires positioning of patients twice during the surgery, it gives an excellent exposure and orientation of the hip and better positioning of implants during THA. We also routinely check the position of both hips at the end of surgery, in supine position using image intensifier to confirm the proper location of the THA. This helps to detect a possible complication of hip dislocation whilst turning the patient twice during the surgery and manage it immediately by manipulation whilst the patient is under anaesthesia, saving embarrassment to the surgeon and a repeat visit of the patient to the operating theatre.

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