

Jung-Mo Hwang, Deuk-Soo Hwang, Chan Kang, Woo-Yong Lee, Gi-Soo Lee, Jeong-Kil Lee, Yun-Ki Kim, Reply:

We thank the readers for their interest in our manuscript published in September 2019 issue of *Clinics in Orthopedic Surgery*.¹⁾ We would like to answer the points raised by the authors of the letter to editor as follows:

First, we agree that the preoperative and postoperative lateral center-edge angles (CEAs) of Wiberg need to be carefully evaluated. However, we did not evaluate the preoperative and postoperative CEAs for some reasons. In the paper you cited, Sanders et al.²⁾ reported that neither preoperative nor postoperative CEA was consistently associated with lower hip function. And many other previous papers reported excellent hip function after arthroscopic treatment of patients with global overcoverage, even when postoperative CEA was greater than 40°. ^{3,4)} Sanders et al.²⁾ reported that a reduction in CEA is a more important determinant of hip function than the magnitude of the preoperative or postoperative CEA. If extraspinal diffuse idiopathic skeletal hyperostosis (DISH) involves the hip joint, particularly the superior acetabulum, hip pain and range of motion (ROM) limitation (femoroacetabular impingement symptoms) could be present.^{5,6)} We believe that assessing the magnitude of the preoperative and/or postoperative CEA is useful for evaluating radiologic results after arthroscopic decompression of hyperostosis of the acetabulum; however, it does not seem to reflect hip function after surgery. In our experience, many patients expect to have improved ROM of the hip joint after surgery. For these reasons, we evaluated the change in hip joint ROM, not the magnitude of the preoperative and postoperative CEA.

Second, we completely agree that the peripheral compartment (PC) of the hip joint would be explored first

when the entry needle access into the central compartment (CC) is blocked because of severe acetabular overcoverage and joint space narrowing. We also experienced this several times in case of Legg-Calvé-Perthes deformity, the peripheral type of ankylosing spondylitis, etc. In these conditions, we also accessed the PC of the hip joint first. Fortunately, in our study, the CC could be approached first because of proper widening of the joint space by traction. Once again thank you for the good surgical technique advice.

Finally, extraspinal DISH seems to be a slowly progressing disease characterized by abnormal calcification and/or ossification of soft tissues around joints, which may be one of the causes of hyperostosis and atypical osteoarthritis.⁷⁻⁹⁾ In our paper, the clinical outcomes were good at a minimum of 2 years postoperatively. However, long-term results need to be assessed to ascertain the effectiveness of the treatment.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

Correspondence to: Deuk-Soo Hwang, MD
Department of Orthopaedic Surgery, Chungnam National University
School of Medicine, 266 Munhwa-ro, Jung-gu, Daejeon 35015, Korea
Tel: +82-42-338-2480, Fax: +82-42-338-2482
E-mail: dshwang@cnu.ac.kr

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