

CORRESPONDENCE

Comment on ‘A T-capsulotomy provides increased hip joint visualization compared with an extended interportal capsulotomy’

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We read with great interest the recent article about the cross-sectional area (CSA) of joint visualization between interportal and T-capsulotomies by Cvetanovich *et al.* [1]. We congratulate the authors for their excellent work performed on 20-frozen cadaveric specimens. We are convinced that the results obtained from this study will enhance capsule management techniques for surgeons. Although we agree with the conclusion similar to our previous studies observed in the clinic, there are some worthwhile issues we like to comment on.

The authors described Full-T-capsulotomy significantly improved CSA of hip joint visualization [1]. However, Full-T-capsulotomy means completed destruction of capsule integrity and poor effect of fluid lavage during the hip arthroscopy surgery. During our practice, two 2-0 Ethibond sutures were used to pass through two sides of the capsule after interportal capsulotomy, then we pulled the sutures, the capsule was suspended, and the visualization of the proximal femur was improved. Based on our clinical experience this simple, reproducible and reliable method avoided T-capsulotomy, protected the capsule tissue and decreased the risk of iatrogenic instability.

We know that many clinical adverse events have been reported associated with interportal and T capsulotomies [2]. The development of heterotopic ossification and joint adhesion has been linked to excessive capsule excision [2, 3]. Micro-instability related to unrepaired capsule may consider as source of post-operative pain in patients who

have had extensive capsulotomy [2]. The capsule repair of large capsulotomies requires post-operative restrictions of motion that may lead to post-operative hip pain and stiffness [2]. Most recently, tissue-friendly techniques of capsule preservation had gradually accepted by hip arthroscopic surgeons. Both ‘Puncture capsulotomy’ [4] and ‘periportal capsulotomy’ [5] can provide safe and sufficient access to the hip joint without disrupting capsule integrity and therefore evading potential complications. So, capsule capsulotomies are not necessary practices *in vivo*.

We appreciate the authors' current work and hope that the biomechanical tests on different kinds of capsulotomies (interportal capsulotomies, Half-T capsulotomies and Full-T capsulotomies) will be performed in the future studies. At that time, we will know which kind of capsulotomies should be repaired during hip arthroscopic procedure, and we will update our knowledge.

ETHICAL APPROVAL

This article does not contain any studies with human participants performed by any of the authors.

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CONFLICT OF INTEREST STATEMENT

None declared.


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AUTHORS' REPLY

A T-capsulotomy provides increased hip joint visualization compared with an extended interportal capsulotomy: commentary response

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Dear *JHPS* editorial team,

Thank you for allowing us the opportunity to respond to the letter concerning our recent article entitled 'A T-capsulotomy provides increased hip joint visualization compared with an extended interportal capsulotomy.' We appreciate their critical analysis of our work and encourage others to question the literature as well. However, we believe that we can adequately account for and respond to these limitations in the context of our study without compromising its impact.

Previous studies in the literature have unequivocally indicated that the most common cause for revision hip

arthroscopy in patients who have previously undergone arthroscopic correction of cam impingement is incomplete femoral pathology resection. This coincides with revision cases seen in our practice, as most patients who present to clinic with persistent symptoms after undergoing surgical treatment at other outside institutions are due to both residual cam deformities, followed by capsular insufficiency in the setting of incomplete capsular closure. Although it is possible that incomplete cam correction is correlated with level of surgeon experience, based on our experience and what is previously reported in the literature, complete cam resection with the use of periportal capsulotomy may be