

Editorial

Every surgical career has seminal moments—when we undertake our first operation, when we pass our exit exams, when we receive a thank you letter from a patient whose life has been transformed by our efforts and so on. One of the earliest such moments in my career occurred while I was working as a junior doctor at the Royal National Orthopaedic Hospital, Stanmore. It was 1982; Doctors still wore a collar and tie, starched, pressed white coats and surgical teams wandered the wards, presenting, examining and discussing patients. Our patients were admitted the day before surgery, and my role was to present the case to the assembled throng on a pre-operative ward round.

One patient listed for hip replacement was a woman in her mid-thirties. It was clear from the notes that she had attended clinic on numerous occasions and that no one had been able to identify any evidence of degenerative changes on her x-rays [1, 2]. I sensed that our boss was a little wary of the patient and his conversation with her was brief. We regrouped around the light box to consider her x-rays. Before the registrars (residents) had a chance to query why someone with no sign of arthritis was having a hip replacement, the boss launched into an explanation that there were occasional patients whose lives were completely blighted by hip symptoms, who were on the point of losing their jobs and profoundly struggling with their family and social life. Despite the lack of radiological evidence of joint degeneration, hip replacement was the only way to relieve their pain and restore their function. He finished by saying that he suspected that the patient had had sub-clinical Perthes at some point and her symptoms were the consequence of a currently unrecognized sequelae of this condition.

This case intrigued me because it was so clear that there should have been a better solution for the patient's problem and if there was ever a reason for wanting to undertake hip preservation surgery this was it. A quarter of a century passed before I read Ganz's papers [3–5] that gave us a vocabulary to understand femoroacetabular impingement, and I wonder whether those seemingly innocent x-rays would now be assessed differently. The case also taught me a valuable lesson on clinical thinking. My boss's most cited research study had been an investigation on the effect of vascular compromise to the femoral capital epiphysis [6] and how this related to the development of Legg–Calve–Perthes disease. I cannot help wondering how his diagnostic thinking was influenced by this experience and reflect on how we all view our patients through the prism of our preconceptions.

Almost 20 years after Ganz's seminal papers, the hip preservation community continues to unravel the sequelae of femoroacetabular impingement and Shimodaira et al.'s study on

The prevalence and risk factors of pubic bone marrow edema in femoroacetabular impingement and hip dysplasia [7] broadens our understanding of the link between the hip and the adjacent bony junctions [8, 9].

For surgeons treating athletic injuries, one of the hottest controversies is the role of hamstring repair [10]. Lawton's paper on *Achievement of the minimal clinically important difference following open proximal hamstring repair* [11] provides a valuable contribution to this debate and provides hard data that can be used when informing patients with these injuries.

For the last 2 years, online conferences have provided a way to maintain contact with our national and international communities. I have found it a slightly sterile experience to watch or deliver lectures through my computer screen and hope that, by the end of 2022, live audiences and face-to-face social intercourse will be restored. The founding Editor of this journal has long been one of the most entertaining and eloquent speakers to grace our conference podiums, and one of his favoured topics is the ligamentum teres. He must be heartened to see that his enthusiasm for ligamentum teres reconstruction [12–14] is growing and that Lee et al.'s paper [15] investigating the longer-term consequences of ligamentum teres injuries has demonstrated that, at a minimum of 10 years, patients with partial ligamentum teres tears show a higher grade of chondral damage, experience decreased exercise capacity and have significantly worsened Tonnis grades than patients with an intact ligamentum teres.

I wish you all well and hope that you will share my enjoyment of JHPS issue 8.4.

References

1. Harrison MHM, Schajowicz F, Trueta J. Osteoarthritis of the hip: a study of the nature and evolution of the disease. *J Bone Joint Surg* 1953; **35-B**: 598–626.
2. Kellgren JH, Lawrence JS. Radiological assessment of osteo-arthrosis. *Ann Rheum Dis* 1957; **16**: 494–502.
3. Ito K, Minka-II M-A, Leunig M et al. Femoroacetabular impingement and the cam-effect. *J Bone Joint Surg* 2001; **83-B**: 171–6.
4. Ganz R, Parvizi J, Beck M et al. Femoroacetabular impingement. *Clin Orthop Relat Res* 2003; **417**: 112–20.
5. Beck M, Kalhor M, Leunig M et al. Hip morphology influences the pattern of damage to the acetabular cartilage. *J Bone Joint Surg* 2005; **87-B**: 1012–8.
6. Kemp HB. Perthes' disease: an experimental and clinical study. *Ann R Coll Surg Engl* 1973; **52**: 18–35.
7. Shimodaira H, Hatakeyama A, Suzuki H et al. The prevalence and risk factors of pubic bone marrow edema in femoroacetabular

- impingement and hip dysplasia. *J Hip Preserv Surg* 2021: hnab081.
8. Akgün AS, Agirman M. Association between cam-type femoroacetabular impingement and osteitis pubis in non-athletic population on magnetic resonance imaging. *J Orthop Surg Res* 2019; **14**: 1–6.
 9. Krishnamoorthy VP, Beck EC, Kunze KN *et al*. Radiographic prevalence of sacroiliac joint abnormalities and clinical outcomes in patients with femoroacetabular impingement syndrome. *Arthroscopy* 2019; **35**: 2598–605.e1.
 10. Haddad FS. Hamstring injuries and surgery: a new perspective. *Bone Joint J* 2020; **102-B**: 1269–70.
 11. Lawton CD, Sullivan SW, Hancock KJ *et al*. Achievement of the minimal clinically important difference following open proximal hamstring repair. *J Hip Preserv Surg* 2021: hnab068.
 12. Simpson JM, Field RE, Villar RN. Arthroscopic reconstruction of the ligamentum teres. *Arthroscopy* 2011; **27**: 436–41.
 13. Philippon MJ, Pennock A, Gaskill TR. Arthroscopic reconstruction of the ligamentum teres. *J Bone Joint Surg* 2012; **94-B**: 1494–8.
 14. Knapik DM, Farivar D, Kunze KN *et al*. Indications and outcomes after ligamentum teres reconstruction: a systematic review. *Arthrosc Sports Med Rehabil* 2021; **3**: e939–4.
 15. Lee J-K, Hwang D-S, Kim S-B *et al*. The role and clinical relevance of the ligamentum teres: long-term outcomes after hip arthroscopic surgery of cam-type femoroacetabular impingement. *J Hip Preserv Surg* 2021: hnab080.

Richard Field

Editor-in-Chief, Journal of Hip Preservation Surgery