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Letter to the Editor

Comment on: The Effect of Intra-articular Hyaluronic Acid Injections and Payer Coverage on Total Knee Arthroplasty Procedures: Evidence From Large US Claims Database

Dear Editor,

We read with great interest the article recently published in your journal, entitled "The Effect of Intra-articular Hyaluronic Acid Injections and Payer Coverage on Total Knee Arthroplasty Procedures: Evidence From Large US Claims Database". [1] Even if the interest in intra-articular hyaluronic acid in the treatment of knee osteoarthritis (OA) is of clinical importance, we sincerely believe this work presents some important limitations. The first important limitation is that no idea of the severity of knee OA [2], at the time of diagnosis or when the Intraarticular Hyaluronic Acid (IAHA) administrations were initiated, was reported. On the contrary, several guidelines based on high-quality articles, clearly reported that IAHA should be recommended only as a second-line treatment, that is, for patients who do not respond to background therapy with symptomatic slow-acting drug for OA or to Non Steroidal Anti-Inflammatory Drugs. [3,4] In other words, the patients included in the study of Molloy et al. [1] might have a greater level of severity than people who might be handled by nonpharmacological approaches or with a background treatment. Therefore, it seems quite obvious that those patients have a higher rate of total knee arthroplasty or a quicker need for total knee arthroplasty, finally leading to an important selection bias. Moreover, since these authors used administrative data, they were not able to differentiate important characteristics of the IAHA, namely the number of injections, the molecular weight of hyaluronic acid, and/or the number of injections that, on the contrary, play a significant role in the benefits that we can obtain from the IAHA. [5,6] Other important flaws in the study of Molloy et al. [1] are the limited consideration of important potential confounders, including pain severity, quality of life, or disability that, on the contrary, may affect the response to IAHA [7]. Finally, we would like to take into consideration a recent commentary stating that seven published reviews representing more than 65,200 patients have confirmed the efficacy of IAHA. [8]

In conclusion, even if we thank Molloy et al. [1] for their contribution, we believe that their findings should be considered very cautiously since several important biases are present and since these data are not representative of the entire population affected by knee OA, which probably requires a step by step approach, based on a tailored therapy that includes the use of IAHA in some cases in which oral therapy failed.

Conflicts of interest

N. Veronese reports personal fees from IBSA, Mylan, Viatris, Fidia, MSD; J. Y. Reginster was consultant with IBSA France and received a fee for speech from IBSA Italy; O. Bruyère reports consulting or lecture fees from Amgen, Aptissen, Biophytis, IBSA, Mylan, Novartis, Orifarm, Sanofi, UCB and Viatris; F. Pegreffi did not report any conflict of interest for this work.

For full disclosure statements refer to https://doi.org/10.1016/j.artd.2023.101128.

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