Correspondence

Incomplete periacetabular acetabuloplasty

Sir—We read the article entitled "Incomplete periacetabular acetabuloplasty" with great interest (Carsi et al. 2014). The treatment of developmental dysplasia of the hip is still problematic because of the residual acetabular dysplasia.

Without doubt, the "one-stop procedure" of Carsi et al. is very interesting. However, there are a few points that we could not understand.

First point is about the patients younger than 1 year old. As the results of open surgical reduction without an osteotomy are very satisfactory, we wonder why they used periacetabular osteotomy in these young patients (Morrissy and Weinstein 2006).

Second point is the osteotomy technique which is defined as incomplete periacetabular osteotomy. We think that the technique actually is an intraarticular osteotomy as the fulcrum point for the correction is over the acetabular weight bearing area as seen in Figure 1 (Carsi et al. 2014).

Third point is about patients older than 2 years old. Although classical periacetabular techniques do well in this age group we wonder why they used incomplete osteotomy instead of complete osteotomy (Morrissy and Weinstein 2006).

Furthermore their data showed a patient who underwent open reduction and periacetabular osteotomy with an acetabular index of 23 degrees. Although the age of the patient has not been given in the text this patient's hip can be classified as mild acetabular dysplasia which might benefit from simple observation after open reduction (Tonnis 1987).

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Sir—We want to thank Dr. Aydin and Dr. Senaran for his valuable comments.

Firstly, we recognise the scope for waiting in the younger population; however, we want to emphasize how acetabuloplasties are a simple step at the time of the open reduction that precludes residual acetabular dysplasia without adding significant surgical time or morbidity. In our previous series (Clarke et al. 2005, Bolland et al. 2010) residual acetabular dysplasia, albeit less frequent after open reduction than after closed, was still (around 20%). An incomplete periacetabular acetabuloplasty minimizes this risk at all ages.

Secondly, we politely disagree in calling the acetabuloplasty an intra-articular osteotomy, as the entry point is above the reflective head of the rectus tendon, well into the pelvic bone and not at the cartilaginous junction. The hinge probably occurs both through the bone at the weight bearing area and triradiate cartilage (much like a Dega osteotomy does), although we would like to stress that acute correction of the acetabular index is not the aim, but stimulation of the remodeling cascade.

Thirdly, incomplete periacetabular acetabuloplasties (IPA) are less invasive than complete acetabuloplasties, whilst requiring no additional bone graft and they have proven effective in this age group as well.

Finally, as the main purpose of the IPA is not the acute correction of AI, but the 'firing up' of the remodelling, they are useful adjuncts, even in those patients who present with instability and normal acetabular indices.

As our paper stresses, this simple added step has proven effective in a range of patients, earning the title of a 'one-stop' procedure for DDH. We understand that many authors would still prefer an a la carte approach. However, it is an easy procedure to learn and teach, removing the uncertainty about residual acetabular dysplasia.

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