



Hip Arthroscopy of a Painful Hip with Borderline Dysplasia: Letter to the Editor

Mingjin Zhong, MD, Kan Ouyang, MD

Department of Sports Medicine, The First Affiliated Hospital of Shenzhen University, Health Science Center; Shenzhen Second People's Hospital, Shenzhen, China

Dear editor

Hip arthroscopy for treatment of borderline developmental dysplasia of hip (BDDH) is a quickly evolving procedure. Although the clinical outcomes of hip arthroscopy in the treatment of BDDH are encouraging¹⁻³, there are still some problems worth discussing. For this reason, we read with great interest the article entitled “Hip Arthroscopy of a Painful Hip with Borderline Dysplasia” by Yoon et al.⁴. On the basis of a retrospective series of 45 patients (47 hips), their results show that arthroscopic management may be beneficial for patients with BDDH. In general, we agree with the authors' conclusions as we have observed in our clinic. However, there are some issues we like to point out.

The definition of BDDH is a very important issue that may affect the treatment decisions and clinical outcomes for these patients. In this article, BDDH is defined as lateral center edge angle (LCEA) between 20° and 25° by Yoon et al.⁴. We do think use only one parameter to define BDDH may not be very strict. Actually, there is

no uniform diagnostic criteria for BDDH according to the published literatures. Therefore, we need to carefully and comprehensively evaluate various radiographic parameters, such as LCEA, anterior center-edge angle, Tönnis angle, vertical center anterior angle and Shenton line from X-ray films to define BDDH^{1,5}.

This study concludes that the preoperative pain score (visual analogue scale) appears to be the sole indicator for poor outcomes. It reinforces the need for accurate patient selection. Previously, we have known that patients with BDDH who have a lower LCEA and greater age will be at higher risk of failure after primary arthroscopic hip surgery². We thank the authors for providing a new indicator for clinical decision-making. Unfortunately, the details of the degree and duration of preoperative pain that can be a relative contraindication are not mentioned by the authors. And pain as an abstract concept can hardly be evaluated objectively. Pain symptoms of patients with BDDH can be caused by joint synovitis, labral tears, ligamentum teres injuries, cartilage delamination or instability. So, we do think intra-articular pathology is also the key indicator for prognosis after hip arthroscopic surgery⁵.

Some patients with BDDH were performed hip arthroscopic labral debridement, T-shape capsulotomy or capsule unrepaired by the authors. However, we advocate soft tissue-friendly restorative techniques such as labral repair and capsular plication in dysplastic hips, because these are static stabilizers of the hip joint³. It is unclear whether the difference in operative details will affect the long-term results. We agree with the authors that future research on hip arthroscopy in management BDDH may require long-term follow up, larger sample sizes, multicenter and prospective studies. At that time, we will also update our knowledge.

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Address reprint request to

Mingjin Zhong, MD

(<https://orcid.org/0000-0002-8851-1424>)

Department of Sports Medicine, The First Affiliated Hospital of Shenzhen University, Health Science Center; Shenzhen Second People's Hospital, 3002 Sungang West Road, Futian District, Shenzhen 518000, Guangdong province, China

TEL: +86-0755-83366388 FAX: +86-0755-83356952

E-mail: sportsmedzhong@sina.com

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CONFLICT OF INTEREST

The authors declare that there is no potential conflict of interest relevant to this article.

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