We welcome letters to the Editor concerning articles which have recently been published. Such letters will be subject to the usual stages of selection and editing: where appropriate the authors of the original article will be offered the opportunity to reply.

Letters should normally be under 300 words in length, double-spaced throughout, signed by all authors and fully referenced. The edited version will be returned for approval before publication.

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Robert Jones, Gathorne Girdlestone and excision arthroplasty of the hip

Sir,
I wish to make some further observations on the article published in the January 2005 issue.1

Conference was held thrice weekly at the Nuffield Orthopaedic Centre in my years in Oxford 1948 to 1953, firstly with Professor Seddon in the Chair and after 1950 with Professor Trueta in charge. Girdlestone was very much in evidence prior to his death in 1950. Many patients with osteoarthritis of the hip were presented by the registrar in front of assembled staff who then migrated through a sliding door to discuss the case in the absence of the patient in the adjacent room. In every case the final question was raised, “Well, what shall the treatment be, pseudarthrosis, osteotomy or arthrodesis?”. In every case the inevitable answer was pseudarthrosis, excision arthroplasty of the hip! Girdlestone’s experience with tuberculosis of the hip as described by Horan1 was applied to the osteoarthritic hip in hundreds of patients, operation was followed by traction for several weeks and the patient then walked on an ischial-bearing caliper with a knee flexion hinge. Some of the results were excellent and some were very disappointing. Girdlestone’s operation therefore extended long beyond its initial application to tuberculosis and continues for some patients with septic failure of total hip replacement.

doi:10.1302/0301-620X.16753

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The prevention of traditional bone setter’s gangrene

Sir,
We read with interest the article in the January 2005 issue by Eshete1 entitled ‘The prevention of traditional bone setter’s gangrene’. We appreciate the concern shown by Dr Eshete and his colleagues towards their community. Shah2 also reported encouraging results from an effort to bridge the gap between orthodox and unorthodox medical practitioners in Nepal. Although most reports of traditional healers originate from African countries, their impact is felt in all developing countries. In India, it is estimated that there are about 70 000 traditional healers and bone setters who treat 60% of all trauma patients.3 Little or nothing is known of how well these patients recover, although incidences of failure reported to health centres are damaging to the bone setters’ reputation.

Bone setters will continue to exist. With their unscientific methods and without knowledge of anatomy, physiology or radiography, complications will inevitably occur. However, education plays a key role in influencing their method of treatment. They should be urged to adopt the fine example of Chinese healers, who refer complicated cases to orthopaedic experts in equipped centres. Interaction with traditional healers should not necessarily be one-sided. Some healers are experienced and have a sound knowledge of regional resources. For example, the Puttur bandage, which is a type of forearm bandage used in southern India, is considered superior to the normal ‘collar and cuff sling’ used by orthopaedic surgeons.4 This bandage supports the arm at the wrist and angle of thumb and palm, preventing wrist-drop.4

Integrating the services of traditional bone setters into primary health care also requires a strong political commitment. They should be permitted and encouraged to attend as orthopaedic assistants in primary trauma departments of district hospitals.5 A particular village can be adopted by a teaching medical institution as part of a rural health scheme to provide education and to address the health problems of that particular region. This should be supplemented by legislation to regulate these traditional practices so as to limit them to what is considered safe.

doi:10.1302/0301-620X.16755

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R. AGARWAL, MD
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Author’s reply

Sir,
I would like to thank Drs Agarwal and Agarwal for their interest in my paper. I agree entirely with their comments and suggestions. Although there is a significant shortage of both qualified surgeons and well-equipped hospitals in Ethiopia at the moment, I have shown that the confidence and co-operation of traditional
The importance of leg length discrepancy after total hip arthroplasty

Sir,
I read with interest the article by Konyves and Bannister\textsuperscript{1} in the February 2005 issue entitled ‘The importance of leg length discrepancy after total hip arthroplasty’. Leg length discrepancy (LLD) is a common post-operative complication following total hip replacement and, as expected, patients who had increased LLD were more likely to detect discrepancy than those with short or equal leg lengths. Given the range of leg length discrepancy of the sample (-22 mm to 27 mm), it would have been interesting if the authors had been able to determine whether a correlation exists between the length of the discrepancy and resulting change in the Oxford hip score. If the perception of LLD does not change with time as suggested by the authors, such data may provide useful prognostic information.

doi:10.1302/0301-620X.87B8.16725

W. Y. KIM
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Author’s reply:

Sir,
We thank Mr Kim for his interest in our article. We found that patients who detected lengthening of their limbs had a less satisfactory outcome than those who perceived their limbs as being of shorter or equal length. The degree of lengthening did not correlate with a change in the Oxford hip score, which was the instrument we used to measure outcome. It appears that once the patients had perceived limb lengthening, the outcome of their hip arthroplasty was adversely affected for a year following hip arthroplasty, which was the duration of our study.

In a previous study from this unit, it was found that the greater the lengthening, the greater was its perception. Thus lengthening of 5 mm was perceived by 16% of patients, 6 mm to 10 mm by 53% and more than 10 mm by 100%. This study did not address functional outcome.

doi:10.1302/0301-620X.87B8.16727

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Surgical treatment of late developmental displacement of the hip

Sir,
We read with interest this article in the March 2005 issue by Angliss et al\textsuperscript{1} entitled ‘Surgical treatment of late developmental displacement of the hip: results after 33 years’ and would like to congratulate the authors upon their excellent results.

We consider iliopsoas to be a key factor in both operative and non-operative treatment of developmental displacement of the hip. We always use vertical instead of longitudinal traction for conservative treatment. Operative reduction and visualisation of the joint through a Smith-Petersen approach without exposure of iliopsoas is almost impossible. Iliopsoas is always shortened and it should be lengthened. This can be done by using the transverse two-incision technique, strictly in the zone of tendinous fibres. Careful protection of the medial circumflex artery is vital.\textsuperscript{2}

The majority of revisions which we have performed were required because of unresolved pathology of iliopsoas. With adequate exposure and meticulous surgical technique, the circumflex vessels can be protected.

doi:10.1302/0301-620X.16754

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