Letter to the editor

Reply to the letter by C.J. Fontaine

Total hip replacement (THR) quickly proved more effective than proximal femoral resection (PFR) in reducing pain. PFR has become the exception in our center, which ruled out designing a level II prospective comparative study between THR and PFR. The study objective was mainly to confirm the usefulness and above all feasibility of the procedure.

We have no explanation for the fact that verticalization was lost in 5 out of 10 patients. Pain and functional scales were filled out by the physicians, but the question of why there was no verticalization (rather than loss of verticalization) was not included.

The surgical technique is particular. So far as possible, we took account of frontal and sagittal pelvic orientation, especially in case of oblique pelvis of spinal origin. Acetabular reaming systematically respected the quadrilateral lamina. The main precaution to be taken to prevent intrapelvic migration is in our opinion femoral shortening, which moreover avoids surgery on retracted and/or spastic muscles.

The technical problem of implant size mainly concerns the femur in patients in whom it is of small diameter, sometimes curved and sometimes modified by a varization procedure performed in infancy. We therefore measure it systematically when surgery is indicated, not on CT but on whole-femur X-ray with graduated ruler.

The decision to operate can obviously not be taken solely by the surgeon, who is not acquainted with the everyday life of these young adults with multiple disability. Almost all the patients had been seen in their residential center by the surgeon, the center physician, one or both parents and the nursing assistants, so as to make the right decision, which was taken only after “objective” confirmation of pain, which is often possible even in such severely disabled patients by using the San Salvador pain scale.

We would like to conclude by underlining the fact that it was the care staff in these residential centers who, having seen the difficult postoperative course associated with the proximal femoral resections we used to perform, now ask us, whenever reasonable, to use THR. It must not be forgotten, however, that, in these fragile patients with non-negligible risk of complications, this is a much more technically difficult operation than classic THR.

Disclosure of interest

The authors declare that they have no competing interest.

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