

Editorial Commentary: Hip Arthroscopy—Bimodal Bump and Volume Matters



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Abstract: In the experience of a high-volume hip arthroscopic surgeon with a referral practice, a bimodal age distribution could be common. Younger patients presenting with symptomatic hip pathology recalcitrant to nonoperative management may seek or be referred to high-volume surgeons, and older patients absent significant osteoarthritis may also be surgical candidates. Lower-volume hip surgeons could have higher complication rates, and it is incumbent on higher-volume surgeons to train upcoming colleagues as hip arthroscopy continues to grow.

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As I become older, my patients become younger . . . compared with me. Indeed, by my ever-upward trending age, one might say I see pediatric 50 year olds. But my dedicated hip arthroscopy practice has a bimodal distribution of young and old patients. The study “A Shift in Hip Arthroscopy Utilization by Patient Age and Surgeon Volume: A New York State–Based Population Analysis 2004-2016” by Schairer, Nwachukwu, Suryavanshi, Yen, Kelly, and Fabricant¹ reached a conclusion that makes perfect sense yet matches only the younger extreme of my practice.

In a New York State–based longitudinal epidemiologic study, Schairer et al.¹ report a significant increase in hip arthroscopic procedures performed in the 10- to 19-year-old age group, with patients of higher-volume surgeons tending to be younger than those of lower-volume surgeons. The younger bump of my bimodal practice is fully consistent with this finding and makes sense. With growing recognition by referring providers, inquisitive patients or parents, and evidence-based studies supporting similar successful if not better outcomes in adolescent patients with femoroacetabular impingement (FAI) treated with hip arthroscopy,² a

greater volume of adolescent patients are being evaluated for recalcitrant symptoms. Schairer et al. also speculate that many of these young, often athletic patients, in particular, may seek out more experienced higher-volume surgeons. I have performed arthroscopic femoroplasty in some patients as young as 11 years of age and have not had any adolescent patient undergo iatrogenic slippage of the capital femoral epiphysis or any deformity from premature physeal closure. I intentionally retain a greater than 180° arc of intact perichondral ring. An emerging study supports my experience.³

But what about the bump at the other end of the age spectrum? Shouldn't an old dog like me have the experience and judgment to just say no to the older ilk? In that case, summarily dismissing an older cohort could be the wrong answer. Some background: My practice is closely associated with several high-volume minimally invasive spine surgeons who often refer older patients with hip-spine syndrome to me. (Spoiler alert: This is a next big thing in hip arthroscopy.) This can explain at least in part my relatively high practice volume of patients aged 50 years or older. Although some studies have suggested older age as a relative predictor of poorer outcomes, we recently published a study showing that active patients aged 70 years or older with recalcitrant FAI and no or minimal arthritis had arthroscopic outcomes similar to a younger control group while having no osteoarthritic progression.⁴ If this finding holds true (and further studies on this topic are needed to verify or refute it), the authors, including myself, raise a controversial issue. If an active 70-year-old patient with recalcitrant FAI syndrome has no

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radiographic evidence of arthritis, is he or she told to live out the golden years with it (making these years perhaps less golden)? Or is total hip arthroplasty (THA) the only surgical option? How about the patients who were informed by respected joint reconstruction colleagues that THA is not indicated and/or are referred for hip arthroscopy? Or what if medical comorbidity precludes THA, even if offered? I submit that hip arthroscopy may be an attractive option, enabling outpatient surgery with rapid postoperative rehabilitation. In this older patient subset (which is small), by decreasing 1 (cam) bump, I am increasing another at the far right of the age distribution.

Another interesting finding from the study by Schairer et al.¹ is that of 128 total surgeons performing hip arthroscopy, 119 were low-volume surgeons, performing a mean 12.3 cases per annum. With any technically challenging procedure, (case) volume matters. One recent study reported a career volume of at least 519 cases had a significantly lower risk of subsequent hip surgery than cases performed by lower-volume surgeons.⁵ Another study reported that a minimum surgeon volume of 60 cases per annum was needed to decrease major complication rates.⁶ As more surgeons add hip arthroscopy to their proffered procedures, rather than discourage this, those of us veterans should remind and humble ourselves (weren't we once rookies?) and embrace a local, national, or even international movement to teach and mentor, just as we were once taught and mentored. My father-in-law, a businessman, once asked me, almost 2 decades ago, why Dr. Thomas Sampson, now a dear friend, would share with me his then newly developing techniques for arthroscopic femoroplasty rather than retain his proprietary secrets. My reply was something akin to "Medicine is a career that transcends business."

Medicine in general, and I believe orthopaedics in particular, is an honorable profession. I am blessed, honored, and humbled to pay it forward, in this case, as hip arthroscopy continues to grow, refine, and evolve across the globe to the benefit of the patients who seek our help as we seek to help them.

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