

Comment on: “The Influence of Bone Loss on Glenoid Version Measurement: A Computer-Modeled Cadaveric Analysis”



We read the article, “The Influence of the Bone Loss on Glenoid Version Measurement: A Computer-Modeled Cadaveric Analysis” by J. W. Griffin et al.¹ with great pleasure. We are currently conducting a study on glenoid morphology. The literature demonstrates the importance of the natural replacement of glenoid morphology and its implications in practice in instability and joint replacement surgeries.^{2,3}

The technique described by Friedman is still used in our day in glenoid version measurements. In this technique the position of the joint line, with respect to the line of neutral version defined regarding the scapular axis, is defined as anteversion or retroversion.⁴ The effect of the anterior and posterior glenoid defects, created on a computer using this technique, on the version has been investigated in the above-mentioned study. It was reported in the study that all specimens were retroverted and that the anterior defects decreased this angle of retroversion, whereas the posterior defects had an opposite effect, as stated in the Results section. Despite the usage of the term “version” for reflection of the glenoid defect in the measurements in Table 1, the authors used the wording “decreased anteversion” instead of the term “version” in the paragraph that talks about anterior instability, under the Discussion section. In anterior glenoid defects, retroversion decreases, not anteversion. On the contrary, anteversion increases. We wanted to highlight that this expression may cause misunderstandings.

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Regarding “Patient Satisfaction With Nonopioid Pain Management Following Arthroscopic Partial Meniscectomy and/or Chondroplasty”



We read with great interest the study by Daniels et al.¹ titled “Patient Satisfaction With Nonopioid Pain Management Following Arthroscopic Partial Meniscectomy and/or Chondroplasty.” We want to thank Daniels et al. for taking the time to explore the critical topic of non-opioid-mediated postsurgical pain management. In their single-center prospective study of 163 patients, they compared the patient satisfaction rate for opioid and non-opioid treatment after meniscectomy and chondroplasty. This article is of great interest to us as it evokes important topics by addressing the opioid over-prescription by orthopaedic surgeons.² Currently, as mentioned in the study, orthopaedic surgeons are the third-highest prescribers of opioids among American physicians.² With the opioid epidemic in full

effect, there is a glaring and immediate need for alternative postoperative pain management in less involved operations.² As mentioned by Daniels et al. in their work, multiple studies have described non-opioid regimens in various procedures offering similar pain management to opioid regimens.^{3,4}

Daniels et al.¹ did a great job collecting patient demographic characteristics such as age, body mass index, sex, race, preoperative depressive symptoms, and preoperative opioid use. It is mentioned in the limitations that the study was not sufficiently powered to show an association of patient satisfaction with demographic characteristics, and thus, nonsignificant findings do not eliminate a possible correlation.¹ We believe including more detailed demographic characteristics would have allowed further clarification regarding patient satisfaction. Additional demographic characteristics would also better clarify the results and aid readers in understanding the satisfaction of certain patient populations with postoperative non-opioid treatment. Because this was a single-center study and although limited generalizability was referred to as a limitation, it is crucial to have detailed information regarding not only the general location of the study (i.e., suburban, urban, or rural) but also the patient population that is being studied. Specifically, using patient socioeconomic factors in patient demographic characteristics would allow for a more complete understanding of patient satisfaction and a possible correlation.

In the current literature, patient education level has been shown to be correlated with opioid prescription use. Moreover, patients with a lower education level were shown to receive significantly more opioid prescriptions than their more highly educated peers.⁵ Somewhat contrarily, patients in the higher income quartile were significantly more likely to be prescribed opioids than patients with a lower income.⁶ These results were noted to be independent of sex and race.⁵ With disagreement between studies linking social demographic characteristics to opioid prescriptions, inclusion of education, income, and other social determinants of health in patient demographic characteristics would help better clarify the demographic characteristics correlated with higher non-opioid satisfaction rates and allow readers to understand which patient population was being studied.

Nonetheless, we commend Daniels et al.¹ on their exceptional work in evaluating postoperative non-opioid patient satisfaction. Ultimately, though, we believe inclusion of additional demographic characteristics, such as patient education and socioeconomic status, would provide greater clarity and potentially provide correlation between patient demographic characteristics and patient satisfaction with postoperative non-opioid prescriptions. We invite any clarification that would

help further support the authors' findings and propose additional dialogue for future projects.

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We would like to thank the authors, Mehta and Gupta, for taking interest in our recently published article, "Patient Satisfaction With Nonopioid Pain Management Following Arthroscopic Partial Meniscectomy and/or Chondroplasty". Mehta and Gupta make an important