

Besides, patients are always admitted for anterior cruciate ligament reconstruction procedures in Taiwan because of the national insurance policy. Therefore, during the admission, recording drain output in the early postoperative period is relatively simple and convenient.

Another question mentioned by Gobbi et al. relates to potential tamponade and clot formation in the drain. Our control-group patients also had the drain clamped for 2 hours; therefore, the tamponade effect was the same in both groups. In our patients, we did not find the drains plugged by clots. Hence, clot formation might not be as evident as expected.

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Regarding “Midterm Outcomes Following Repair of Capsulotomy Versus Nonrepair in Patients Undergoing Hip Arthroscopy for Femoroacetabular Impingement With Labral Repair”



I read the study by Bolia et al.¹ with great interest. As the annual number of hip arthroscopy procedures performed is increasing, there is a clear need for studies investigating outcomes of this procedure. Because the technique itself is still evolving, it is important to investigate surgery-related factors to optimize the outcome of this procedure. One controversial issue is the management of capsulotomy performed during the surgery.^{2,3} Although the hip joint is an inherently stable joint, there is emerging concern about the effect of capsulotomy on postoperative stability of hip joint, especially if the capsulotomy is left unrepaired.⁴ Capsulotomy resulting from a violation of ligamentous structures is suggested to result in long-term deterioration in hip function ultimately requiring a conversion to a total hip arthroplasty (THA).⁵ Current evidence for this is conflicting and the exact pathomechanism of this process is poorly established but is under extensive investigation.

Bolia et al. sought to examine the conversion rate to THA in patients having undergone a repair of capsulotomy compared with those without a repair. Their study was a case-control study in which 42 patients without a repair were matched to 84 patients with a repair. The authors reported that 6 of 42 patients (14%) without a repair and 3 of 84 (4%) patients with repair were converted to a THA. This result was accompanied by a *P* value of .01. This result was further communicated as “Patients in the nonrepair group were 6.8 times (95% confidence interval, 1.2-52) more likely to require THA than patients in the repair group.”

I have 2 concerns regarding their main outcome result. First, expression of “times more likely” is a probabilistic statement that is inadequate in case-control studies. Second, and most important, the authors do not report any test to handle this binary data in the Methods section.

Using Fisher’s 2-sided exact test, the associated *P* value is .059. Chi-square test with and without Yates

correction results in P values of .067 and .028, respectively. Using univariate logistic regression, patients without a repair has a crude (unadjusted) odds ratio of 4.5 (95% confidence interval, 1.1-22.3, $P = .041$) for conversion to THA.

As can be seen, statistical significance of the main result is located just around the borderline value of .05 depending on the test used. Interpretation of such a result is full of caveats, such as labeling the finding as “significant” or “not significant.”⁶ Small sample size and low event rate indicate high uncertainty around the point estimate for THA conversion, which should be appreciated to avoid P value fallacy. Methods to handle binary data, however, are not reported by the authors, which is very concerning. Thus, the robustness of the main outcome result about THA conversion cannot be evaluated.

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Author Reply to “Regarding ‘Midterm Outcomes Following Repair of Capsulotomy Versus Nonrepair in Patients Undergoing Hip Arthroscopy for Femoroacetabular Impingement With Labral Repair’”



We appreciate Dr. Reito’s comments on our recent publication. We apologize for the incorrect numbers in the manuscript. These numbers were for 2 failures in the repair group; however, as the final paper stated, we had 3 failures. We used Pearson’s chi square for our P value, which was .028, using SPSS, version 25. We updated the data and changed the odds ratio. The odds ratio should have been 4.5 (95% confidence interval, 1.1-19). We will submit a correction to *Arthroscopy* immediately. In addition, we agree that the statement “times more likely to” is a suboptimal statement; however, it is commonly used in the literature. In our future publications, we are now just stating the odds ratio instead of using it in a sentence regarding increased risk.

As for the use of P values for statistical significance, for this study and many like it, we set .05 as our threshold for statistical significance. Although there are some looking to move this threshold, it is currently the most common used in the literature. We believe the results of total hip arthroplasty conversion in this study are robust. However, to supplement this, we also included measures of clinical improvement. We showed that the percentage of patients who reached minimal clinically important difference for the hip outcome score-activity of daily living and hip outcome score-sport was significantly higher in the repair group. As with all studies, we will leave it to the readers to interpret our findings and apply them to their practice.

Thank you for catching our mistake and for your interest in our research.

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