Regarding "Return to Work Following High Tibial Osteotomy With Concomitant Osteochondral Allograft Transplantation"

We read with great interest the article "Return to Work Following High Tibial Osteotomy With Concomitant Osteochondral Allograft Transplantation" by Agarwalla et al.[1] The authors performed a retrospective analysis on 26 patients who underwent high tibial osteotomy (HTO) + concomitant osteochondral allograft (OCA) and concluded that HTO + OCA provides a high rate of return to work (RTW) for the treatment of focal chondral deficiency and varus deformity in the knee. We think this finding is of value for clinicians in decision-making. However, there are several concerns that need to be addressed.

First, this retrospective study did not have a control group of patients with malaligned knees who were treated with OCA alone without HTO. Thus, the success of this combined procedure could not be compared with the natural history of transplanted OCA in malaligned knees. In addition, this study also did not have a control group treated with HTO alone without OCA to evaluate the effect of the performed cartilage-addressing procedure. Previously, several articles have demonstrated the encouraging effects of simple HTO without any cartilage repair procedures on clinical outcomes. [2,3]

Second, the authors assessed many aspects in the follow-up, including the timeline of RTW, work outcomes, postoperative complaints, and complications However, other validated patient-reported outcome measurements, such as Western Ontario and McMaster Universities Osteoarthritis Index, could be used to evaluate the graft survivorship and the clinical status of each knee.

Third, despite the high rate of RTW, postoperative complaints were still common and the reoperation rate was high at the final follow-up. Whether or not a concomitant surgery leads to a significantly increased risk of complications is unclear. We are wondering if the authors might have insight as to whether the complications and failures were more a result of HTO or OCA or whether the effects were mixed.

Last but not least, we are wondering why the authors treated these cases with different surgical methods (1 unicompartmental knee arthroplasty and 1 total knee arthroplasty) for failed surgeries. Young and high-demand patients are a relative contraindication for total knee arthroplasty, whereas unicompartmental knee arthroplasty is a bone-conserving and ligament-sparing procedure that reliably restores normal knee kinematics and function for younger and more active patients with limited medial compartment of the knee.[4]

We appreciate that Agarwalla et al.[1] have provided us with a clinical meaningful study. We would welcome comments by the authors, as this would help to further support the findings of this important study.

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