Evidence base on the orthopaedic NICE report

Sir,

I enjoyed reading Mr Toms and Mr Isbister's editorial on the orthopaedic NICE (National Institute for Clinical Excellence) report on hip prostheses (vol 64(10), 2003, p. 572). I agree that NICE has not considered a number of non-cemented acetabular components which have excellent track records, e.g. a prosthesis with a titanium mesh contact surface.

There is no mention that over time polythene acetabular components almost inevitably loosen. Such prostheses are entirely appropriate in older patients. The test of a prosthesis is its use in younger patients, e.g. under 50 or 55 years of age.

NICE has recognized metal on metal resurfacing for younger patients. Quite properly it has recommended that all data be submitted to the UK National Joint Registry which is currently up and running in some hospitals. Unfortunately although the authors mentioned clinical end points they have not commented that these should have been incorporated in the National Joint Registry requirements. Any prosthesis should be periodically be reviewed, both clinically and radiologically, as recommended by the British Hip Society and British Orthopaedic Association. The orthopaedic community at large is disappointed that the Joint Registry does not provide complete data, for example, as the Trent Arthroplasty Registry where patients are followed up with a questionnaire and X-rays. There is no mention of the Swedish Hip Registry findings.

This editorial was valuable comment on the NICE report. There is a certain amount of bias, perhaps of political origin.

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Lesser toe trauma is under reported

Sir,

We read Dr Dawson's case report on traumatic dislocation of the fourth metatarsophalangeal joint (vol 64(8), 2003, p.494) with interest. We would like to suggest a few corrections.

The introduction documents that these injuries are extremely rare. In fact, they are quite frequently seen and dealt with in emergency departments. Although they are uncommon (De Palma et al, 2001), they are extremely under reported, because of their less important anatomical location and their categorization as minor injuries.

The author stated that metatarsophalangeal articulations are ball and socket in nature. The metatarsophalangeal articulations are condyloid, not ball and socket. They are formed by the reception of the rounded heads of the metatarsal bones in shallow cavities on the ends of the proximal phalanges. Movements permitted in the metatarsophalangeal articulations are flexion, extension, abduction, and adduction, while ball and socket articulations also allow internal rotation, external rotation and circumduction movements (Gray, 1918).

Traumatic lesser toe problems are managed under local anaesthesia, with or without sedation in most cases and discharged to GPs without further follow-up (as in this case). Results are anecdotally good, as shown by the very infrequent re-attendance of patients.

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De Palma L, Santucci A, Marinelli M (2001) Traumatic dislocation of metatarsophalangeal joints: report of three different cases. *Foot Ankle Surg* **7**(4): 229–34

Gray H (1918) The metatarsus. In: Lewis WH, ed. *Anatomy of the Human Body.* 20th edn. Lea & Febiger, Philadelphia

Sir,

I thank Messrs Sharma and Rana for their comments on my case report, to which I am happy to respond.

I am reported to state that traumatic dislocation of the fourth metatarsophalangeal joint is extremely rare, which is an inaccurate quote of my article. My report opens with: 'Acute dislocation of the first metatarsophalangeal joint (MTPJ) is an uncommon injury, but well reported in the literature. Traumatic dislocation of the MTPJ in the lesser toes, especially the third, fourth and fifth, is much rarer....' De Palma et al (2001)'s discussion, as cited by Sharma and Rana, supports this statement.

Use of words such as 'rare' and 'uncommon' has been debated many times in the scientific literature, as they have no clear definition. Numerical values for disease incidence should be quoted in preference to subjective statements, although data collection and interpretation is often poor, inaccurately reflecting the frequency of certain pathologies. Sharma and Rana fall into this trap, as they describe this type of injury as 'uncommon'.

The second apparent factual inaccuracy is that I describe the metatarsophalangeal articulation as ball and socket in nature, an intentional action which requires explanation. In their description of the condyloid or ellipsoid/ovoid joint, Sharma and Rana neglect to appreciate that a combination of flexion/extension and abduction/adduction results in circumduction, a movement permitted over this type of joint (Williams, 1999); ball and socket articulations allow movement in three planes, as internal/external rotation is also permitted. While the MTPJ is indeed described as an ellipsoid joint, it has the accessory movements of gliding, and of rotation about the bone's long axes (Williams, 1999). These accessory movements contradict the true definition of a condyloid joint, and give the impression of a ball and socket articulation.

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De Palma L, Santucci A, Marinelli M (2001) Traumatic dislocation of metatarsophalangeal joints: report of three different cases. *Foot Ankle Surg* **7:** 229–34

Williams PL, ed. (1999) *Gray's Anatomy.* 38th edn. Churchill Livingstone, London: 499; 729