The synovium in the rheumatoid arthritis patients showed a greater tendency of bleeding, which was controlled by a thorough hemostasis with electrocautery. As stated before, the synovium resection was performed only until a proper visualization was obtained.

3. "What was outcome if synovium was removed in both groups of patients with RA?"

The synovium in the rheumatoid arthritis patients showed a greater tendency of bleeding, which was controlled by a thorough hemostasis with electrocautery. As stated before, the synovium resection was performed only until a proper visualization was obtained.

4. "Author reported 2 cases of patellar injury in group B managed conservatively. Was any difference in postoperative rehabilitation of these patients and any brace given for it. As we delay range of motion exercises and start protective weight bearing in patients with patellar tendon injury. Outcome of these patients at final followup was same as with others?"

In both cases of partial patellar tendon injury that occurred intraoperatively, the lesion was less than one-third of the tendon's width, therefore we decided not change the postoperative protocol. The results at follow-up did not show differences between the injured knee and the contralateral knee.

5. "Lastly we want to know approximate value of intra operative B.P. kept by anesthesit. As in most cases anesthesit will lower down B.P. for arthroplasty do decrease the blood loss. Did anaesthesit reduce B.P. while whole procedure or selectively."

The anesthesiologist used hypotensive technique for all patients during the entire surgical procedure, meaning a diastolic pressure between 65 and 70 mm Hg and a systolic blood pressure not more than 100 mm Hg, with a tendency to lower the heart rate.

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most patients with these devices still in situ would not consider these results from targeted cross-sectional imaging acceptable. The authors have used the area under the curve (AUC) to assess the discriminatory ability of their new algorithm (AUC of 50% = a nondiscriminatory algorithm; AUC of 100% = algorithm with perfect discrimination). Although their new algorithm had the highest AUC of the other guidelines assessed, it was still only 63% [1]. This does not therefore represent a clinically useful algorithm, especially given the context of the clinical problem. Furthermore, the confidence intervals for the AUC associated with the new algorithm actually overlap with those from the 2 other sets of guidelines assessed, therefore the authors cannot claim any superiority of their algorithm over existing guidance. Interestingly, in both studies the authors have knowingly compared their algorithm in ASR patients to the non-ASR MoMHA guidance published by the MHRA, rather than using the ASR-specific MHRA guidance, which exclusively recommends cross-sectional imaging in all cases. This therefore makes both the current study and their previous study unnecessary [1,5].

In light of the high revision rate of ASR implants, the widely publicized manufacturer recall, the related medico-legal issues, coupled with the ever increasing revision rate in arthroplasty registries, I would urge clinicians reading these 2 articles by Connelly et al to continue to follow-up patients with the ASR device on a regular basis. This follow-up must include regular cross-sectional imaging, given blood metal ions alone are not adequate in this patient population with Connelly et al [1] themselves reporting that blood metal ions only have a sensitivity between 69% and 75% for identifying ALTR on MARS-MRI. Finally, care should be taken when embarking on future studies to ensure the research questions set are clinically relevant.

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References


Response to Letter to the Editor on “Indications for MARS-MRI in Patients Treated With Articular Surface Replacement XL Total Hip Arthroplasty”

In Reply:

We appreciate the thoughtfulness of Dr Matharu’s insightful comments on our recent manuscripts. As we know, currently established national follow-up guidelines for metal-on-metal (MoM) hip replacement patients are not evidence-based and vary significantly between countries [1]. With regards to metal artifact reduction sequence magnetic resonance imaging (MARS-MRI) specifically, guidelines vary considerably. The authors agree with the commenting author that the safest and most comprehensive way to identify all adverse local tissue reactions (ALTRs) in MoM hip arthroplasty is to perform MARS-MRI annually on all patients regardless of blood metal ion levels or symptoms. This approach is endorsed by the Medicines and Healthcare Products Regulatory Agency for all Articular Surface Replacement (ASR) patients, but not other MoM implants [2]. However, the authors of the articles in question acknowledge that this type of stringent follow-up is not being performed on ASR patients worldwide and may not be feasible depending on the financial resources available and the country’s healthcare environment. MARS-MRI can present a significant burden to patients due to high costs and availability may be limited in some places [3]. Given our large dataset of ASR patients, we sought to determine evidence-based algorithms for identifying the most high-risk patients without requiring annual MARS-MRI on those who were unlikely to exhibit ALTR. We then evaluated our evidence-based algorithms by...