

Letters

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Joint first for hip and knee replacements

We read with great interest the article by Linsell *et al.*¹ The cross-sectional population-based postal survey reported the incidence and health service utilisation of 5500 Oxfordshire residents over the age of 65. The aim of the study was to investigate whether systemic differences in the primary care management of hip versus knee problems might explain the disparate rates of hip and knee joint replacements.

The National Joint Register (NJR)² has been collecting data regarding hip and knee joint replacement in England and Wales since 1 April 2003. The NJR will quickly become the largest database collecting such data in the world. The NJR 1st Annual Report has recently been published. In the period reported, 22 672 primary total hip replacements were undertaken in comparison to 20 854 primary total knee replacements.² This is contrary to the statement that UK rates of primary arthroplasty are considerably higher for hips than knees. We suggest that the disparity that Linsell *et al* proposed may be historical.

John Charnley developed total hip replacement in the 1960s, and there is evidence to suggest the prosthesis that he pioneered (still the second most commonly implanted femoral stem in England and Wales) has a 30 year survival of 88%.³ Total knee replacement implants were developed throughout the 1970s but the vast majority of early implants failed due to poor design.⁴ The evolution to anatomical resurfacing implants utilising soft tissues to balance the knee was a significant step forward. Current prostheses are developed from this ideology. The AGC knee has been available since the early 1980s and has a reported 14 year survival of 97% (only 3% of knee replacements needed to be revised due to implant failure or infection).⁵ Many orthopaedic surgeons would argue that the longevity and success of total knee replacement is comparable to that of total hip replacement.

We suggest that the number of hip and

knee replacements in England and Wales are comparable, and that the perceived success rate among those questioned is based on historical implant development. It would not, in our opinion, be unreasonable for GPs to inform their patients that the long-term results of both hip and knee replacement are excellent.

MAX EDWARDS

*Specialist Registrar in Trauma and Orthopaedics, South East Thames.
E-mail: drmaxedwards@hotmail.com*

HANNAH JOSTY

General Practitioner, Greenwich.

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A pain in the neck for steroids

We have some concerns regarding the proposal to treat acute pharyngitis with high dose oral steroids.¹

Kiderman *et al* suggest that steroids may reduce short-term pain in a selected group of patients with sore throat presenting in primary care.¹ The selection criteria for their study are similar to the Centor criteria and thus likely to select a group with higher probability of positive throat swab, better response to antibiotics and higher complication rate.² Antibiotics were administered at the treating physicians recommendation and all those with positive swabs were subsequently treated. The authors fail to account for this potential confounder in their analysis. The study had

insufficient power to detect differences in relapse rates and more importantly complications. Quinsy, for instance, would be expected in 1:60 cases with the Centor criteria² and there may be rare complications resulting from the steroid treatment.³ The authors' conclusion that high dose steroids are safe in this context is unjustified. Moreover, this group have a predominantly self-limiting illness and treatment with steroids is likely to parallel antibiotic treatment in producing a medicalising effect and increasing reconsultation rates.⁴ Any potential benefit in short-term symptom relief must be balanced against unknown harm and altered illness behaviour.

More and better evidence of safety and effectiveness is needed before prescribing steroids can be advocated in acute pharyngitis.

MICHAEL MOORE

E-mail: research.3swans@virgin.net

PAUL LITTLE, IAN WILLIAMSON GREG WARNER, RICHARD COPPIN

Primary Care Minor Illness and Treatment Decisions Programme, Southampton University and Wessex Primary Care.

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Authors' response

We agree with Moore *et al* that the study did not have sufficient power to confirm the safety of this treatment, indeed this limitation is clearly stated in the discussion section in our paper. Similar trials with