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Funk, Lennard and Littlewood, Chris (2020) Letter to the Editor. Knee Surgery, Sports Traumatology, Arthroscopy : Official Journal of the ESSKA. ISSN 0942-2056

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**Downloaded from:** <https://e-space.mmu.ac.uk/626512/>

**Version:** Accepted Version

**Publisher:** Springer

**DOI:** <https://doi.org/10.1007/s00167-020-06268-y>

Please cite the published version

<https://e-space.mmu.ac.uk>

1 Dear Professor Karlsson

2 We would like to share our views on a paper recently published in Knee Surgery, Sports  
3 Traumatology, Arthroscopy. Feichtinger et al [1] conclude that conservative treatment should be  
4 recommended for patients with Rockwood (RW) type III acromioclavicular joint (ACJ) dislocations  
5 and that surgery should be recommended in patients with RW type IV ACJ dislocations. Although we  
6 applaud the authors for their hard work on this in an attempt to tackle some still unanswered and  
7 important questions on ACJ injuries, we are concerned that these conclusions are potentially  
8 misleading due to a high risk of selection and attrition bias, as well as measurement and  
9 classification concerns, that essentially render the study fundamentally flawed.

10 When comparing conservative and surgical approaches within the RW type III and IV classifications,  
11 patients are selected according to the treatment received rather than through a process of random  
12 allocation. Such non-random selection risks selection bias meaning that the groups being compared  
13 differ systematically in important ways that might influence their response to treatment. So, any  
14 attempt to compare the effectiveness of treatments is not valid because if the groups are different  
15 to begin with, they will be different at the end of treatment for reasons other than the treatment  
16 received. An example validating our concern regarding selection bias is the difference in age of  
17 patients in the conservatively and surgically treated patients. For RW type III ACJ dislocations, those  
18 treated surgically were on average 39.8 years old, whereas those treated conservatively were on  
19 average 49.1 years old. This is almost a 10-year difference and any clinician will reflect the clinical  
20 importance of this age gap in this condition and how it might influence treatment selection.  
21 Feichtinger et al [1] report this difference as not significant, inferring this is not a concern, but this  
22 reflects a misuse of significance testing. In declaring no significant difference in age between the two  
23 groups, data from 19 patients treated conservatively was analysed and 10 patients undergoing  
24 surgery. Hence, a lack of significant difference is due to a lack of data to detect a difference and it is  
25 certainly not safe to assume the groups are comparable. In patients with RW type IV ACJ  
26 dislocations, the age difference between the conservatively managed and surgical groups was 20  
27 years. Clearly, any comparison of treatments cannot be made when groups differ markedly to begin  
28 with.

29 Our second major concern relates to attrition bias. Of 226 patients, only 56 (25%) were followed-up.  
30 This means that data from the vast majority (75%) is missing. Such attrition alone would be regarded  
31 as a fundamental flaw because the response of the vast majority of the patient group is unknown  
32 and would effect any inference about comparative treatment effectiveness if included.

33 Thirdly, the chosen scoring system (ACJI) is a non-validated outcome scoring system that heavily  
34 favours radiological alignment over clinical parameters. It is well recognised that surgery achieves  
35 better joint alignment than non-operative treatment, so unsurprising that this score is higher. This is  
36 not addressed by the authors and in fact the conclusion and title claim surgery provides better  
37 'clinical and radiological outcomes'. This is not supported by the results of the validated clinical  
38 measures.

39 Finally, there is no clarification on how the injuries were classified. The method of classifying ACJ  
40 injuries is not standardised in the literature and there is a large degree of inter- and intra-observer  
41 disagreement with radiographic methods (radiographs and CT scans). This adds another level of  
42 possible error, especially given the small sample sizes at final evaluation.

43 We recognise that the authors of the paper acknowledge some of these limitations briefly but they  
44 are not reflected in the conclusion of the paper. Given the seriousness of these flaws, they need to

45 be clearly reflected in the conclusion as follows: Due to high risk of selection and attrition bias, use  
46 of a non-validated outcome measure and potential for classification error, significant caution should  
47 be exercised when interpreting these results that could be misleading.

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49 **Conflict of interest**

50 We declare no conflicts of interest

51 **References**

52 [1] Feichtinger X, Dahm F, Schallmayer D, Boesmueller S, Fialka C, Mittermayr R (2020). Surgery  
53 improves the clinical and radiological outcome in Rockwood type IV dislocations, whereas  
54 Rockwood type III dislocations benefit from conservative treatment. *Knee Surgery, Sport  
55 Traumatol Arthrosc.* <https://doi.org/10.1007/s00167-020-06193-0>.