CENTRAL SPINAL STENOSIS DUE TO PSEUDOGOUT

Sir,
I was interested in the brief report of a case of spinal stenosis due to pseudogout in your July 1994 issue (1994;76-B:672-3), having reported a very similar case of nerve-root compression in a 64-year-old patient with unilateral intermittent claudication (Dehais et al 1977). I agree that pyrophosphate deposition should be considered as a possible cause of nerve-root compression in patients with intermittent claudication suggestive of lumbar stenosis.

J. DEHAIS, MD
Centre Hospitalier Universitaire Pellegrin
Bordeaux, France.


Author's reply:

Sir,
Thank you for the opportunity to comment on Dr Dehais' letter, which draws our attention to his case report. We have found no other such reports, but would point out that 99 cases have been described, most in the neurosurgical or radiological literature, of thickening of the ligamentum flavum due to deposition of calcium pyrophosphate crystals which has presented as cervical myelopathology (Baba et al 1993).

I therefore agree that such crystal deposition should be included in the differential diagnosis of nerve-root compression.

T. SADIQUE, FRCS
St James's University Hospital
Leeds, UK.


SHOULD THE ROTAFLEx PROSTHESIS BE WITHDRAWN?

Sir,
Thank you for your rejection letter concerning this paper. I accept the criticisms of its retrospective nature, low rate of follow-up and of the fact that the prosthesis has since been 'modified'.

I would, however, be grateful if you would kindly reconsider the paper. Despite its shortcomings, it has a very important message for all orthopaedic surgeons in the UK who undertake total knee replacement and especially those who have used or continue to use the RotaflEx prosthesis. The unacceptable complication rate which we reported should lead to discontinuation of its use and also alert surgeons to the need to follow up every RotaflEx patient both clinically and radiologically, so that early loosening and femoral cortical erosion can be treated before the lamentable salvage operations of attempted knee fusion or amputation are necessary. This general message can also be applied to other fully constrained prostheses.

I would be most grateful if you would again review this paper, particularly in view of the fact that the RotaflEx is still being used in a number of units in the UK.

E. T. R. JAMES, FRCS, FRCS Ed(Orth)
Morriston Hospital NHS Trust
Morriston
Swansea, UK.

Response by the Editor:
The paper had been discussed at length at an Editorial Board meeting before its original rejection.

In response to the above letter it was again reviewed at a full Board meeting. The majority opinion supported the original rejection in terms of the anecdotal nature of the paper and a belief that the prosthesis was little used, except for a few revision procedures.

The Board recommended, however, that the author's letter be published. Copies of the letters have been sent to the manufacturer.

Response by the manufacturer:

Sir,
Thank you for advising us that the Journal has recently received a paper reporting poor results with the above prosthesis at 10 to 12 years, and for offering us the opportunity to respond. Although we have not yet reviewed Mr James's paper, we would like to offer the following general comments on the RotaflEx knee prosthesis.

From the stated follow-up, the prosthesis under review was the original RotaflEx I prosthesis, then marketed by D. Howse & Co. Ltd. Watt and Hughes (1987) reported satisfactory results in 15 patients followed for up to 44 months. These findings for short-term results were confirmed by Jones and Davies (1988) in an unpublished series of 53 cases reviewed at between 9 and 36 months. Following the company's acquisition by Johnson & Johnson, several design improvements were made and the RotaflEx II prosthesis was introduced in 1984.

With increased understanding of the limitations of fully constrained prostheses, the indications for the use of this prosthesis were also revised. We recommended that it be limited to use for the primary treatment of grossly unstable or severely deformed knees in low-activity, low-demand, older patients or for revision cases in which insufficient soft tissue or bone prevented the use of a semiconstrained design.

With the development and acceptance of modern semiconstrained modular prostheses, designed to deal with more challenging deformities and revision situations, the use of the RotaflEx II prosthesis has dramatically declined, and we accept that its role today is now extremely limited.

Whether the findings of Mr James's review paper are relevant to the current design of the RotaflEx II prosthesis in its narrow range of indications will depend on the original patient selection and the specific modes of failure. We look forward to reviewing this detailed information with the author in the near future.

D. W. EVANS
Johnson & Johnson Orthopaedics
New Milton
Hants, UK.


FEMORAL VEIN BLOOD FLOW DURING THR

Sir,
We recently read the thought-provoking study in the November 1994 issue by Warwick et al entitled 'Measurement of femoral vein blood flow during total hip replacement' (1994;76-B:918-21). This confirmed the thoughts of many surgeons in that it demonstrated the cessation of blood flow in the femoral vein during total hip replacement (THR). The study, however, did not correlate the presence, degree or duration of this occlusion with the incidence of venous thrombosis, and we are left with the feeling that although the finding is of interest, it may or may not