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Is there a registry solution?

Virtually all practicing orthopaedic and trauma surgeons would agree that registries have been one of the single biggest advances in orthopaedic governance over recent years. Although the Scandinavian countries have been updating their registries for many years and there have been mandatory requirements in many Northern European countries for decades, many developed nations do not have a requirement to submit registry data. Following the high profile failure of the Capitol hip from 3M (which resulted in the eventual folding of the 3M medical devices division), the UK government ordered a public enquiry which resulted in a number of publications including one by the Royal College of Surgeons in 2001 and led to the formation of the UK's joint registry. Designed to provide ongoing continuous surveillance of new implants and this year becoming a mandatory requirement, the National Joint Registry in England and Wales captures around 80% of arthroplasties with surgeon-recorded data and the remainder is from health economic coding data. So, how is it that with a well designed joint registry devised specifically to catch early failure in large joint arthroplasty we find ourselves a decade later facing the same disaster as the 3M one with the ASR metal-on-metal hip? There were 100,000 ASR hips implanted worldwide, many in the UK. The system we set up failed to catch the early failure. This is essentially a flaw in the design of registries which collate retrospective outcome data based on revisions. Inevitably, there will be lag time and large numbers of implantations required to detect failures. Tim Briggs outlines one possible way forward in his "Getting It Right First Time" report which compliments the Beyond Compliance system from the British Orthopaedic Association. Arguing that innovation should be restricted to specialist centres, and new technology policed more by the profession and less by the industry, this does make a lot of sense on the face of it. Restricted introduction, however, will not solve the problem entirely, and runs the risk of stifling improvements in health care and introducing a two-tier health system. Further, this in itself may not catch the early failures. What is required is likely more sensitive end points in the registrys.

This month in *360* we have the second in a series of articles examining what the worldwide registries are able to offer us. It is interesting that with the massive volumes of data being captured in the world today there is still such a diversity of treatment options. The majority of registries focus on 'models' of joint replacement rather than design themes (such as posterior-stabilised, metal-backed, etc) which would improve the usefulness of these registries. Improving the usefulness of registry data is key to pushing forward the quality of healthcare delivery and appraisal across the whole of orthopaedics. With pushes for surgeon-level outcome data to be available, more and more we will stand or fall by what the registries say about us, not necessarily by what they say about our patient case mix, complexity and comorbidities. As a surveillance tool, registries should include more sensitive markers of failure. New prostheses should be introduced but with more robust follow-up data. Inclusion of RSA and central collation of follow-up radiographs (which can now be achieved using a 'beadless' technique) would allow for far more sensitive outcomes for new prostheses. Patient outcomes should be assessed in a more robust manner than just 'failure'. The beginnings of inclusion of PROMs into some registries is an important first step in carefully characterising outcomes and patient case mix.

My very best wishes to you all.