Correspondence

We welcome letters to the Editor concerning articles which have recently been published. Such letters will be subject to the usual stages of selection and editing; where appropriate the authors of the original article will be offered the opportunity to reply.

Letters should normally be under 300 words in length, *double-spaced throughout*, signed by all authors and fully referenced. The edited version will be returned for approval before publication.

At the crossroads – neonatal detection of developmental dysplasia of the hip

Sir,

We read with interest the Editorial in the March 2000 issue, moderated by Mr D. H. Jones,[1] entitled 'At the crossroads - neonatal detection of developmental dysplasia of the hip'. We were surprised to find that none of the contributors mentioned the role of litigation in answering the question 'What are the current problems?' with regard to screening for developmental dysplasia of the hip (DDH). Recent settlements for missed DDH have reached six-figure sums and have therefore a considerable impact on the financial costings of any screening programme. Clegg, Bache and Raut[2] have recently published detailed information with regard to the financial justification for universal screening. According to their costings a sum of £100 000 would provide an ultrasonographer to perform universal screening for four years, or alternatively cover the screening of 16 667 births at a cost of £6 per child. This factor could therefore play a significant role in considering the benefits of any screening programme, and should not be overlooked.

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1. **Jones DH, Dezateux CA, Danielsson LG, Paton RW, Clegg J.** At the crossroads - neonatal detection of developmental dysplasia of the hip. *J Bone Joint Surg [Br]* 2000;82-B:160-4.
2. **Clegg J, Bache CE, Raut VV.** Financial justification for routine ultrasound screening of the neonatal hip. *J Bone Joint Surg [Br]* 1999;81-B:852-7.

Author's reply:

Sir,

I thank Messrs Chell and Hunter for their letter. It contains an important message and I recognised the significance of the medico-legal aspect in my comments.

Any system of screening for DDH in the UK will have limitations in effectiveness or implementation with inevitable medico-legal consequences.

It is only by reassessment of our guidelines for good practice that we will arrive at practicable and fair standards, robust and clear enough to satisfy patients, clinicians and lawyers alike.

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Thromboprophylaxis – which treatment for which patient?

Sir,

In his Editorial entitled 'Thromboprophylaxis - which treatment for which patient?' in the May 2000 issue, Professor Prentice[1] states that the results of the Pulmonary Embolism Prevention (PEP) trial[2] showed that aspirin produced significant reductions in total thromboembolism, total pulmonary embolism (PE), fatal PE and deep-vein thrombosis (DVT), as compared with a placebo. While this is true for the main body of the study, in which patients with fractures of the hip were assessed, it is manifestly untrue for the subgroup of 4000 patients who had replacement arthroplasties. In these latter patients, there were eight cases of PE in those given aspirin and eight in those given placebo; there was also no significant difference in the incidence of DVT (15 cases *v* 19). In terms of overall mortality, there were nine deaths in the aspirin group and 11 in the placebo group.

In a symposium devoted to prophylaxis after total hip replacement, it is therefore misleading to state that "aspirin reduces the risk of clinical PE and DVT by at least one-third, and of fatal PE by about one-half", without noting that these figures relate only to patients with fractures of the hip. The PEP study showed no such effectiveness after replacement arthroplasty, and indeed in these patients the only reasonable conclusion is that aspirin is no more effective than placebo as a thromboprophylactic agent.

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1. **Prentice CRM.** Thromboprophylaxis - which treatment for which patient? *J Bone Joint Surg [Br]* 2000;82-B:483-5.
2. **Pulmonary Embolism Prevention Trial Collaborative Group.** Prevention of pulmonary embolism and deep vein thrombosis with low dose aspirin: pulmonary embolism prevention (PEP) trial. *Lancet* 2000;355:1295-302.

Author's reply:

Sir,

The findings of the Pulmonary Embolism Prevention (PEP) trial,[1] together with those of the previous meta-analysis of antiplatelet trials, demonstrate clearly that daily aspirin for a few weeks can reduce the risks of deep-vein thrombosis and pulmonary embolism by at least a third in a wide range of patients. It would be inappropriate to suggest, as Dr Thomas does, that the lack of significant result among the relatively small number of patients in the arthroplasty subgroup of the PEP trial, considered on its own, shows that aspirin is not effective among patients undergoing elective arthroplasty. As discussed in my Editorial, the hazard ratio for venous thromboembolism of 0.81 (95% CI 0.47 to 1.42) among elective arthroplasty patients allocated aspirin was entirely

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