EMPHASIS ON PREVENTION

I read with interest the editorial "Canadian health care is not universal."[1] This article brings to light some of the disparities in trauma care delivery between Quebec and the rest of Canada. There is no doubt that, as health care providers, we expect to have at our disposal the best possible tools for taking care of the sick and injured; without these tools we are invariably left with feelings of futility and frustration. Nonetheless, on a broader scale, prevention should certainly play a central role in any discussion addressing the issue of trauma care. This is particularly true when examining the cost-effectiveness of competing means of prevention and treatment and competing priorities. The economic and social costs of trauma are enormous.[2] It is clear that high-risk behaviour, particularly alcohol consumption, is a major contributing factor to accidental injury and death.[2,3] It has been shown that public education, legislation regulating speed limits and the enforcement of alcohol laws have had a substantial impact on lowering the trauma burden and are highly cost-effective.[2] Yet we remain lenient and continue to accept aberrations such as the sponsorship of major motor-racing events by alcohol companies. There is no question that our mindset as a society still needs to evolve. When it comes to allocating our collective resources, trauma prevention through the targeting of high-risk behaviour such as speeding and impaired driving should remain paramount on our list of priorities.

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HEMI- VERSUS TOTAL HIP ARTHROPLASTY FOR FEMORAL NECK FIXATION

We read the article "Cemented bipolar hemiarthroplasty in osteoporosis for failed femoral neck fixation"[1] with interest. We found a discrepancy in the title and content of article that most probably appears a typo. The title should contain "osteopetrosis" instead of osteoporosis. The authors describe a 58-year-old patient with osteopetrosis and nonunion of the femoral neck and failed fixation treated with bipolar hemiarthroplasty. In spite of finding cartilage degeneration perioperatively, the authors chose to perform a hemiarthroplasty rather than a total hip arthroplasty.

We think that total hip arthroplasty would have been a better option than hemiarthroplasty. The long-term results of total hip arthroplasty compared with hemiarthroplasty to treat a fractured femoral neck are clinically important and include less pain and better Short Form Health Survey (SF-36) mental health subscale and Western Ontario and McMaster Osteoarthritis Index (WOMAC) function scores.[2,3] Thus, reasons for not replacing the acetabulam despite cartilage degeneration at 58 years of age are not well understood.

There are reports of good results for total hip arthroplasties (cemented, uncemented and hybrid) with 5 to 10 years of follow-up in patients with osteopetrosis.[4-6] Therefore, the authors' concerns about cement interdigitation and long-term fixation does not seem to be supported by available facts.

We also noted that the follow-up period in the study was just 6 months. We would have appreciated if the patient could have been followed up longer as this would have added to existing literature on arthroplasties in osteopetrosis.

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