

symptoms over a mean period of 3.5 years. Whereas relief of pain is thought to be the result of denervation, in-situ denervation by pedicle stripping does not appear to be of benefit. Would orthotopic autotransplantation help? Perhaps, but there may be benefit in moving the kidney to a new location, partly from a psychological perspective and possibly from the effect of reinnervation. As Taguchi pointed out, the decision to perform this procedure is made as a last resort, the alternative for these patients being nephrectomy.

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## Reference

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## OPEN VERSUS ARTHROSCOPIC ACROMIOPLASTY

The article comparing open and arthroscopic acromioplasties by Kinnard and associates in the February 1996 issue of the *Journal* (pages 21 to 23) is of great interest. The authors are to be congratulated for attempting to compare the relative benefits of the two procedures. However, there are a couple of points that merit clarification.

First, they did not report on the power of their study. This is important since they conclude that there was no significant difference in time off work between the two procedures. With a total sample of 20, they would only have an 80% power of determining a difference in the means of one standard deviation, which is considered a "large-effect" difference. Also, they did not report the confidence interval for the difference in means. Considering that the data may well be skewed rather than normally distributed, these data would be important.

The authors state that "in reality, it [arthroscopic acromioplasty] is much more difficult than open acromioplasty . . . ." Many would take strong exception to this statement. Although surgeons recognize that arthroscopic acromioplasty is an exceedingly difficult operation for some to learn, the majority of surgeons experienced and skilled in this technique find that the procedure is easier and faster to perform than open acromioplasty.

Finally, the difference in morbidity between these two procedures is striking. Having had an arthroscopic acromioplasty myself, I can attest to the fact that I was able to take part in a scientific meeting later on the day of the procedure and take an international flight and drive for 1 hour by myself the next day. I would not anticipate being able to do this after an open acromioplasty.

I do not believe that every orthopedic surgeon who has mastered the open technique should feel obliged

to learn the arthroscopic technique. Nevertheless, the advantages of the arthroscopic technique should not be underestimated and should be evaluated in a rigorous scientific fashion.

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*Dr. Kinnard replies*

I thank Dr. O'Driscoll for his useful comments and criticisms.

Undertaking a retrospective study is always a frustrating experience because it is difficult to retrieve patients, and this weakens the study.

It is possible that arthroscopic acromioplasty, as Dr. O'Driscoll mentions, may allow a speedier recovery, but, by using the smallest incision possible, many of my patients were able to return to work after 1 or 2 days. The difficulty with arthroscopic acromioplasty lies in the learning curve, which is much longer than for the open technique. Dr. O'Driscoll's pointed remarks have opened a debate, and the final answer will come from large-centre studies. If the findings of such studies corroborate Dr. O'Driscoll's comments, I will certainly learn the arthroscopic technique.

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