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LETTER TO EDITOR

Refixation of Labrum in Pincer type of Femoroacetabular Impingement

Dear Editor,

We read the article "Refixation of labrum in pincer type of femoroacetabular impingement" by Shao *et al*.,[1] with a lot of interest. We commend the authors' efforts. Accurate radiographs are very important for foot and ankle deformity diagnosis. We have to point out some issues of this study, as some might lead to biased results.

The author only mentioned the parameters such as crossover sign, lateral center-edge angle (LCEA) was 40.6°, and preoperative degenerative tear of the upper anterior labrum with prominent pincer lesion when examined by magnetic resonance imaging. Alpha-angle, anterior center-edge angle, and Tönnis grade for osteoarthritis were not mentioned.

Litrenta *et al*.[2] mentioned that the crossover signs in their definition, these signs were the only defining feature. The presence of the crossed sign does not necessarily indicate an actual retroversion and may be caused by an overhanging anterior inferior iliac spine. In addition, the presence of the crossed sign or other findings of acetabular retroversion can also be found in asymptomatic individuals.[3]

Enhanced diagnostic specificity and accuracy for the diagnosis of femoroacetabular impaction (FAI) may help to avoid misdiagnosis. Lerch *et al*.[4] mentioned that the definition of acetabular retroversion is a positive cross-over sign, positive ischial spine sign, positive posterior wall sign, and retroversion index >30%, independent from an alpha angle. Cam-type FAI: alpha angle >50° with the neck-shaft angle of 125°–140° and with normal acetabulum (LCEA 23°–33°), not all retroversion signs positive. Mixed-type FAI: Alpha-angle >50° and LCEA 34°–39°, not all retroversion signs positive. Moreover, a study reported that higher preoperative Tönnis grades were associated with decreased hip survival.[5]

On the basis of the systematic review by Litrenta *et al*.,[2] arthroscopic procedures can also be used safely and adequately for trimming the rims of the pincer impingement caused by the retroversion. However, it is probable that patients with more severe retroversion or with significant dysplasia may be better indicated for anteverting periacetabular osteotomy. We appreciate the author's effort again, and we wrote this letter to express our opinion that it should offer much more information to let the readers know the differential diagnosis of this case report.

Data availability statement

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study.

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Conflicts of interest

There are no conflicts of interest.

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