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Editorial

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Long Covid – a cause of concern for surgical training

During the first waves of the coronavirus (Covid-19) pandemic, some surgeons documented the effects of the virus on their patients. For others, the pandemic provided an opportunity to write up their ongoing research studies and submit manuscripts to journals. Sadly, some surgeons succumbed to the virus and their absence weighs heavily on their families, friends, colleagues and patients. Globally, the pandemic reduced opportunities for elective operating and extended waiting lists for surgery [1–3]. Investigators have studied the consequences of surgical delay for patients [4–6] as well as the impact of the pandemic on surgeons [7] and surgical training [8, 9].

Orthopaedic training programmes involve a rotation through sub-specialties, with long hours in clinic—often not being the person that the patient was hoping to see, much surgical assisting, some hands-on surgical experience and challenging exit examinations. While a growing number of training programmes now include some exposure to hip preservation surgery, few trainees will acquire sufficient experience, of this sub-speciality, to undertake independent hip preservation practice without additional post-training fellowships. Some trainees are being obliged to delay their fellowships to acquire the elective surgical experience that they were denied over the last few years [10], and many who undertook fellowships during this period did not enjoy the surgical experience that they had anticipated.

Throughout society, people have re-evaluated their priorities and many have elected to pursue new life goals [11]. For some senior surgeons, this has meant the end of their clinical practice. There is now a global backlog of patients seeking surgery [12]. Healthcare providers are serving communities who carry the burden of pandemic-related debt [13], and public healthcare systems face financial constraints that will necessitate new strategies for healthcare rationing [14]. Over the next few years, healthcare providers will face demands to demonstrate the efficacy and cost–benefit of their work to public funders, private insurers and self-paying patients.

Surgical trainees generally take longer to perform procedures, require close supervision to avoid complications [15] and their trainers will be ever more closely scrutinized for outcome and cost-effectiveness. Post-pandemic initiatives to increase patient throughput may also adversely affect trainees if healthcare administrators put pressure on faster, more experienced surgeons to undertake as much of the backlog operating as possible. These factors are likely to adversely affect training opportunities for the next generation of hip preservation surgeons. Indeed, the ramifications of the Covid-19 pandemic will be with us for many years and the full extent of consequences for surgical training remains unknown. The Journal of Hip Preservation Surgery (JHPS) is dedicated to the advancement of hip preservation surgery, and we would welcome submissions on topics related to the effects of Covid-19 on our community through all stages of training, surgical practice and post-surgical experience.

Patient benefit is the primary theme of the paper from John Clohisy and his colleagues at the Washington University School of Medicine. Their paper in JHPS issue 9.3 provides a 'Comparison of modern periacetabular osteotomy for hip dysplasia with total hip arthroplasty for hip osteoarthritis—10-year outcomes are comparable in young adult patients' [16]. While the paper does not advocate periacetabular osteotomy (PAO) as a treatment for young patients with degenerative hip disease, it does demonstrate that, if hip dysplasia is treated before the onset of significant degenerative change, the results of PAO are as good as hip replacement in this age group. The benefit of restored function without the sequelae of joint replacement cannot be overstated. Any surgeon who is asked to deny PAO surgery to patients with symptomatic hip dysplasia should cite this paper as evidence that leaving the patient until they require hip replacement is counterproductive, poor medicine, and a failure to best utilize healthcare resources.

As every hip preservation surgeon knows, gluteus medius and minimus pathology are relatively common in post-menopausal, females and particularly those with an elevated body mass index. It is often difficult to provide such patients with effective and long-lasting help. While a proportion of these patients may be exhibiting gluteal stress to protect a deteriorating hip joint, many have localized pathology that does not always respond to physical therapy, steroid or platelet-rich plasma injections, shock wave treatment and other non-surgical strategies. Surgical interventions are usually only offered as a treatment of last resort, and many surgeons will have seen patients for whom such interventions have failed to provide the desired benefit. Anil Ranawat and his colleagues at the Hospital for Special Surgery address the challenge of such patients in their paper on 'Repair of gluteus medius tears with bioinductive collagen patch augmentation: initial evaluation of safety and imaging' [17]. The authors

demonstrate that their strategy offers a solution that merits consideration. The paper also provides data that can be cited to potential patients and healthcare funders to justify the allocation of valuable operating time and healthcare resources for this problem.

JHPS does not focus exclusively on the benefit of surgical interventions and health economics. Getting the diagnosis right is essential for good clinical practice, and the paper from Myung-Seo Kim and his colleagues at Kyung Hee University Hospital on 'Patterns of labral tears and cartilage injury are different in femoroacetabular impingement and dysplasia' [18] provides valuable information that can help us better understand the pathophysiology of labral injury. The paper confirms that femoroacetabular impingement (FAI) and dysplasia patients exhibited different labral and cartilage injury patterns. It is also useful to know that increased body mass index can be correlated with the development of articular delamination injury in femoroacetabular impingement, and this observation should help to guide clinicians in planning their surgical interventions.

As ever, I hope that you enjoy reading all the papers in this issue and that you will feel inspired both to engage in the training of the next generation of hip preservation surgeons and undertake research projects to help us best diagnose and treat our patients.

CONFLICT OF INTEREST STATEMENT

None declared.

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