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Do We Operate too Much?

Operieren wir zu viel?

EDITORIAL

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These days, we orthopedic and accident surgeons are accused in the press that we operate too much and without proper indication. We are placed under general suspicion of overstepping the indication spectrum without scientific basis and possibly even for pecuniary reasons.

Conspicuous increases in the number of cases which cannot be explained by the demographic development are cited in this connection. According to an article in the Spiegel, the number of operations with subacromial decompression (SAD) in the impingement syndrome of the shoulder increased significantly by 30% from 2008 to 2015. Exact analysis shows a completely different picture: SAD is frequently not the only procedure but is made only at the same time as, for example, suture of a torn shoulder tendon or removal of calcific deposits. The numbers registered with the Federal Bureau of Statistics show a decrease of overall in-hospital SAD (open/arthroscopic) between 2010 and 2017: 104,894 (1998/84,896) to 102,062 (12,086/89,976) – nearly 3% less.

Economizing Medicine

In the last 20-30 years, numerous steps have been taken by providers and politics to suppress and reduce health costs: the budgeting of treatment in outpatient cases and the introduction of DRGs in hospital wards are examples. This has resulted in perceptible economizations of our medicine. Our system demands that hospital profits be increased by an increased number of cases. Senior physicians report in personal conversations that they feel subjected to high pressure to achieve economic goals, whereby they cannot always control important framework conditions, such as the number of personnel. This means that our claim of always offering our patients optimal treatment does not fit in with the hospital funders for higher profits in individual cases. Our inner compass is needed here to continue doing the best for our patients!

New Data

Moreover, attention has been paid to several prospective randomized studies which criticize frequently-performed operations on the knee and shoulder. There are two studies on the treatment of gonarthrosis: one with joint lavage, a sham OP and arthroscopic debridement (3) and the other a study with joint lavage and debridement (+physio and medications) versus a group with only physiotherapy and drug treatment (2). A broad spectrum of knee pathologies was included in the studies, including attrition and meniscus damage. The authors conclude that a speculum procedure of the knee had no significant advantage over a conservative treatment of a sham operation.

Another study which has received considerable attention was published in the Lancet by Beard et al. in 2018. The authors examined subacromial shoulder pain which had lasted more than 3 months, been unsuccessfully be treated with at least 1 injection and physiotherapy, but with an intact rotator cuff (RM) (1). Here, too, several pathologies including partial RM tears and biceps pathologies were included. In the authors' analysis, SAD brings no advantage for patients over a sham operation, but there is a significant effect of the operation compared to conservative treatment.

What Conclusions Are to Be Drawn?

The main criticism of the above-cited studies is that relatively unspecific patients were included and it was not determined which patient profits from what operation. In the study by Beard et al., for example, only 58% of the patients in the group that was to have undergone only diagnostic arthroscopy actually received this treatment after 6 months, 48% refused operation or received RM refixation or SAD. This underlines that the correct diagnosis and exact indication are decisive for successful intervention!

The studies cited are important for the development of our knowledge and for optimal treatment of patients and should therefore not be underestimated. We must continuously critically examine and further develop our treatment methods. This is one reason why my team designed a similar shoulder study, which was supported by the research promotion section of the Deutschen Vereinigung für Schulter and Ellenbogenchirurgie. In this study, we are attempting to analyze and focus the criteria and the patient collective as precisely as possible. This has the result, however, that it is difficult in practice to recruit patients for this prospective randomized approach: although the study has been recruiting patients for three years, the target group sizes have not yet been reached. This demonstrates how difficult it is to perform good and valid studies in day-to-day practice. ›

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What does this mean exactly for us?

Discussion in scientific societies is always intensive when it comes to the conclusions to be drawn from the cited studies. The health insurance companies, however, have already withdrawn the key and refuse to pay costs, for example in knee treatment, as soon as the diagnosis "knee joint attrition" is named – independent of other possible biomechanically-acting pathologies like free joint bodies or meniscus lesions. This illustrates that – independent of a differentiated scientific assessment – the providers create their own facts.

For us as scientifically-involved physicians, it is thus important to work on the differentiated assessment of our therapies, present the collected results uniformly by our specialist society and continue to do the optimum in the best interests of our patients. Based on published data, there are clear and relative indications for operations. In the relative indications, I hold to the principle that conservative therapy should be applied first. If this treatment fails, an operation can be considered later.

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