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An Important Use of a National Joint Registry

I enjoyed the 2 articles on the issue of “Orthopedic Registries” by Dr. Sarmiento and Dr. Mont and colleagues in the April 2015 issue of *The American Journal of Orthopedics* (pages 159-162). Both authors have valid points, but I think they both miss what is to me the most important use of a national registry. It is for identifying an old prosthesis.

Many times in my 35-plus years of practice, I have seen patients that need revision hips or knees that were initially done 15 or 20 years ago. It would be extremely helpful if the physician could call the registry with the patient’s name, Social

Security number, birth date, and approximate date of surgery to find out what prosthesis was used—specifically, the size and manufacturer. So often the implanting surgeon has retired and the hospital where the patient thinks he or she had the surgery is closed or cannot find old records.

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Authors’ Responses

Dr. Cobey should be congratulated for expressing his sincere concern and suggestion regarding the national registry dealing with long-term follow-up of total joint implants.

However, I think that the registry must maintain a consistent evaluation criterion throughout. Needless to say, adherence to it is essential when addressing revision surgery. Dr. Cobey’s proposal would allow a possibly large number of patients to enter the registry without meeting the established criterion. They would enter without having provided truly relevant information, such as history of infection, trauma, fracture, recurrent dislocations, wear, lysis, etc, which are the most common conditions leading to revision surgery. The data from patients entering with only the minimal information proposed by Dr. Cobey—date of birth, size of the prosthesis, and name of the manufacturer—is meaningless. It could even be harmful by trivializing and weakening whatever sound goals the national registry hopes to reach.

On the other hand, if Dr. Cobey’s suggestion is favorably considered by the registry’s leaders and its value is felt to be potentially significant, the issue should be seriously studied and debated prior to its implementation.

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We would like to thank Dr. Cobey for his comments and thoughts regarding the American Joint Replacement Registry (AJRR). We wholeheartedly agree that an important purpose of this effort is to provide hospital staff and surgeons with as much information as possible regarding our patients. Incorporating information on previous surgeries, and specifically, previous prostheses that have been implanted, is no exception.

The registry is a process that requires the gradual accumulation of data. The AJRR has collected level I data, which, from a 2011 article in *AAOS Now*, “is an institutional responsibility and includes several core data elements, such as patient data (name, sex, date of birth, social security number, ICD-9 code for diagnosis), surgeon data (name, number of surgeries performed), procedure data (ICD-I code for type of surgery, date of surgery,

patient age at surgery, laterality, implant), and hospital data (name, address, number of surgeries performed there). Each patient, surgeon, and hospital has a unique identifier, which enables index procedures to be linked to subsequent events, permits patients to access their own information, allows data to be linked to other databases, and helps maintain confidentiality.”¹ Therefore, it would certainly be possible for a surgeon to collect the data that Dr. Cobey has mentioned, which would be “extremely helpful.”

In addition, as the AJRR continues to evolve its component element database, identification of implants will become easier. Also, collaborative efforts are underway with the International Society of Arthroplasty Registries (ISAR) to expand and harmonize data collection, including the recognition of implants.² The US Food and Drug Administration has also proposed the incorporation of unique device identifiers into patient medical records, although this is a concept that remains in debate with the Centers for Medicare & Medicaid Services (CMS).³

We would like to thank Dr. Sarmiento and Dr. Cobey for their contributions to this discussion, and we welcome any ongoing suggestions and queries to improve the development of the AJRR.

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