

though we will concede that to be successful these individuals have agreed to the expectations of their department and their academic institution. We recognize that many surgical trainees leave training programs and many academic surgeons leave university departments to go into community practice because they cannot, or will not, make the compromises required to deal with the demands of their roles. We agree that many capable women leave surgical training or drop out of academic surgery because of the difficulty of combining family and professional roles.

We also acknowledge the limitations of our study group. We were interested in the case study represented by a department of surgery that intentionally set out to change the gender mix and to change policies to be more “family friendly.” We would contend that departments of surgery can make choices about how to support women and men during their training and as faculty members, and these choices will make trainees more likely to be successful. This is an evolutionary rather than a revolutionary approach.

Our paper indicates the critical importance of mentorship. If mentors are not assigned or identified in one's own department, individuals need to look elsewhere—to national surgery organizations or other national organizations such as the Canadian Medical Association, which has a mentorship program to faculty members outside of surgery.

Again, we thank the authors for their comments and observations, all directed at inclusiveness in surgical training and academic pursuits.

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### COMMENT ON “COMPARISON OF THE MAJOR INTRAOPERATIVE AND POSTOPERATIVE COMPLICATIONS BETWEEN UNILATERAL AND SEQUENTIAL BILATERAL TOTAL KNEE ARTHROPLASTY IN A HIGH-VOLUME COMMUNITY HOSPITAL”

It was with great interest that we read the recent article by Spicer, Thomas and Rumble,<sup>1</sup> which provides an insight into the safety of unilateral total knee arthroplasty (UTKA) versus sequential or simultaneous bilateral total knee arthroplasty (BTKA) in a high-volume community hospital. The authors excluded from their study patients who underwent staged TKA, defined as “2 distinct surgeries on both knees within a 1-year period.” Instead, candidates with bilateral knee symptoms who were deemed eligible for surgery were given the option of BTKA or 2 UTKAs.<sup>1</sup>

In our experience with patients who present with bilateral fixed flexion knee deformities, even if a UKTA is initially successful, it may develop stiffness and adopt the fixed flexion of the contralateral knee if the latter is not likewise replaced within a few months. Residual flexion contractures after knee replacement have been associated with poor outcomes.<sup>2</sup>

The limitation of movement and impact on quality of life caused by a residual flexion contracture<sup>3</sup> should be considered a complication in itself. This complication might be avoided by performing a BTKA or careful pre- and postoperative management to safely complete staged TKA procedures in considerably less than 1 year. Although it seems reasonable that “individuals who decline the second operation may have been better served by a 1-step BTKA,”<sup>1</sup> the alternative is perhaps more relevant to orthopedic departments where there is less experience and expertise in performing BTKAs.

The merits of BTKA versus staged TKA have been extensively discussed in the literature. Reduced

costs, single anesthetic and decreased total recovery time have been highlighted as advantages of BTKA,<sup>4</sup> but an increased risk of serious postoperative complications have also been reported.<sup>5</sup> We hope that future studies will continue to objectively evaluate the risks and benefits of each, and identify which patients might be more suited to a particular method.

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### THE AUTHORS RESPOND

We thank Razii and Morgan-Jones for their comments regarding our study that compared the incidence of serious perioperative complications between unilateral and bilateral total knee replacements.

They make the additional observation that replacing 1 knee when the patient has a deformity in both knees

presents difficulties with rehabilitation and may compromise the outcome for the knee. We agree that this may very well be the case, though it was not the focus of our study.

They also comment on the omission of staged procedures, in which the 2 knees are replaced on separate occasions within the first year. In our hospital there were only 69 such patients during the time frame of our

study, which did not reach statistical significance; hence, we omitted them.

They encourage further study to “identify which patients might be more suited to a particular method.” This may be useful to surgeons in different settings. In our case, we found that replacing both knees under 1 anesthetic was safe in the setting of a high-volume community hospital.

Once again, we appreciate the feedback.

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