LETTER TO THE EDITOR

Regarding the instability severity index score (ISIS)

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Sir,

We read the article in your journal by Bouliane et al. on 'The intra- and inter-rater reliability of plain radiographs for Hill–Sachs and bony glenoid lesions: evaluation of the radiographic portion of the instability severity index score' with some interest [1]. We do, however, find ourselves disagreeing with their conclusions about the instability severity index score (ISIS).

The ISIS score was designed as a guide to help the surgeon identify those patients at high risk of recurrence of instability after an arthroscopic Bankart procedure [2]. We intentionally decided to use standard anteroposterior radiographs that identify deep posterosuperior Hill–Sachs lesions and glenoid erosions because these studies are readily available at the initial outpatient consultation. We do not propose that all glenoid or humeral lesions of instability can be identified with only two plain radiographs. Our research found that the presence of lesions that are significantly sufficient to show up on standard radiographs increases the likelihood of recurrent instability following arthroscopic Bankart repair.

Looking at individual components of a scoring system in isolation may lead to erroneous conclusions being drawn about the scoring system itself. The ISIS must be used and studied as a whole. Rouleau et al. have recently validated the ISIS score in a prospective multicentre reliability study in 114 consecutive cases [3]. In their study, two independent evaluators at five centres in Europe and North America met all patients at least 1 week before surgery. The inter-observer reliability of the ISIS was excellent, with an intraclass correlation coefficient of 0.933 ($p < 0.001$). Rouleau et al. conclude that their results show that ISIS measurements are highly reliable and support the clinical use of the ISIS for traumatic anterior instability severity grading for surgeons wishing to do so [3].

We agree with Bouliane et al. that three-dimensional imaging is required to establish an accurate representation of bony lesions in this patient population [1]. We consider the ISIS to be a useful clinical tool and recommend its use in conjunction with computed tomography, particularly with an 'en face' glenoid view, in the planning of surgery.

Bouliane et al. found that the surgeon with the most years of experience reported the highest overall accuracy in identifying Hill–Sachs and glenoid lesions [1]. We propose that the surgeon must also take into account his or her own level of ability and expertise before treating shoulder instability.

REFERENCES

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