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Letter to the Editor on “Implementation of Preoperative Screening Criteria Lowers Infection and Complication Rates Following Elective Total Hip Arthroplasty and Total Knee Arthroplasty in a Veteran Population”

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To the Editor:

We read with interest the article published in the *Journal of Arthroplasty* by Nussenbaum et al entitled “Implementation of Preoperative Screening Criteria Lowers Infection and Complication Rates Following Elective Total Hip Arthroplasty and Total Knee Arthroplasty in a Veteran Population.” The authors established very restrictive eligibility criteria for total joint arthroplasty at their institution and demonstrated a reduction in their complication rate after implementation. We appreciate and share the authors’ commitment to improving patient outcomes and the overall quality of care provided to veterans.

The authors note in their discussion that they “... cannot say how many consultations initially failed screening criteria ...” We feel that this is a critical consideration. Patients who fail the screening must be accounted for when assessing the value of screening. Restrictive screening criteria have the effect of selecting the least risky patients for surgery. This predictably will reduce complications and improve surgical statistics. However, because complications are rare and hard to predict, restrictive screening criteria also result in denial of care to a large number of patients who would not have had complications. We have previously described the magnitude of this effect in the Veterans Health Administration for the hemoglobin A1c and body mass index (BMI) cut-offs implemented by the authors [1,2].

One may think that the factors used for screening are reversible, and thus application of these criteria should not restrict access to care. However, many seemingly “reversible” risk factors are actually not reversible for a large number of patients [3,4]. Well-intended goals for patient optimization before elective surgery can have the unintended effect of becoming

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insurmountable barriers to receiving surgery, even for motivated and engaged patients. This is well-demonstrated in the obesity literature. Studies have shown that patients with high BMIs engaged and participating in structured weight loss programs lose about 8% of body weight on average over a period of 6–18 months, and patients who are enrolled in a comprehensive inpatient weight loss program lose about 14% body weight on average [5–9]. Thus, a patient with a BMI of 43 kg/m² would have about a 50–50 chance of getting below a BMI threshold of 40 kg/m² with active participation in a structured outpatient weight loss program, and would be extremely unlikely to get below a threshold of 35 kg/m².

Total joint arthroplasty has been shown to provide comparable improvement in patient-reported outcomes in morbidly obese and nonmorbidly obese patients [10,11]. We feel that a balance must be struck between reducing complications and providing access to care for patients. Where the appropriate balance resides remains to be determined, and a one-size-fits-all approach is unlikely to adequately consider the varying individual perspectives and preferences of all stakeholders—patients, surgeons, and the health care system. Our experience and research [1–4] has convinced us that eligibility criteria as described by Nussenbaum et al exclude too many patients from surgery who would not have a complication from surgery. Rigidly adhering to such restrictive criteria may improve surgical statistics for the medical center, but we are concerned that such a practice may ultimately end up being a disservice to the entire population of veterans whom we are charged to care for.

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