CORRESPONDENCE

Percutaneous Vertebroplasty in Vertebral Compression Fractures of Benign or Malignant Origin: A Prospective Study of 1188 Patients With Follow-up of 12 Months

by Dr. med. Anastasios Mpotsaris, Razmin Abdolvahabi, Bastian Hoffleith, Dr. med. Janpeter Nickel, Dr. med. Ali Harati, Dr. med. Christian Loehr, Dr. med. Chun Hee Gerdes, Dr. med. Svenja Hennigs, PD Dr. med. Werner Weber in volume 19/2011

Disappointing

I read the article by Mpotsaris et al with interest, hoping to gain an understanding of the effectiveness of the increasingly widely used percutaneous vertebroplasty (1). Table 1, showing the patients’ pre-interventional status, seemed informative and well structured. But what followed was a disappointment and unsatisfactory from a clinical as well as a scientific perspective. The result tables show only P values. Not a single symptom was quantified or qualified according to the original table. Since no control group with conservative treatment had been evaluated in the study, readers do not learn whether any advantage exists for the intervention. In many patients receiving conservative treatment for osteoporosis and vertebral fractures, at least pain and mobility improve within one to three months. A current study with a comparison group showed exactly the same P values for symptom improvement in both therapeutic arms (2).

Instead, the discussion dismantles the “negative” results of two high ranking, published, prospective randomized studies by using questionable arguments (3, 4); both studies had at least attempted to make a genuine comparison by means of elaborate sham procedures. In terms of the popularity, reputation, and visibility of Deutsches Arzteblatt International, I would have wished for a more objective and understandable presentation of the topic. Maybe a critical editorial would have been helpful, too.

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REFERENCES

S3 Guideline Was Not Mentioned

In the study reported by Mpotsaris et al., osteoporosis was the cause of the vertebral fractures treated with vertebroplasty in three out of four cases. The authors even conclude that the “socioeconomically most important group of patients with vertebral body fractures, namely, those whose fractures are due to osteoporosis” experienced clinical improvement potentially for up to six months.

The authors do not mention the written consensus of the German governing body for osteology (Dachverband Osteologie, DVO) on the prophylaxis, diagnostic evaluation, and treatment of osteoporosis in adults, in the form of the S3 guideline (www.dv-osteologie.org/dvo-leitlinien/dvo-leitlinie-2009), published first in 2006 and updated in 2009. In this guideline, vertebroplasty and kyphoplasty are discussed and it is recommended that interdisciplinary discussion of the individual case and a documented attempt at conservative treatment should precede the intervention, as should excluding degenerative changes as the cause of the existing pain.

In the present article, the authors “retrospectively” conclude that the selection of suitable patients is an important criterion for achieving good results during follow-up. The authors must have been unfamiliar with the cited S3 guideline as such a selection should already be routine standard these days. Maybe this is also why readers do not learn what is used to provide the osteoporosis patients with osteoprotective treatment, although this may influence the degree of pain and constitutes the actual treatment for osteoporosis, which particularly needs to be taken into consideration in this group of patients. Furthermore I wish to point out that the authors acknowledge in their article the limitation of the lacking control group, but do not deal with the possible distortion of results owing to the “placebo effect” of the intervention. Publications on this topic can also be found at www.dv-osteologie.org.

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In Reply:
We thank our colleagues for their critical comments and wish to point out once again that the main part of the section on material and methods had to be placed into the online version of the article, for reasons of space. The exact approach, including inclusion criteria, is detailed there. On this background, questions or misunderstandings may have arisen. We wish to respond to Rabenstein that, consistent with the guideline, unsuccessful conservative treatment for vertebral fracture was the prerequisite for undertaking vertebroplasty. Only conservative “treatment failures” were therefore included. It goes without saying that conservative treatment may also produce a successful outcome. However, the Vertos II study (a prospective, randomized, multicenter study) impressively confirmed the superiority of the intervention compared with the study arm that received conservative treatment (1). The cited study by Wang et al concludes that pain reduction, improved mobility, and reduced need for painkillers in the vertebroplasty group were better than in the conservative treatment arm (2). It goes without saying that conservative treatment may also produce a successful outcome. However, the Vertos II study (a prospective, randomized, multicenter study) impressively confirmed the superiority of the intervention compared with the study arm that received conservative treatment (1). The cited study by Wang et al concludes that pain reduction, improved mobility, and reduced need for painkillers in the vertebroplasty group were better than in the conservative treatment arm (2).

In conclusion, we think that vertebroplasty is a piece in the mosaic that is the total therapeutic concept. If the indication is consistent with the guidelines and is undertaken by an experienced specialist it provides a clinically valuable contribution accompanied by low risk, just as we showed in more than 1000 patients.

REFERENCES