

Retraction

Retracted: Comparison of the Early Results of Lateral Direct Anterior Approach (L-DAA) and Traditional Posterolateral Approach (PLA) in Hip Arthroplasty

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This article has been retracted by Hindawi following an investigation undertaken by the publisher [1]. This investigation has uncovered evidence of one or more of the following indicators of systematic manipulation of the publication process:

- (1) Discrepancies in scope
- (2) Discrepancies in the description of the research reported
- (3) Discrepancies between the availability of data and the research described
- (4) Inappropriate citations
- (5) Incoherent, meaningless and/or irrelevant content included in the article
- (6) Peer-review manipulation

The presence of these indicators undermines our confidence in the integrity of the article's content and we cannot, therefore, vouch for its reliability. Please note that this notice is intended solely to alert readers that the content of this article is unreliable. We have not investigated whether authors were aware of or involved in the systematic manipulation of the publication process.

Wiley and Hindawi regrets that the usual quality checks did not identify these issues before publication and have since put additional measures in place to safeguard research integrity.

We wish to credit our own Research Integrity and Research Publishing teams and anonymous and named external researchers and research integrity experts for contributing to this investigation.

The corresponding author, as the representative of all authors, has been given the opportunity to register their agreement or disagreement to this retraction. We have kept a record of any response received.

References

- [1] L. Wang and Z. Xu, "Comparison of the Early Results of Lateral Direct Anterior Approach (L-DAA) and Traditional Posterolateral Approach (PLA) in Hip Arthroplasty," *Computational and Mathematical Methods in Medicine*, vol. 2021, Article ID 1187011, 6 pages, 2021.

Research Article

Comparison of the Early Results of Lateral Direct Anterior Approach (L-DAA) and Traditional Posterolateral Approach (PLA) in Hip Arthroplasty

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Objective. To evaluate the early results of lateral direct anterior approach (L-DAA) and traditional posterolateral approach (PLA) in hip arthroplasty. **Methods.** A total of 24 patients who underwent hip replacement from 2018 to 2021 were divided into PLA group ($N = 12$) and L-DAA group ($N = 12$) according to the method of random table number. Outcomes were evaluated between the two groups. **Results.** The length of incision was shorter; the amount of bleeding was less in the L-DAA group than that in the PLA group. The visual analogue scale (Vas) pain scores for the L-DAA group were significantly lower than that for the PLA group at 24 h, 72 h, and 1 month after operation, and Harris hip scores in the L-DAA group were significantly high in the PLA group at 1 month after operation. In addition, there are no statistically significant differences in acetabular anteversion, abduction, and angle between the two groups. **Conclusion.** L-DAA was superior to PLA for early recovery after hip arthroplasty.

1. Introduction

Hip arthroplasty has proven to be very successful in relieving pain and improving function in patients with advanced hip arthritis or femoral neck fractures [1]. Driven by this increasing demand and patients' higher expectations, the optimal surgical approach can improve the outcome of total hip arthroplasty [2]. The direct anterolateral and posterolateral approaches have been the subject of many previous studies [3–5]. Proponents of the direct anterior approach (DAA) argue that its advantages include the preservation of muscle through the use of true interneuronal and intermuscular planes, reduction of the risk of dislocation, and enhancement of early functional recovery [6, 7]. The lateral direct anterior approach (L-DAA) was used in the study group. The posture was consistent with the traditional posterolateral approach. Proponents of the posterolateral

approach (PLA) to the lateral decubitus position note that surgeons have a higher incidence of complications and revision in their early experience with DAA [8]. Although several studies [9, 10] have reported similar long-term outcomes for DAA and PLA in total hip arthroplasty, there are differences in early postoperative outcomes. Therefore, we compared the two groups clinically, including postoperative blood loss, postoperative walking time, postoperative pain score, operative time, and postoperative hip Harris score.

2. Methods

2.1. Study Population. The clinical data of 24 patients undergoing hip arthroplasty (including total and hemiarthroplasty) from 2018 to 2021 were retrospectively analyzed; all cases were divided into the PLA group ($N = 12$) and the

DAA group ($N = 12$). This study was approved by the hospital's Medical Ethics Committee.

The inclusive criteria are as follows: (1) patients with hip disease (femoral neck fracture, femoral head necrosis, hip arthritis, or developmental dysplasia of the hip) needed joint replacement; (2) no history of any hip surgery or infection; (3) patients signed informed consent.

The exclusion criteria are as follows: (1) poor general condition, unable to tolerate surgery; (2) severe acetabular dysplasia.

Preoperative and postoperative data were collected by independent researchers. Routine preoperative preparation was completed in both groups.

2.2. Direct Anterior Approach. In the L-DAA group, the patients were treated in the lateral decubitus position. In the lateral decubitus position, a skin incision from the lateral 2 cm of the anterior superior iliac spine to the fibular head or greater trochanter block is made. The skin, subcutaneous tissue, and fascia lata are incised layer by layer. The fascia lata is separated from the deep muscle fibers, and the Sartorius from the tensor fasciae latae and retract the muscle is separated with a retractor, fully exposing the anterolateral femoral muscle and the anterior articular capsule. After the femoral neck is fully exposed, the femoral neck is amputated along the intertrochanteric line and the osteotomy block and femoral head are removed. The retractor fully exposes the acetabulum. After removing the labrum of acetabulum margin and hyperplastic osteophytes, the acetabulum is polished with acetabulum file one by one until the subchondral bone oozes blood. Adjust the forward angle, abduction angle, and the cup and inner liner. The affected limb is rotated and stretched backward, and the upper articular capsule of the lateral posterior femur is completely released and resected. The proximal femur is fully exposed, and the hip joint is repositioned by inserting the stem of the femoral prosthesis and the femoral head prosthesis. After checking the stability of hip joint and good flexion and extension, irrigate the operation area, suture repair, duplicate joint capsule, indwelling drainage tube, and close the incision.

2.3. Posterolateral Approach. In the PLA group, patients received hip arthroplasty or femoral head replacement via a posterolateral approach. A posterolateral incision is made at the apex of the greater trochanter of the femur, and the skin, subcutaneous tissue, and fascia are cut layer by layer, so that the external rotating machine is fully exposed at the stop point of the large and rotor. And the middle gluteal muscle is retracted and protected, and the external rotating muscle is cut off at the stop point; the posterior capsule of the joint was fully exposed and resected for posterior flexion, adduction, and internal rotation. The femoral neck was transected above the trochanter to extract the femoral head. After checking the stability of hip joint and good flexion and extension, irrigate the operation area, suture repair, duplicate joint capsule, indwelling drainage tube, and close the incision.

2.4. Clinical Observation Indexes. (1) The perioperative related indexes including the amount of blood loss during the operation, the operation time, and the length of incision were observed; (2) functional outcomes were evaluated with the visual analogue scale (Vas) scores and Harris hip score at preoperation and 1 month postoperatively. (3) Imaging indexes including acetabular anteversion and abduction angle were recorded

2.5. Statistical Data. All data were processed by SPSS 20.0 statistical software (SPSS Inc., Chicago, USA). The measurement data were expressed as mean \pm standard deviation (SD), and differences were assessed using the Student *t*-test. The count data were expressed as number (percentage), and the chi-square test was used to assess the differences. *P* values < 0.05 were considered as statistically significant.

3. Results

3.1. General Data. The baseline characteristics of 24 patients are presented in Table 1. There was no significant difference between the two groups in age, gender, hospital stays, and operation type ($P > 0.05$).

3.2. Outcomes. Compared with the PLA group, patients in the L-DAA group had shorter incision length and less intraoperative bleeding, and the difference was statistically significant ($P < 0.01$; Table 2).

No statistically significant differences in Vas and Harris hip scores were found before the surgery in both groups ($P > 0.05$; Tables 3 and 4). After operation, the VAS pain scores for the L-DAA group were significantly lower than those in the PLA group at 24 h, 72 h, and 1 month postsurgery ($P < 0.05$). And the Harris hip scores for the L-DAA group were significantly high compared to the PLA group at 1 month after operation ($P < 0.05$).

Furthermore, there was no significant difference in acetabular anteversion, abduction, and angle between the two groups ($P > 0.05$; Table 5).

In addition, Figures 1(a)–1(d) show preoperative and postoperative images of the anterior approach, intraoperative postures, and partial photographs of a typical case.

4. Discussion

In the present study, we found that patients in the L-DAA group had shorter surgical incisions and less intraoperative bleeding compared to the PLA group. Early postoperative VAS pain scores and Harris hip scores indicated that DAA resulted in less pain and faster functional recovery in the early postoperative period in postoperative patients. Several studies have also shown faster recovery of hip function in DAA patients in the short term [1, 11]. DAA, a new minimally invasive approach, is often compared to PLA by researchers. Cao et al. [12] demonstrated that patients with DAA had elevated Harris hip scores and low reduction in VAS scores compared to PLA, and its advantages in both early postoperative recovery and rehabilitation. In addition, another advantage of the DAA group in this study was a significant reduction in hospital stay, which was consistent with

TABLE 1: Patient characteristics.

Variable	DAA group ($n = 12$)	PLA group ($n = 12$)	P
Age (years)	63.92 \pm 9.395	69.67 \pm 11.41	0.192
Gender (male/female)	3/9	5/7	0.665
Hospital stays (days)	13.83 \pm 3.973	13.33 \pm 2.462	0.715
Disease type			
Femoral neck fracture	4 (33.33%)	6 (50.00%)	
Coxarthropathy	3 (25.00%)	0	
Osteonecrosis	4 (33.33%)	5 (41.67%)	
Arthritis	1 (8.33%)	1 (8.33%)	
Operation type			
Total hip arthroplasty	10 (83.33%)	9 (75.00%)	
Femoral head prosthetic replacement	2 (16.67%)	3 (25.00%)	0.614

Data are mean \pm SD or n (%). DAA: direct anterior approach; PLA: posterolateral approach.

TABLE 2: Comparison of perioperative parameters between the two groups.

	DAA group ($n = 12$)	PLA group ($n = 12$)	t	P
Incision length (cm)	8.80 \pm 1.25	10.12 \pm 1.40	1.674	0.032
Intraoperative bleeding (ml)	196.5 \pm 6.9	256.8 \pm 7.8	6.766	≤ 0.001

Data are mean \pm SD. DAA: direct anterior approach; PLA: posterolateral approach.

TABLE 3: Postoperative visual analogue scale (Vas) scores of the two groups were compared.

	DAA group ($n = 12$)	PLA group ($n = 12$)	t	P
Preoperation	5.85 \pm 1.25	6.05 \pm 1.23	1.574	0.324
24 h after operation	4.12 \pm 0.34	5.87 \pm 0.32	3.876	≤ 0.001
72 h after operation	2.12 \pm 0.32	3.97 \pm 0.54	5.678	≤ 0.001
1 month after operation	2.10 \pm 0.21	2.89 \pm 0.28	2.878	0.016

Data are mean \pm SD. DAA: direct anterior approach; PLA: posterolateral approach.

other studies [13–15]. However, there was no significant difference in the length of hospital stay between patients in the PLA and DAA groups in this study, which may be related to the small sample size.

DAA was used in the side-lying position in this study group. The operating habit remained unchanged without changing the traditional position, which was beneficial to the operation and judgment during the operation, in particular, the anatomical gap between the tensor fasciae latae muscle and the Sartorius. It can be considered a minimally invasive method that theoretically causes less tissue damage than the more invasive PLA [16]. Thus, these may indicate that the short-term benefits of DAA continue to manifest themselves in superior functionality but disappear after 6 months. In our study, patients who underwent hip replacement through DAA underwent surgery had shorter incisions and less bleeding than the PLA group. Barrett et al. [17] and Spaans et al. [18] reported that the operation time and blood loss in the DAA group were longer than that in the PLA group. Bergin et al. [19] and Rykov et al. [20] indicated that there was no difference in blood loss between the two groups, but the operation time in the DAA group was signif-

icantly longer. Early postoperative complications include trochanteric fractures, hematomas, lateral femoral cutaneous nerve injury, dislocation, persistent pain, leg length differences, and thrombosis. Spaans et al. [18] found similar complication rate results. However, in recent literature [21, 22], the incidence of complications in the DAA group was not significantly higher than that in the PLA group. In the current meta-analysis [23], we found that all surgeons using DAA for hip arthroplasty have a wealth of experience. But the complication rate of the DAA group was high, the operation time was long, and the amount of bleeding was large. This indicates that it is difficult to perform hip replacement with DAA. Despite the excellent surgical skills and experience of the surgeons involved in our study, the results were less satisfactory. And some studies [24, 25] have reported that prolonged surgery is associated with an increased risk of infection. Each new surgical technique is associated with effort and is often associated with a temporary increase in adverse events, which is the so-called learning curve [26, 27]. Therefore, the surgeon should be a well-trained joint surgeon with extensive hip replacement experience before performing hip replacement through DAA.

TABLE 4: Harris scores before and after operation were compared between the two groups.

	DAA group ($n = 12$)	PLA group ($n = 12$)	t	P
Preoperation	44.34 ± 3.12	44.96 ± 2.98	0.675	0.564
1 month after operation	88.54 ± 3.23	72.52 ± 3.33	8.675	≤ 0.001

Data are mean \pm SD. DAA: direct anterior approach; PLA: posterolateral approach.

TABLE 5: Comparison of imaging evaluation between the two groups.

	DAA group ($n = 12$)	PLA group ($n = 12$)	t	P
Anteversion of acetabular	14.89 ± 2.11	15.23 ± 2.12	1.787	0.564
Abduction of acetabular	40.89 ± 2.54	41.23 ± 3.22	1.698	0.134

Data are mean \pm SD. DAA: direct anterior approach; PLA: posterolateral approach.

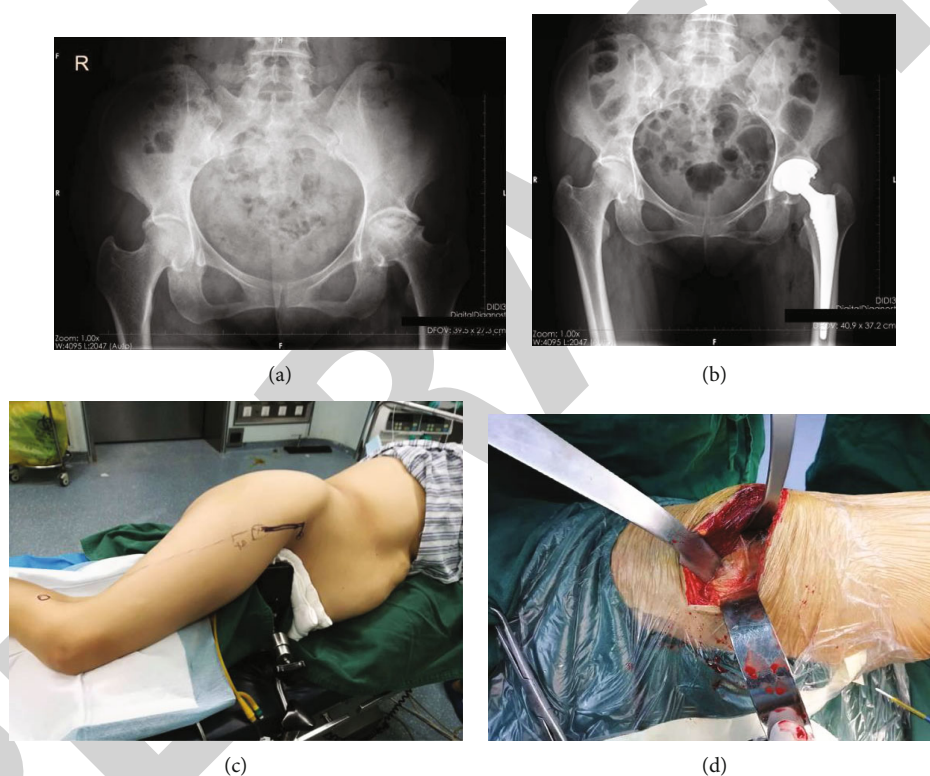


FIGURE 1: Preoperative and postoperative radiographs and intraoperative images were taken in a typical case. (a) A case of necrosis of the right femoral head; preoperative X-ray, collapse of the right femoral head, and narrowing of the HIP joint space. (b) X-ray of the right total hip replacement, the position of the hip joint prosthesis was good. (c) The position was lateral, marked 2 cm behind the anterior superior ILIAC spine, distal to the fibular head. (d) Entering the space between the Sartorius and the tensor fasciae latae muscle, the branches of the lateral femoral artery were seen and ligated.

In conclusion, compared with PLA, patients in the DAA group had shorter postoperative incisions, less intraoperative bleeding, and lower postoperative VAS scores and higher Harris hip scores. This suggests that with DAA in hip arthroplasty, patients can recover function faster in the early stages. Limitations of this study include the small sample size and the different types of prostheses used. Future large sample studies can provide more in-depth analysis, and more evaluation criteria are needed.

Data Availability

The data used to support the findings of this study are available from the corresponding author upon request.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Acknowledgments

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