

Letter to the Editor

Response regarding: “Uncertainty and risk of misleading conclusions: an umbrella review of the quality of the evidence for ankle arthroscopy”



Acta Orthopaedica

Sir,—we appreciate the authors’ thoughtful response to our article [1]. As we understand it, their letter [2] presents 3 main arguments concerning our review:

1. “Large pragmatic trials are invaluable in providing evidence directly applicable to daily clinical decision-making.”
2. “Registry-based and multicenter [observational] data provide important insights when high-quality RCTs are lacking.”
3. “While high-level evidence remains limited, novel minimally invasive approaches continue to expand the scope of ankle arthroscopy.”

1. We fully agree that pragmatic multicenter trials can be invaluable in guiding clinical practice. However, we are unsure whether the authors refer to genuine pragmatic randomized trials or to uncontrolled observational series when making this point. A persistent misconception is that randomized trials are somehow detached from “real life,” and that surgical improvements seen “in my hands” or “in everyday practice” are sufficient evidence. History tells us otherwise: subacromial decompression and arthroscopic partial meniscectomy are clear examples of how this mindset can lead to large-scale harm [3,4]. Meta-epidemiological studies consistently show that non-randomized designs tend to overestimate treatment benefits, something every clinician should keep in mind [5].

2. We agree that, in the absence of RCTs, clinical decisions must rely on the best available evidence. Our review highlights a different issue: that level I conclusions are sometimes drawn from methodologically flawed reviews rather than from robust evidence. While even flawed studies may provide provisional insights, readers should be explicitly alerted to their limitations, and conclusions should be presented with appropriate caution. Most clinicians do not have the luxury of dissecting every review for hidden weaknesses, hence clarity and transparency matter. Finally, it is worth noting that there is no valid reason why RCTs comparing ankle arthroscopy with nonoperative treatment have not yet been conducted.

3. We do not agree that new invasive approaches should be introduced without the support from properly designed studies. We certainly are not opposed to technical innovation. Yet, history again teaches caution: widespread adoption of new surgical techniques without sound experimental evidence often results in wasted resources and patient exposure to

unproven care, as seen with subacromial decompression and arthroscopic partial meniscectomy [3,4,6]. Innovation is vital, but widespread clinical use should be preceded by evidence that patients do benefit, not merely that they might benefit on theoretical grounds. After all, if minimal invasiveness automatically guaranteed better outcomes, then the most minimally invasive strategy—doing nothing at all—could often be the most effective.

Ville Ponkilainen¹, Valtteri Panula², Juho Laaksonen², Anniina Laurem³, Mikko Miettinen⁴, Ville M Mattila^{1,5,6}, and Teemu Karjalainen²

¹ Department of Orthopaedics and Traumatology, Tampere University Hospital; ² Department of Surgery, Central Finland Central Hospital, Jyväskylä;

³ Department of Surgery, Mikkeli Central Hospital, Mikkeli;

⁴ Department of Orthopaedics and Traumatology, University of Helsinki and Helsinki University Hospital, Helsinki, Uusimaa; ⁵ COXA Hospital for Joint Replacement, Tampere;

⁶ Faculty of Medicine and Health Technology, University of Tampere, Tampere, Finland

Correspondence: ville.ponkilainen@tuni.fi

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