

As stated in the article's discussion, a limitation of this retrospective review was that 2 different temperature-measuring devices were used. In the preoperative and postoperative units, a temporal artery thermometer (TAT-5000; Exergen Corp, Watertown, MA) was used. Near-core measurements like the temporal artery thermometer are reasonably accurate except during extreme thermal perturbations. Intraoperatively, an esophageal probe (Covidien Mon-a-therm, Dublin, Ireland) was used to record core body temperature. No temperature was measured on entry into the room until an esophageal probe was placed at induction of anesthesia. The use of an esophageal temperature probe is an accurate way to continuously monitor core body temperatures intraoperatively [13,14]. The measured temperature of the esophageal probe can vary based on positioning and type of anesthesia. Due to the possible variation of measured temperatures between devices, a lower threshold for hypothermia was used in our study at 35.5°C compared to most studies at 36°C. In a follow-up prospective study, the methodology can be refined and only 1 type of temperature-measuring device can be used to avoid possible confounding. However, the limitations of a retrospective review do not invalidate the findings of the study which show a significant temperature decrease from the preoperative holding area until incision is made. The ideal response of the surgical team and the institution to address perioperative hypothermia has not been clearly elucidated.

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Letter to the Editor on “Hospital Discharge Within 1 Day After Total Joint Arthroplasty From a Veterans Affairs Hospital Does Not Increase Complication and Readmission Rates”



To the Editor:

Dear editor, we read with great interest the article by Kiskaddon et al. This is a very interesting study which intends to determine whether there is a difference between discharge on postoperative day 1 (POD 1) and after a longer in-hospital stay in patients who undergo primary total hip or knee arthroplasty [1].

Although this is a trending topic and the conclusion of the article is in line with the expectations of the medical community, we think that selection bias could have played a determinant role in the obtained results, therefore yielding a misleading conclusion.

First of all, patients underwent joint arthroplasty during different historical discharge policies, and it is possible that the second cohort of patients would have benefit of improved protocols such as spinal anesthesia (78% in subgroup 1 vs 11% in subgroup 2) as stated by authors within the Materials and Methods section.

Second, although preoperative patient characteristics seemed to be similar, it is clear that subgroup 1 had a lower proportion of patients in grade III and IV according to the American Society of Anesthesiologists Classification system (ASA); this could explain a longer hospital stay so it is clear that patients who were scheduled for discharge on POD 1 were selected upon some medical criteria that were not described in the Methods of this study.

According to the aforementioned reasons, the results of this study could be the result of a careful selection of patients for the early discharge group and an improved perioperative protocol by the time when discharge on POD 1 was implemented. Therefore, both the title and conclusions of this article might be an overstatement which could mislead the medical community to apply a protocol to general population instead of selecting patients.

Moreover, the selection criteria used by the authors to assign patients to early discharge group should be described because it is of cornerstone relevance for the readers who are willing to benefit their patients with the results of this study.

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Response to “Letter to the Editor on ‘Hospital Discharge Within 1 Day After Total Joint Arthroplasty From a Veterans Affairs Hospital Does Not Increase Complication and Readmission Rates’”



In Reply:

We appreciate the interest of Dr. Bonilla and colleagues in our recent article entitled “Hospital Discharge Within 1 Day After Total Joint Arthroplasty From a Veterans Affairs Hospital Does Not Increase Complication and Readmission Rates.” We would like to thank them for raising these questions, and we will directly address their concerns.

We agree with the conclusion of Dr. Bonilla and colleagues that the early discharge cohort results could have benefited from improved protocols such as spinal anesthesia. However, we would refer them to the results section of the article, in which we discuss in detail the sensitivity analysis that was performed to elicit whether anesthesia type was a confounding factor. To summarize, we found that there was no effect of anesthesia type on discharge disposition, 90-day return to the operating room, 30-day readmissions, and emergency department visits ($P = .973, .651, .174$, and $.170$, respectively) [1].

To the second point, we agree that American Society of Anesthesiologists class could explain a longer hospital stay as this has been shown in the literature to be associated with increased rates of readmission and is also a factor that can predict discharge disposition [2–4]. However, we would like to clarify that all patients under the new protocol were scheduled for discharge on postoperative day 1, and almost 80% of patients were successfully discharged on postoperative day 1. Those who stayed longer due to other issues

were excluded in the same way that patients who stayed longer than 2–3 days under the old protocol were excluded if they had a medical reason that kept them in the hospital longer than the typical length of stay.

To the third point, we would like to emphasize that we do not have an early discharge selection criterion. The same criteria that qualify patients at our institution for a total joint arthroplasty qualify them for early discharge. These criteria are a body mass index <40 , no history of corticosteroid injection in the past 3 months, A1c < 8 if diabetic, and nonsmoker (or smoker who recently quit) for total knee arthroplasty.

Again, we appreciate the interest and hope this clarifies any confusion. We believe that these results obtained within the Veterans Affairs population could be applied with success to most of the general population in the United States.

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