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LETTER TO THE EDITOR

Lumbar disc herniation: long-term outcomes after mini-open discectomy

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We read the article entitled "Lumbar disc herniation: long-term outcomes after mini-open discectomy" [1] with great interest. The results described by the author have very important guiding significance for surgical treatment of lumbar disc herniation (LDH). But we also have some concerns regarding the study:

1. The exclusion criteria include scoliosis (Cobb angle > 15°), is there a specific scoliosis classification? Are we to understand that all LDHs combined with scoliosis are not suitable for mini-open discectomy? Fusion or correction of deformity is necessary for such patients? Sciatic scoliosis is known as a nonstructural scoliosis secondary to nerve root irritation [2]. If the painful stimulus is removed, scoliosis should be improved. Almost 40 LDHs combined with scoliosis (Cobb angle 15°–40°) underwent discectomy in our institution. The scoliosis can gradually be corrected followed post-operative pain relief. So we think the sciatic scoliosis (Cobb angle > 15°) is not a contraindication of discectomy.
2. The authors stated that these results deteriorate gradually during the follow-up. Does this trend have a different distribution among the 552 patients? Are there differences in follow-up outcomes between different surgical segments and different age groups? That is the focus of the reader's attention. For a large sample study with 15-year follow-up, the author does not mention it. We observed 247 LDHs followed discectomy in our institution, we found these lumbar 4–5 disc herniations showing relatively poor results in 40–50 age group. But our sample size and the follow-up time is not enough. It's too early to make a conclusion.
3. In the discussion section, the authors state mini-open discectomy has a longer interval time between initial surgery and revision by comparing mini-invasive techniques. We think this is an inappropriate comparison. First, the spine mini-invasive technique is a very broad concept; microendoscopic discectomy (MED), percutaneous endoscopic interlaminar/transforaminal discectomy (PEID/PETD), and even the mini-open discectomy are all included. In the literature cited by the authors, the objects of comparison just are MED, PETD, and open discectomy. Second, risk factors [3] that had significant relation with recurrent LDH were smoking, disc protrusion, and diabetes. Not only because of surgery. And there is a similar surgical path and decompression method for mini-open discectomy, MED, and PEID. Intra-operative detail processing is critical to the results, including recurrence. So we think it is not appropriate to evaluate the mini-open discectomy by comparing the interval time between initial surgery and revision of mini-open discectomy and mini-invasive techniques.

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