

Radiographic signs of acetabular retroversion using a low-dose slot-scanning radiographic system (EOS[®])

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ABSTRACT

Introduction: Acetabular retroversion is assessed using pelvic X-ray. Cross-over-sign (COS), posterior-wall-sign (PWS) and ischial-spine-sign (ISS) are important radiographic signs of the condition. The pelvic area is sensitive to radiation and thus, possibilities to reduce dose should be considered. The purpose was to compare radiographic signs of acetabular retroversion on conventional pelvic anteroposterior (AP) X-rays with a low-dose slot-scanning system (EOS) in a sample of patients with retroversion of the acetabulum and to compare the radiation doses.

Methods: 34 participants with radiographic signs of acetabular retroversion in one or both hips on conventional pelvic X-ray were consecutively recruited. Pelvic EOS-images were acquired in each patient and COS, PWS, ISS, COS-ratio and PWS-ratio was assessed. Radiation dose comparison of X-ray vs. EOS was performed using Dose-Area Products.

Results: Retroversion was present in 57 out of 68 hips. The absolute agreement was 91%, 84% and 76% for COS, PWS and ISS, respectively. No statistically significant differences were present between COS-ratio and PWS-ratio in either modality and Bland–Altman limits of agreement were narrow. The mean radiation dose was 1053 mGy*cm² in X-ray and 593 mGy*cm² in EOS ($p = 0.003$).

Conclusion: The results indicate that pelvic EOS provides diagnostic qualities similar to conventional X-ray using 44% less radiation when radiographic signs of acetabular retroversion are assessed.

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Introduction

Assessment of acetabular retroversion is currently based on conventional anteroposterior (AP) X-ray of the pelvis using the cross-over sign (COS),¹ the posterior-wall-sign (PWS)² and the ischial-spine-sign (ISS)³ as the gold standard for evaluation and comparison. Retroversion of the acetabulum has been proposed to contribute to femoro-acetabular pincer impingement (FAI) and development of osteoarthritis^{4–7} and thus, radiographic imaging is important in the clinical assessment. FAI is a clinical diagnose where retroversion of the acetabulum may be a cause. Retroversion is a complex 3-dimensional expression where the opening of the

superior part of acetabulum is oriented posteriorly instead of anteriorly. Thus, COS describes the expression and PWS and ISS are signs of rotation of the whole acetabular complex. Since symptoms of FAI often start at young age with groin pain during activity young individuals risk exposure to repeated radiation, as they are referred for repeated X-rays for diagnosis, monitoring, surgical planning and postoperative follow-up. The pelvic region is relatively sensitive to radiation, particularly in children and adolescents and thus, radiation exposure should be as low as reasonably achievable. Previous experimental and clinical research in other anatomical areas has proven the dose reduction potential of the low-dose radiographic system (EOS) as compared to conventional digital radiography systems.^{8–13} The main difference between conventional radiography and EOS is the nature of image acquisition; EOS being a full-body slot-scanner with the option to acquire orthogonal views simultaneously using very low radiation dose associated with the proportional multi-wire chamber detector.¹⁴ Few studies have compared EOS-images of the pelvis with conventional X-rays^{15–17}

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and to our knowledge no studies have made this comparison in a population of patients with retroversion of the acetabulum. The primary aim of this study was to compare radiographic parameters for retroversion of the acetabulum based on conventional X-rays of the pelvis and EOS and secondarily, to compare the absorbed equivalent radiation doses between the two modalities.

Methods

Orthopedic outpatients diagnosed with acetabular retroversion by one of three senior orthopedic surgeons specialized in hip surgery were consecutively recruited from the clinic. Acetabular retroversion was defined as presence of COS on conventional AP X-ray of the pelvis. Individuals who met all the inclusion and none of the exclusion criteria were offered participation in the study (Table 1).

X-rays

Conventional AP X-ray of the pelvis was performed with the participants in standing position with the arms crossed in front of the chest and the legs slightly abducted so the feet could meet in 15 degrees of inward rotation. The X-ray beam was perpendicular to the detector and focused 2–3 cm above the pubic symphysis with a focus-detector distance of 115 cm. The beam collimation included the iliac rim, the pubic bone and the greater trochanter bilaterally. The images were acquired using 70–87 kVp and automatic exposure control.

EOS-images

AP EOS-images of the pelvis were performed in the same position as described for conventional X-rays. The focus detector distance was 130 cm (cannot be altered in EOS) and the irradiated area was identical to that of pelvic X-ray. Scans were acquired using 104–125 kVp and 320–400 mA depending on patient size.

Outcome measures

X-rays and EOS-images of the pelvis were assessed for COS, PWS and ISS radiographic signs of retroversion (Fig. 1) and ratios for COS and PWS were calculated (Fig. 2). Dose-Area-Product (DAP) for AP conventional X-rays and EOS-images was collected after each image was acquired. An orthopedic surgeon in training (A) conducted all measurements after special training by an experienced musculoskeletal radiologist (B) using GE Centricity PACS 4.0 (GE Healthcare, Barrington, IL, US).

Statistical analysis

All continuous data were normally distributed as tested by visual evaluation of Q-Q-plots and by the Shapiro–Wilks normality test.

Results are reported as mean, standard deviation, range and/or percentage. Differences between radiation doses were analyzed using Student's t-test. The level of significance was set at $p < 0.05$ for all statistical analyses. Comparison between COS-ratio and PWS-ratio in X-rays and EOS-images was performed using Bland–Altman plots including limits of agreement. All analyses were performed using STATA/SE 14.0 (StataCorp. LP, College Station, TX, USA).

Ethics

The study was performed in accordance with the ethical standards in the 1964 Declaration of Helsinki and was approved by the local Ethical Committee (S-20140033) and The Danish Data Protection Agency before initiation of the study. The EOS examination was not part of the regular imaging regime and thus, radiation risk estimates were calculated by the regional physicist using PCXMC 2.0 dose assessment software (STUK, Helsinki, FI). For the patient group included in the study the estimated risk of exposure induced cancer death ranged from 0.0008 to 0.0006% translating into an estimated loss of life expectancy of 0.9–1.9 h. The risks associated with the study were considered acceptable by the local Ethical Committee as well as by the participants.

Results

In total 101 individuals were assessed for eligibility (Fig. 3). Forty-four of those did not meet all the inclusion criteria and 23 were excluded, resulting in 34 participants and 68 hips available for analysis. The majority of the participants were females (74%) with an average age of 24 years and four had previous PAO on the contralateral hip (Table 2).

Retroversion of the acetabulum

The absolute agreement between the two modalities regarding COS, PWS and ISS were 91% (62 hips), 84% (57 hips) and 76% (52 hips) respectively (Table 3). No statistically significant differences between COS-ratios and PWS-ratios for X-ray and EOS were found (Table 4). Bland–Altman Limits of Agreement were narrow, i.e. –16 to 14% for COS-ratio and –18 to 15% for PWS-ratio (Fig. 4).

Radiation dose

The X-ray mean DAP was 1053 mGy*cm² (range 186 to 3814) and 593 mGy*cm² (range 452–821) on EOS ($p = 0.003$), and the mean radiation dose for AP-projections was reduced by 44% when using EOS.

Discussion

To our knowledge, this study is the first prospective cohort study investigating whether EOS and X-ray are comparable in the

Table 1
Criteria for the participants in the study.

Inclusion criteria	Exclusion criteria
Age 18–50 years	Previous surgical arthrodesis of the lumbar spine
One or more radiographic signs of retroversion of the acetabulum (COS must be present) on conventional AP X-ray of the pelvis in standing position	Excessive rotation of the pelvis on standing AP X-ray (FOI <0.8 or >1.2)
Previous fracture and/or surgery (except PAO on the contralateral site) on the proximal femur or pelvis	Other conditions that prevent patients from carrying out the examination
Secondary hip dysplasia related to previous Legg-Calvé Perthes disease	Decline to participate
	Inability to speak or read Danish
	Inability to participate for other reasons

COS = Cross-over-sign; AP = Antero-Posterior; PAO = Periacetabular osteotomy; FOI = Foramen obturator index.

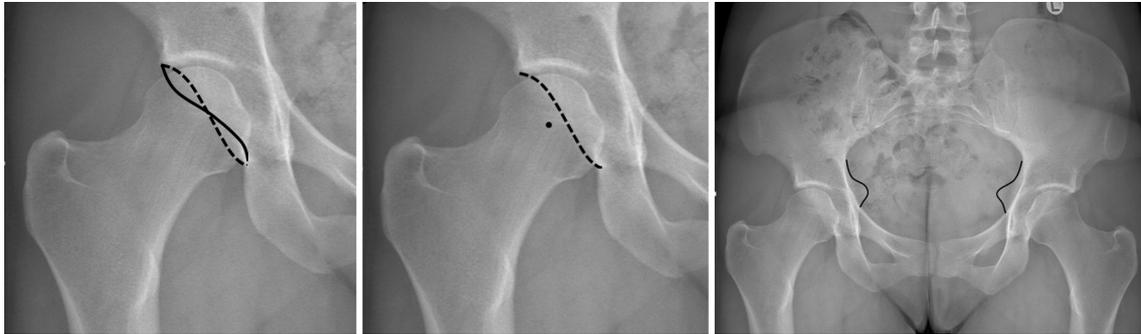


Figure 1. Radiographic signs of acetabular retroversion in AP projections with examples using a pelvic EOS image. Left: Cross-over sign; present when the anterior rim line of the acetabulum is lateral to the posterior rim line in the cranial part and medial in the distal part of the acetabulum. Middle: Posterior wall sign; present if the rim line of the posterior wall is projected medial to the center of the femoral head. Right: Ischial spine sign; present if the ischial spine extends medial to the pelvic ring into the pelvic cavity.

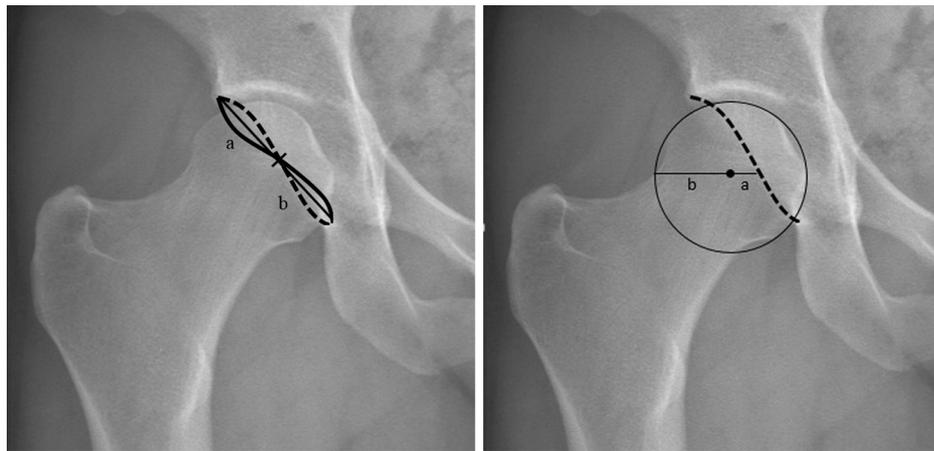


Figure 2. Left: Cross-over ratio; the ratio between; (a) the length of the lateral overlap of the anterior rim line of the retroverted acetabulum and (a + b) the full length of the lateral acetabular opening. Right: Posterior wall ratio; the ratio between the two horizontal lengths; (a) the center of the femoral head to the posterior wall, (b) the radius of the femoral head.

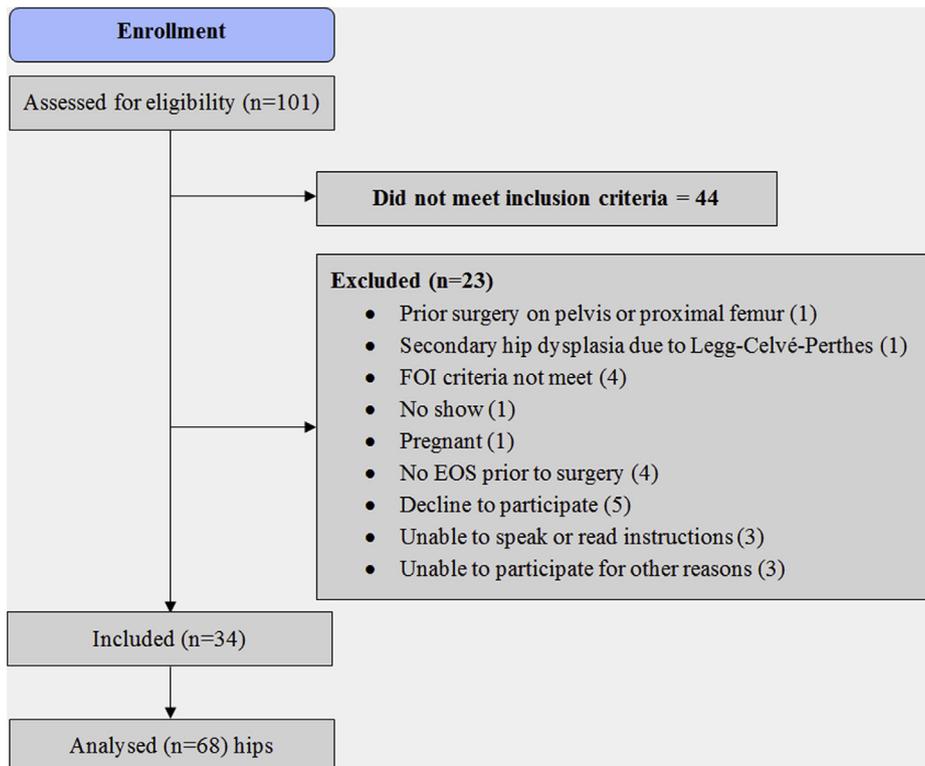


Figure 3. Flow-chart for the study.

Table 2
Baseline characteristics for participants in the study.

Characteristic	n = 34
Female, n (%)	25 (74)
Previous PAO on the contralateral hip (%)	4 (12)
Age (year), mean (range)	24 (18–43)
Weight (kg), mean (range)	71 (55–96)
Height (cm), mean (range)	174 (157–190)

PAO = Periacetabular osteotomy.

Table 3
Diagnostic accuracy of cross-over-sign (COS), posterior-wall-sign (PWS) and ischial-spine-sign (ISS) using EOS and pelvic X-ray (reference).

Characteristic	COS	PWS	ISS
Radiographic sign present on X-Ray and EOS, n	57	36	36
Radiographic sign not present in either modality	5	21	16
Radiographic sign present in EOS only	4	9	14
Radiographic sign present in X-ray only	2	2	2
Absolute agreement, n (%)	62 (91)	57 (84)	52 (76)

Table 4
Mean ratios for Crossover sign (COS) and Posterior Wall Sign (PWS) in X-ray and EOS.

	X-ray % (range)	EOS % (range)	p-value
COS-ratio n = 57	24.3 (6–52)	23.7 (9–45)	0.53
PWS-ratio n = 36	20.6 (7–56)	19.0 (6–46)	0.27

assessment of retroversion of the acetabulum. The results suggest that EOS may be used as a diagnostic tool to identify radiological signs of acetabular retroversion with the benefit of a significant reduction in radiation dose.

X-ray vs. EOS

Despite uncertainty about the reliability of using X-ray for retroversion assessment raised by Wassilew et al.¹⁸ it is still widely accepted that the radiological diagnosis of acetabular retroversion on AP projections of the pelvis is based on the presence of COS,¹ PWS² and ISS³ with COS being the cardinal sign of retroversion. Furthermore, the COS-ratio and PWS-ratio describe the severity of

retroversion. Identification of primarily COS and PWS are of great clinical importance to the hip surgeon when treatment is decided.

The EOS-images showed high levels of agreement for the presence of retroversion parameters and no significant differences between their ratios compared to X-ray suggesting that EOS may be used to identify radiological signs of retroversion of the acetabulum. Other studies that compared acetabular parameters on conventional X-rays of the pelvis with EOS^{15–17} all reported strong or excellent correlations between the two modalities regarding different acetabular parameters, pelvic morphology at different degrees of pelvic tilt, rotation and body position. Bittersohl et al.¹⁶ and Monazzam et al.,¹⁷ who measured the effects of different degrees of pelvic tilt and rotation on parameters describing acetabular and pelvic morphology on cadaveric pelvis, reported Pearson's correlation coefficients ranging from 0.64 to 0.99 and intermodality intraclass correlation coefficients ranging from 0.93 to 0.98 between the two modalities, respectively. Lazennec et al.¹⁵ who measured pelvic tilt and acetabular cup orientation in 50 patients with total hip replacement in standing and sitting positions found Spearman Rank correlation coefficients ranging from 0.82 to 0.98.

Radiation dose

The study demonstrated that using EOS significantly reduces the radiation dose (44%) compared with conventional X-ray. A study by Chiron et al. reported similar dose reduction using EOS versus pelvic x-ray.¹³ Other studies also reported significant reductions in radiation dose using EOS, but most of them reported entrance skin dose reductions in other anatomical regions and in children.^{19–21} Therefore, they are not directly comparable to our study. Other dose reduction strategies in DR may narrow the radiation dose gap between DR and EOS, i.e. increasing focus-detector distance or using grid-less technology with iterative anti-scatter correction. However, the effect of those strategies on radiographic signs of acetabular retroversion has not yet been examined and may be subject to further studies.

Strengths and limitations

The study is strengthened by the prospective design with participants consecutively recruited to avoid selection bias. Furthermore, all participants went through a standardized setup, i.e.

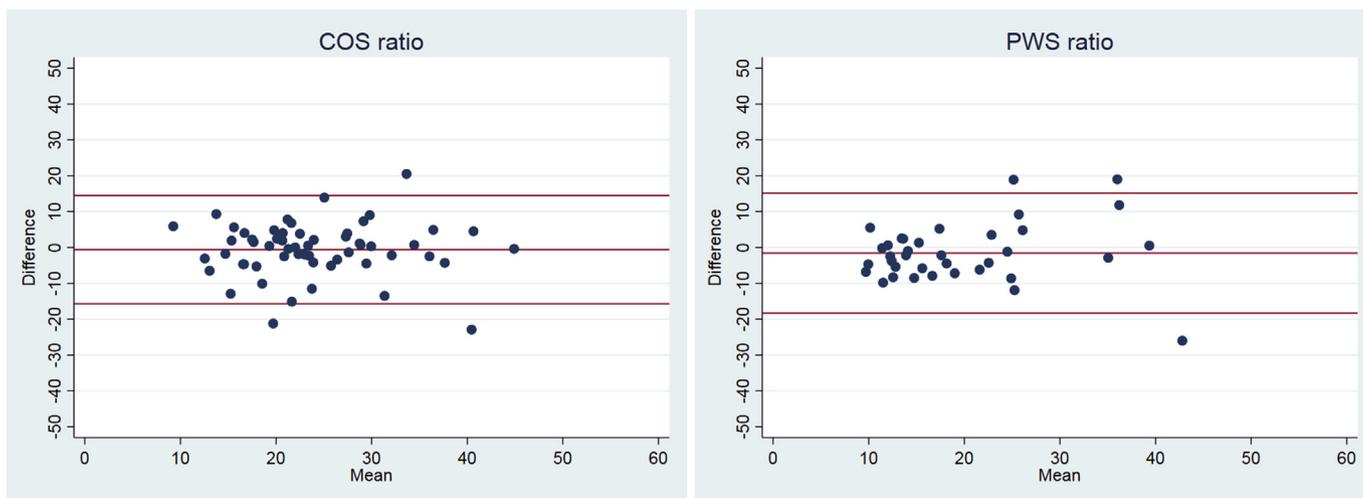


Figure 4. Bland–Altman plots comparing COS-ratio (left) and PWS-ratio (Right) measured using X-ray and EOS. Horizontal lines indicate limits of agreement and the mean difference between the measurements.

examined and included by one of three senior orthopedic surgeons specialized in hip surgery in patients with acetabular retroversion.

The study also has limitations. The sample size is relatively small and for practical reasons X-ray and EOS examinations were performed on two separate days and by two different radiographers. Strictly standardized protocols were used for both X-ray and EOS, but minor variations in the positioning of the participants may have occurred. However, such variation could occur even if the X-ray and EOS examinations were performed consecutively because the images would be acquired in separate rooms. Finally, the study was not designed to assess technical or subjective image quality parameters except for the inherent fact that acceptable diagnostic image quality is imperative for visualization of the acetabular parameters measured. Therefore, the study cannot address if EOS could potentially replace conventional pelvic radiography in general.

In conclusion, high levels of agreement between conventional X-ray and EOS were found for all parameters. Our study indicates that AP EOS projections of the pelvis provide diagnostic qualities similar to conventional X-ray in a population of patients with retroversion of the acetabulum and reduce radiation by 44%. Therefore, we suggest that EOS may be used for assessment of acetabular retroversion, but further studies are needed to assess sensitivity and specificity of EOS in diagnosing acetabular retroversion.

Declarations of interest

None.

Ethical review board

The study was performed in accordance with the ethical standards in the 1964 Declaration of Helsinki and was approved by the local Ethical Committee (S-20140033) and The Danish Data Protection Agency before initiation of the study

Location

The study was performed at the Department of Orthopaedic Surgery and Traumatology and the Department of Radiology at Odense University Hospital, DK-5000 Odense C

Level of evidence

Prospective study

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