Hip Resurfacing

5 years experience in Salisbury

David Cox
Patient Selection

- High demand, fit young patients
- Strong bone with relatively normal anatomy. Congruent joint.
- Avoid AVN, steroids, alcoholics
- Patient choice
- Post menopausal women
- DEXA
Patient Consent

- General - DVT, PE, dislocation, infection, etc
- Specific - Fracture, intra and post operative
- Nerve injury - femoral, sciatic
- Clunking, anterior impingement in flexion
- Groin pain, bursae/metal debris collection
- Leg length inequality
- Long term results?
Pre operative tips

- Templating can be very inaccurate in obese or large patients.
- Intra op measurements are better.
- 8-9 cms from tip of trochanter.
- Valgus is better than varus.
- Cup not too deep, 45 degrees, anteverted.
Operative Procedure Tips

• Patient lateral, posterior approach
• Identify and protect sciatic nerve
• Size and prepare femoral head first
• Ream down to best femoral size
• Avoid superior neck notching
• Cut distal femoral head at correct level
• Extensive capsulectomy and labral resection.
Operative Procedure Tips

• Strong assistant!
• Place 1\textsuperscript{st} Homan over anterior acetabulum
• 2\textsuperscript{nd} over inferior acetabulum
• Capner gouge to `true floor`
• Ream to 1mm below smallest cup
• `condom` over femoral head
• Cement mix for 40 secs, insert at 1 min.
Post op care

• FWB
• Discharge at 2 to 7 days.
• Drive when walking unaided, 3 weeks
• Review, 6,12,26 weeks
Surgical activity

• 195 patients between SDH and NHH
• Age 35 - 75
• Average length of stay, 4-5 days
• Higher blood loss than THRs
• Faster return to walking unaided, driving
• and work than THRs.
• Longer op time than THRs
Results

- The `good` are very good
- Walking unaided at 2 weeks is common
- Return to higher levels of sporting activity than traditional THRs.
- Tennis, running, football.
Complications

• 5 fractures, 4 women, 1 man
• 2 `collapse` of femoral head. ?AVN
• 2 dislocations
• 2 femoral nerve palsy, 1 sensory,
• 1 sensory and motor – both recovered.
• No known infections
Complications

• Minor groin pain. 5%
• Iliopsoas tendonitis. MRI, USS.
• Inject under USS control.
• Bursae around trochanters, aspirate/inject
• Pain/restriction of flexion.
• Clunking. Improves after few months.
Other tips

• "Don’t overstuff" joint. Antevert cup.
• Alternative THRs for young adult hip patients give good results, and offer
  modularity and more flexibilty.
• Older ladies do badly!