

Modern hip replacement

Hip replacement was long ago measured as one of our best operations with the highest quality adjusted life years score (QALYS). On this background we are always trying to improve the short, medium and especially long term results of hip arthroplasty and to minimise the potential complications.

Orthopaedic surgeons are subject to many commercial and market driven forces to continually change for the better. In the presence of 95% 15 year survivorship for large studies of some hip replacements the burden of proof of an improvement rests with the new technique.

Fortunately, the Joint Replacement Register of the Australian Orthopaedic Association provides valuable evidence in monitoring the introduction and performance of changes in techniques and prosthesis. We can make sure that change is for the better, not for change itself.



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Minimally invasive hip replacement

Attempts to reduce the size of the incision and the amount of soft tissue damage have certainly been successful. Minimally invasive can be taken too far and shouldn't be at the cost of a full exposure and prosthesis alignment. The two incision approach, so promising, was abandoned because of an increased complication rate.

Ceramic on ceramic, and metal on metal

Both of these bearing surfaces are hard and produce few wear particles. They are less forgiving than the metal on polyethylene hips and are generally reserved now for young, high activity patients. There remains a doubt about metal ion sensitivity in metal on metal bearings.

Hip resurfacing

The idea of resurfacing the head of the femur does preserve bone on the femur. There may need to be more bone loss on the acetabular side. Although there are still centres of enthusiasm in Australia most of us in Western Australia have gone away from resurfacing in view of the higher initial complication rate.

Computer navigation

There is certainly a role for computer navigation in positioning the orientation of the acetabular component and in ensuring the correct leg length is achieved. Unlike computer navigation in knee replacement, in hip replacement we are still working out the most useful application.

'Rapid transit' post-op

With adequate home nursing and physiotherapy it has been possible to greatly reduce hospital inpatient stay without increasing complications. This is a matter of pre-operative organisation and modifying patient expectations. The right patient with the right support can be home after 3-5 days, rather than a more usual 7 days.

Taking hip replacement to the community

Most hip replacements go smoothly and if that is the case, operation in a peripheral hospital would be adequate. However, to meet a 99% success rate means that some hip replacement surgery will need sophisticated back-up implants, fracture wiring systems, infectious diseases specialists, intensive care physicians, cardiologists and other specialist expertise. It is probably best to carry out the index surgery where all this is available, rather than transport patients when and if they develop a problem.

Choice of technique

Choose an experienced and skilled orthopaedic surgeon who specialises in hip replacements. Ensure the anaesthetist is a regular part of the surgical team. Discuss the options with the surgeon and be guided by his recommendation of type of prosthesis and surgical technique.

Avoid selecting experimental or unproven approach to what is already our most successful operation. ■