INDICATIONS AND PRE-OPERATIVE AND TEMPLATING

INDICATIONS

Primary Osteoarthritis

Secondary osteoarthritis — DDH, SUFFE, Perthes', failed ORIF hip [head, neck, acetabular fracture]
Burnt out infective joint
Protrusio acetabulum

Rheumatoid arthritis

Extensive AVN

Fracture neck of femur in elderly mobile patient

Tumor situation

PRE-OPERATIVE ASSESSMENT

1. Detailed history
   Document disability: walk; Work; Hobbies; ADL; Sleep
   Womac and SF12 Forms for assessment
2. Look for medical co-morbidity: Chest; Heart; Respiratory
3. Look for site for infection: UTI [MSU]; Any skin lesion; Dental problems, burning urinary problem
4. Neuromuscular problems
5. Patient on Warfarin: Start on LMWH
6. Medication: Diabetes, Asthma,
7. Informed consent:

   90-95% Good to excellent results.
   Early complications:
   - <1% infection
   - 1% Dislocation with lateral and 2-3% with posterior
   - 0.2% PE death with prophylaxis
   - 2% Proximal DVT
   - 20%: 1 cm LLD
   - 10% revision at 10 years
   - 10% UTI

8. Bloods FBC, E&U, MSU, Group and Hold
Chest X ray
ECG
Hip: X rays of pelvis with both hips

X ray AP [15º Internal rotation [standard distance is 100 cm]
10% magnification]
Lateral of the hip in question

PRE-OPERATIVE TEMPLATING

Measure

1. Actual limb-length discrepancy:

2. The functional limb-length discrepancy: is what the patient perceives while in a standing position; it can be determined by placing blocks under the affected side until the patient feels the limbs' length to be "equal."

3. When there is a difference between the actual and functional limb length, pelvic obliquity may

be evaluated by comparing the level of both hemi pelvises with the patient standing and sitting.

Suprapelvic obliquity: Associated with scoliosis or degenerative disease of the lumbosacral spine, persists in the seated position.

Infrapelvic obliquity: The most common cause: flexion and/or abduction contracture.

Template technique

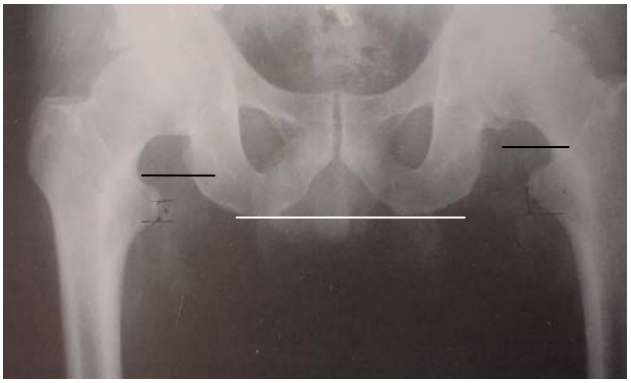
1. Draw line joining Ischial tuberosity

` 2. Vertical distance from this to the top of bottom

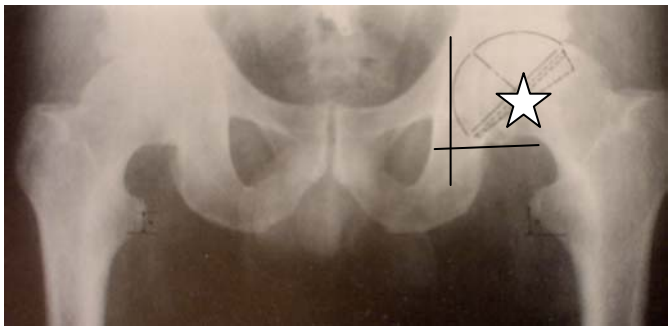
of the Lesser trochanter

3. Distance between two lines gives indication

Of limb length discrepancy



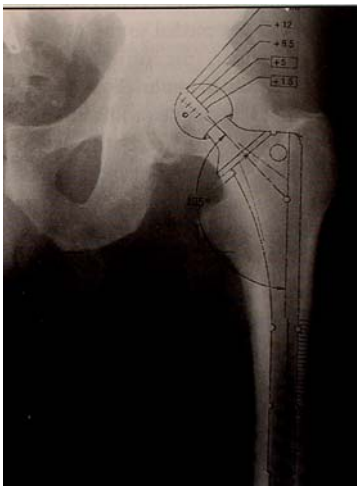
Acetabular



First with normal side
Face of the cup is 45º to bi-ischial line
The cup is placed just lateral to the tear drop
Template cup from these landmark and give
2-3 mm gap [allowance for cement]

Mark the center of rotation
Now measure the vertical and horizontal distance from the tear drop.
Using these measurements, mark the centre of the joint in the affected side

Femoral



Measure size, offset, neck resection
Cementless: Type of Proximal femur
Distal: 4-5 cm contact
Cemented: allowance of 2-3mm
If anatomy is abnormal: transpose on normal side
If lengthening is required, the head centre should lie
directly above the cup center.
If the femoral centre is lateral to the proposed acetabular centre
means the it needs increase offset prosthesis

Neck length marked in relation to lesser trochanter