

What would be my “window of opportunity” time frame for having hip resurfacing?

Anytime symptoms warrant. Patients need to have resurfacing procedures performed while their bone remains healthy.

Is hip resurfacing new? No, but it has greatly improved as the result of better instruments, implants and knowledge.

My orthopedic surgeon does not recommend hip resurfacing. Why? Hip resurfacing is more difficult to perform and special training is required. It also takes longer and we do not charge more for the procedure. Most surgeons find total hip replacement quite satisfactory.

Do you see an increased risk of loosening of the cup component due to bone stock, and would that be the same for resurfacing as for total hip replacement? There are more options for cup fixation with total hip replacement although the risk of loosening should be minimal with resurfacing.

Are there issues for resurfacing due to leg length? Leg length is not addressed with the resurfacing procedure. It is very unusual for patients to have a significant leg length issue after resurfacing. Patients often feel the leg is longer at first since the wear of the joint results in gradual shortening over the proceeding months or years.

With hip dysplasia, do you anticipate any need for bone grafting or screw fixation in the cup component? We have the ability to perform both if necessary

I have heard that the C+ may have advantages over the BHR due to its availability in smaller size increments and screw fixation. Which device would you use for my case? Either one will work well.

Would you have me participate in any studies? No.

I understand that you bill insurance for THR. Would that be any different if using the BHR? No. Insurance carriers like resurfacing because it works well and is somewhat less costly than total hip replacement.

What will the availability of the devices be in the next six months? The metals on metal resurfacing implants are functioning well. I continue to always look for other options but there is nothing new that will be available in the USA over the next few years.

Do you use spinal or general anesthesia resurfacing surgery? The surgery can be done with either anesthetic. The choice of anesthesia used is generally decided by the patient and the anesthesiologist. Most patients prefer a spinal anesthetic with sedation that has them asleep during the procedure.

How long does an average resurfacing procedure take? Usually between 1 and 2 hours

Which incision approach would you use for a case such as mine? Either a posterior or anterior approach can be used. Patients seem to recover faster with the posterior approach. I have done an equal number of each at this point.

What do you use to close the incision? Usually intradermal sutures (they don't need to be removed).

Will there be a need for banking my own blood, or do you use a blood salvaging technique? Under normal circumstances blood transfusions are not necessary. We do not need to save or predonate blood.

Do you anticipate any post-op weight-bearing restrictions? No

What are your other post-op restrictions and for how long? Limit flexion to 90 degrees for one month.

How many C+ resurfacings have you performed? More than 350

How many BHR resurfacings have you performed? Not released in the USA until June 2006. Since then approximately 300. Experience matters with all resurfacing procedures. Overall, we have been involved with more than 1200 resurfacing procedures.

How many resurfacings with predecessors of current devices have you performed? We performed 456 TARA resurfacing procedures (curved stem).

How many resurfacings have you performed on repaired dysplasia patients and how many of those would you consider successful? Approximately 10% of my cases have been dysplasia patients and of these cases, approximately 95% have been successful. The success rate for cases overall is a little higher.

How many planned resurfacings have you had to convert to THR during surgery? None as of yet. We would do this though in the very unlikely event of an intraoperative fracture.

How many THR's a year/month do you perform? It varies. Have performed approximately 4000 hip procedures.

When did you complete your BHR training with Ronan Treacy? January 2006. Trained on the TARA and C+ in the 1980's and 1990's.

Can you provide your personal statistics on your resurfacing successes and failures? See PDF of our prior publications in Clinical Orthopaedics and Related Research and Hip Resurfacing edited by Derek McMinn. Current statistics are the same as metal-on-metal group.

What are the statistics of getting a post-operative infection at the hospital? Less than a 1% chance.

Is there any chance I could come out of a surgery with a THR rather than a resurfacing? Not at all likely.

Is there an increased risk of AVN with a femoral head deformity? Yes, there is still a small risk.

Is there a risk of dislocation? Yes, but this does not reach a percentage point as a risk. The risk is less than with total hip replacement.

Is there a risk of nerve damage? Yes. 1-2%

Are there any unusual risks or complications as compared with THR? Yes. Component positioning is more difficult with resurfacing.

How long would you anticipate a resurfacing to last for me? The implants will not wear out. The main concern is the bone.

Do you see a possibility of any unusual device wear or load issues? No.

Should I go out of the Country for Hip Resurfacing? No. Hip resurfacing can be done here. We are concerned about the Americans that go abroad. We are not seeing that accurate follow-up of Americans that have gone abroad is occurring.

What do you see as the advantages of resurfacing over THR? Better function with resurfacing. Shorter recovery time. It preserves bone for future need.

Is there anything I will not be allowed to do after my hip resurfacing procedure? Not really. We have a number of professional athletes from a variety of different sports (skiing, tennis, golf, marathon running).

My Training Includes:

1. Board Certified, Orthopaedic Surgery
2. Original hip resurfacing training with Charles Townley (pioneer surgeon and resurfacing designer)
3. More than 20 years experience with hip resurfacing.

Criteria for Resurfacing:

1. Educated patient who understands the risks and procedures.
2. Relative youth and need for high activity.
3. Good bone quality
4. Limited deformity (major bone loss and leg shortening cannot be effectively addressed with resurfacing).

When Should a Resurfacing not be performed?

1. When there is major bone loss.
2. When there is insufficient experience of the surgical team.
3. When there is renal insufficiency or certain other medical conditions.