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RIPROTESIZZAZIONE

Patrocino



**“LA RIREVISIONE IN PROTESI DI ANCA:
COME PREVENIRLA, COME GESTIRLA”**

L'AQUILA Sabato 19 Ottobre 2024
Hotel La Dimora del Baco

Presidente Coordinatore Scientifico
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Comitato Scientifico
M. Saracco, A. Fianza, F. Di Petrillo (L'Aquila)

Segreteria Organizzativa



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***La giusta informazione
al paziente e ritorno
alla vita normale***

Dott.ssa Michela Saracco

***P.O. San Giovanni di Dio, ASL Napoli 2 Nord –
Dipartimento di Sanità Pubblica, Università Federico II
Napoli***

2022

Report Annuale

REGISTRO ITALIANO ARTROPROTESI

Dati 2007-2021

riap

Registro Italiano ArtroProtesi

Report
Annuale 2022

Dati 2007-2021

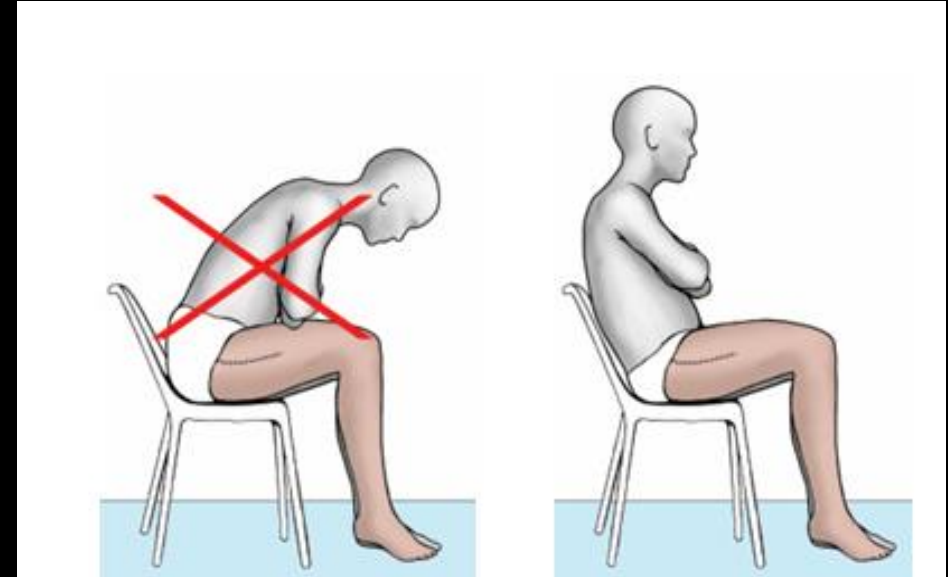
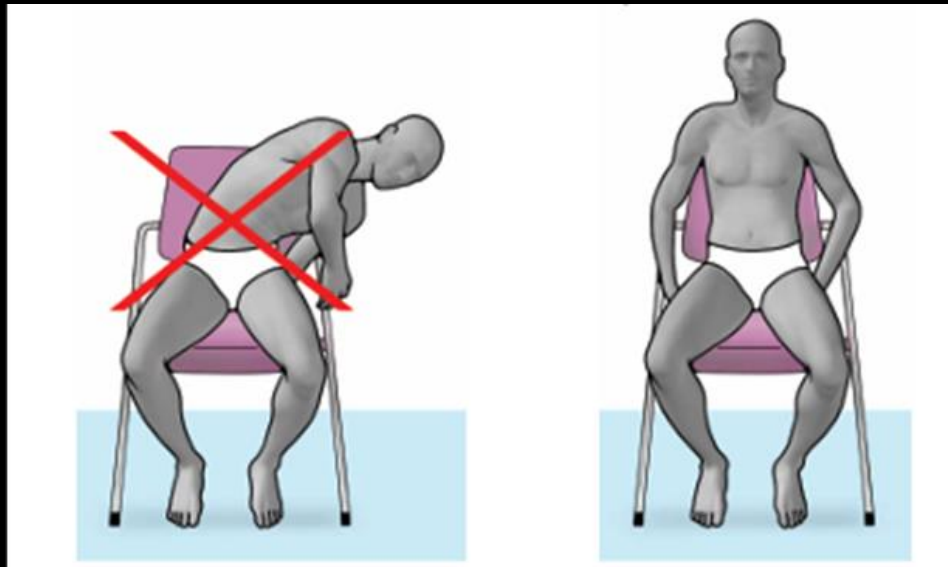
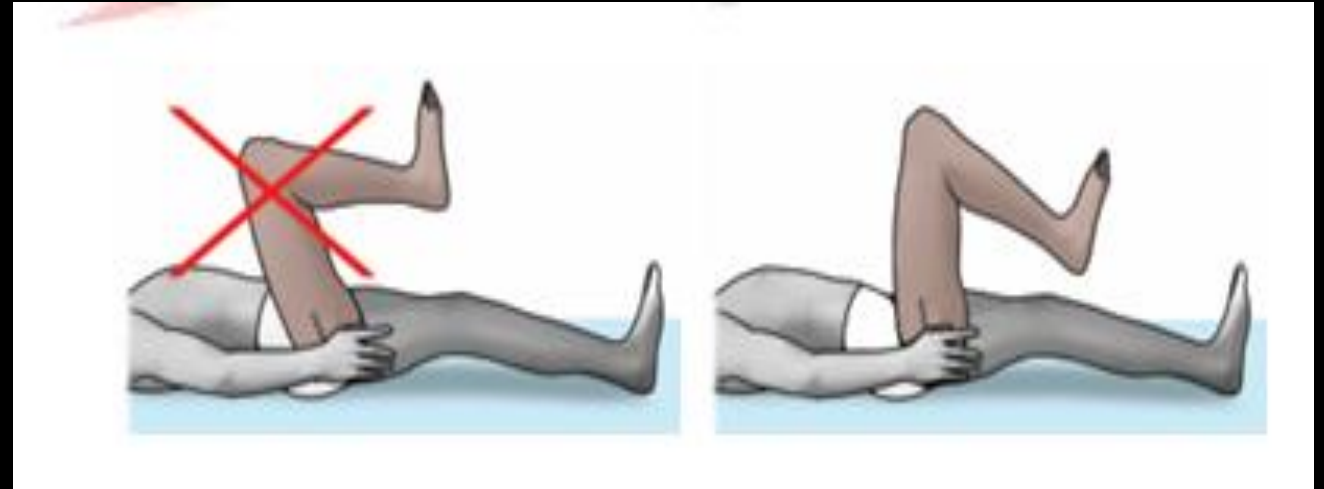
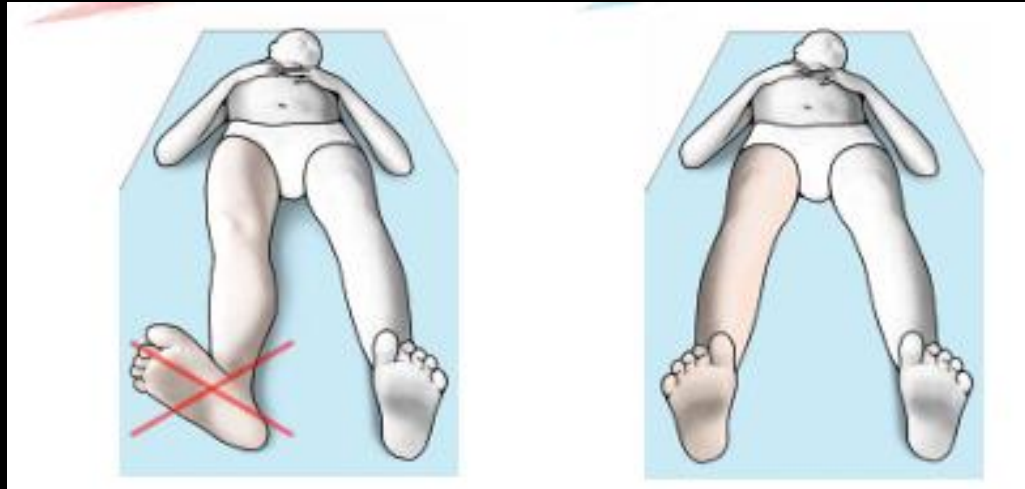
Tabella 2.8. Anca. Numero di interventi di revisione per causa e tipologia di intervento precedente (anni 2007-2021)

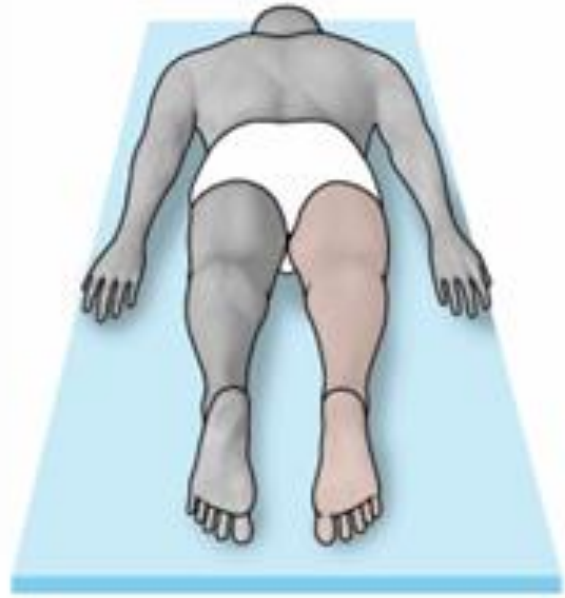
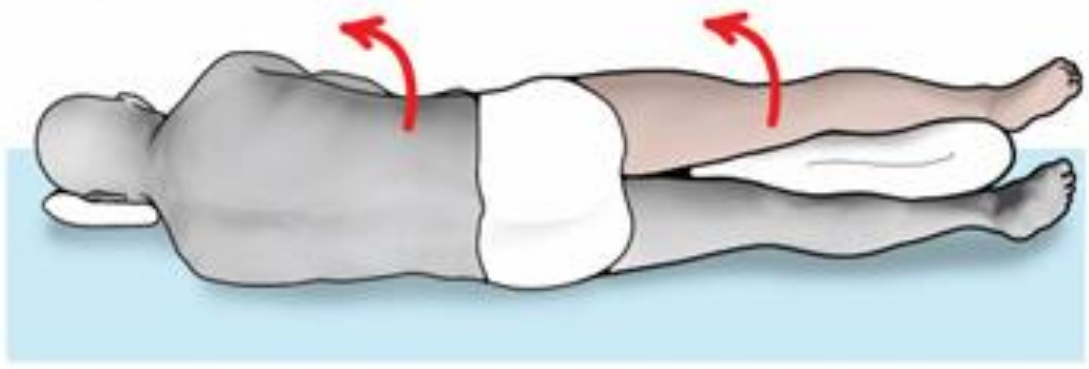
	Revisione (*)	
	N	%
Causa di intervento	21.599	
Protesi dolorosa	1.250	5,8
Osteolisi da detriti	628	2,9
Usura dei materiali	1.719	8,0
Rottura dell'impianto	584	2,7
Lussazione	2.911	13,5
Frattura periprotetica	2.375	11,0
Infezione	1.639	7,6
Esiti rimozione impianto	381	1,8
Mobilizzazione asettica della coppa	4.633	21,5
Mobilizzazione asettica dello stelo	2.380	11,0
Mobilizzazione asettica totale	1.829	8,5
Progressione della malattia	13	0,1
Elevata concentrazione di ioni metallidi	4	0,0
Rottura dello spaziatore	6	0,0
Altro	1.247	5,8
Intervento precedente	21.599	
Sostituzione totale dell'anca	17.096	79,2
Revisione di sostituzione dell'anca	1.267	5,9
Impianto di spaziatore o rimozione protesi (**)	1.420	6,6
Sostituzione parziale dell'anca	1.366	6,3
Altro	450	2,1

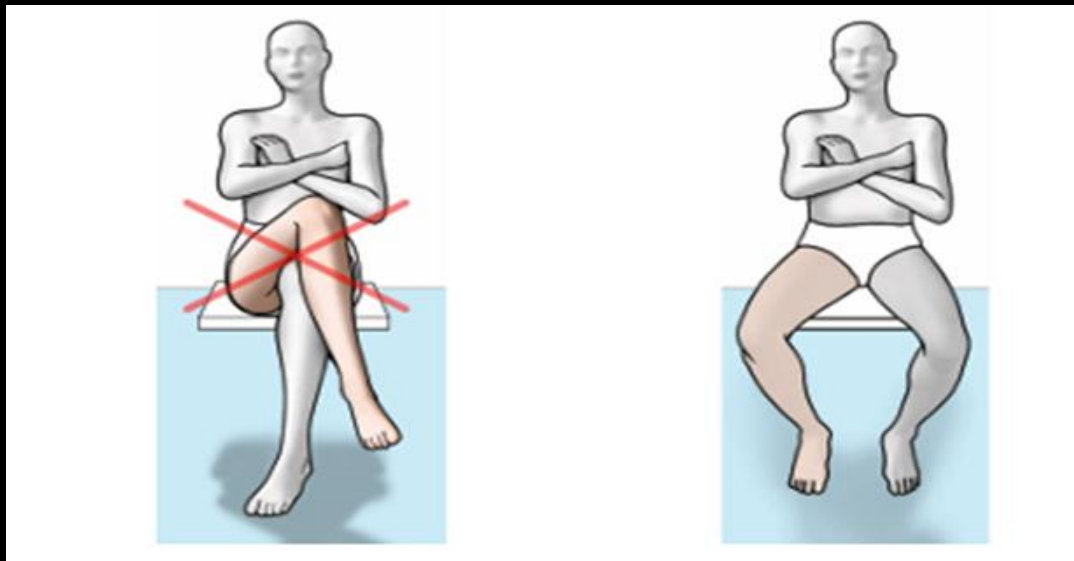
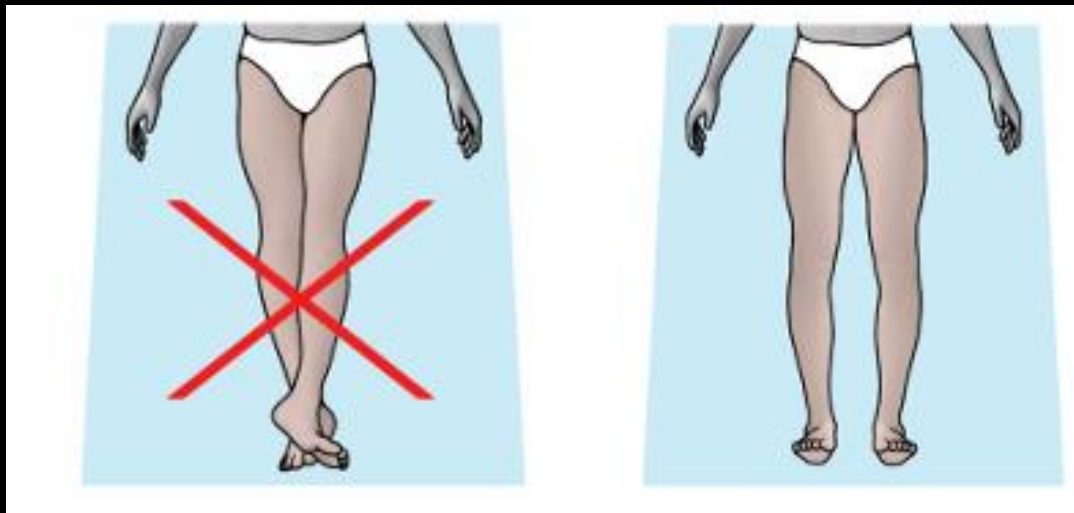
(*) Interventi di revisione parziale o totale, conversione da endoprotesi ad artroprotesi, rimozione, rimozione con impianto di spaziatore, sostituzione spaziatore

(**) Include rimozione, rimozione con impianto di spaziatore, sostituzione spaziatore

LE RACCOMANDAZIONI POST-OPERATORIE

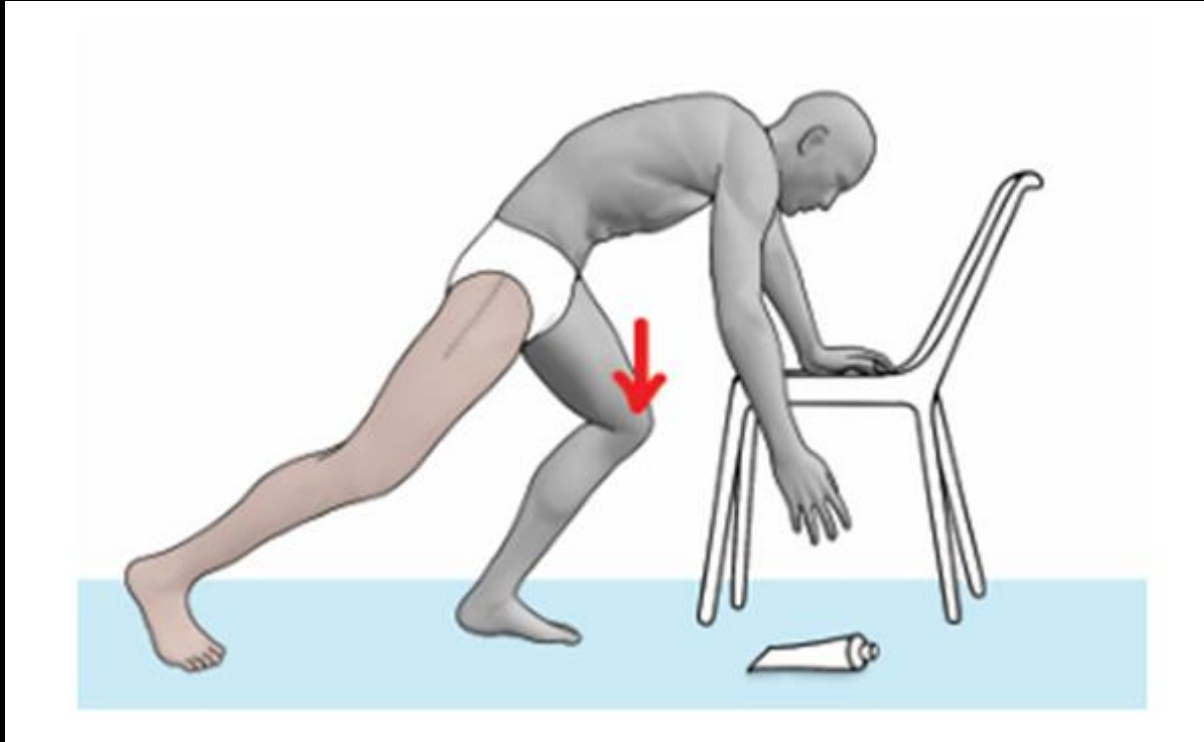


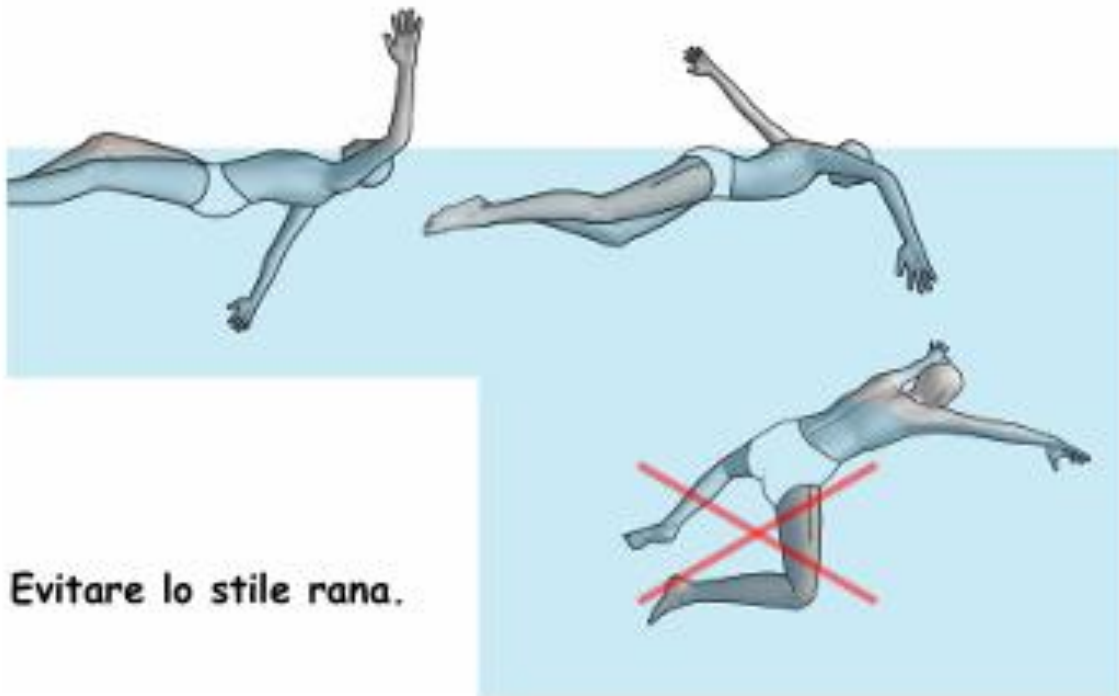




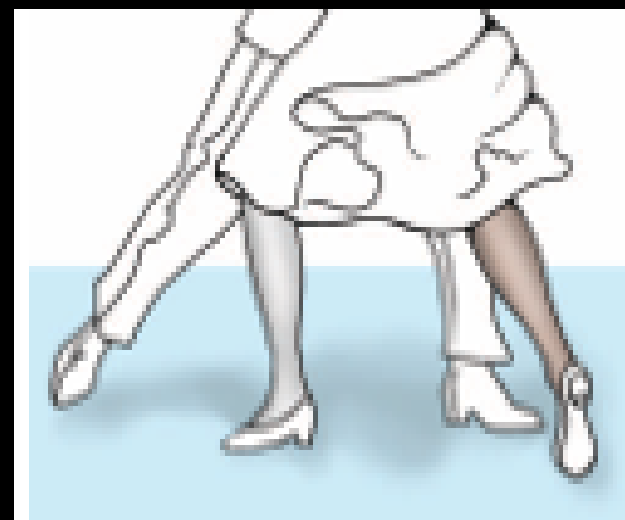
Si consiglia l'acquisto di un calza-scarpe dotato di asta lunga per aiutarsi nelle operazioni di vestizione. Esiste in commercio un "calza-calze" che consente di indossare le calze in autonomia senza flettere l'anca oltre i 90 gradi.







Evitare lo stile rana.



REVISIONE: TANTI METODI... E TANTI MODI DI CONCEDERE IL CARICO !!

> Acta Orthop Belg. 2019 Sep;85(3):352-359.

404 Porous titanium revision shells permit early weight-bearing and rapid rehabilitation in revision hip surgery

Fiachra E Rowan, Joseph M Queally, Gloria Avalos, John Newell, Derek M Bennett

PMID: 31677632

The authors sought to determine evidence of implant instability in a cohort of patients that are mobilised early. Radiological data were analysed for stability.

Primary endpoint was revision of implant.

Mean age at surgery was 69.9 (± 10) years. Median time since primary surgery was 13 years (range: 0.3-37).

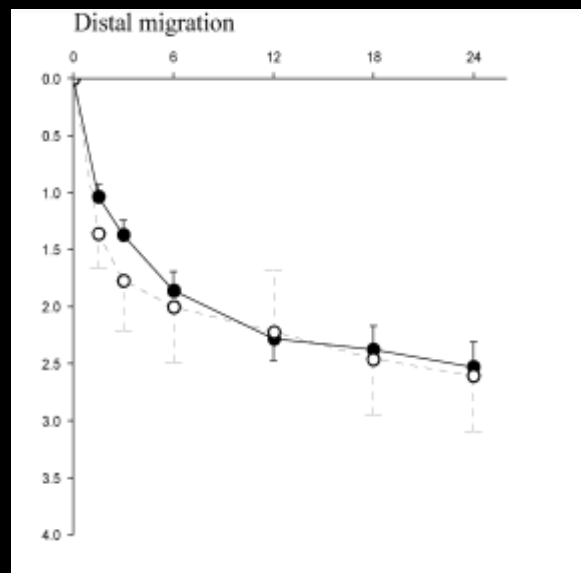
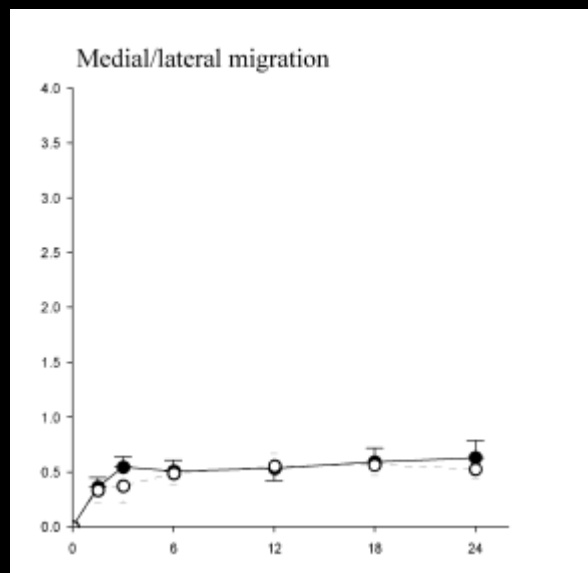
Forty-nine per cent had Paprosky Type IIb or greater acetabular deficiency. Bone graft and augments were not used.

.... There were no screw fractures.

Porous titanium shells in revision arthroplasty are stable and permit rapid rehabilitation.

Hip revision with impacted morselized allografts: unrestricted weight-bearing and restricted weight-bearing have similar effect on migration. A radiostereometry analysis

Ewald Ornstein¹, Herbert Franzén, Ragnar Johnsson, Anna Stefánsdóttir, Martin Sundberg, Magnus Tägil



stricted weight-bearing. *Conclusion:* No increased migration occurred in the group free to bear weight as compared to restricted weight-bearing. We shall continue to allow unrestricted weight-bearing in cases where the femoral bone feels competent to withstand the initial load. It simplifies the postoperative mobilization, and we speculate that it might increase the remodeling of the graft.

Quality of Life Outcomes in Revision vs Primary Total Hip Arthroplasty

A Prospective Cohort Study

Sanjeev Patil, FRCS, FRCS (Orth), Donald S. Garbuz, MD, FRCSC,
 Nelson V. Greidanus, MD, FRCSC, Bassam A. Masri, MD, FRCSC,
 and Clive P. Duncan, MD, FRCSC

Table 1. Patient Demographic Characteristics

	Primary THA	Revision THA
Sex		
Women	57 (40%)	77 (54%)
Men	87 (60%)	66 (46%)
Charnley class		
A	81	51
B1	23	8
B2	5	39
C	35	45
Age (y), mean (SD)	61 (13)	67 (12)

groups is summarized in Table 2. The mean pre-operative function of patients with primary THA was significantly worse than that in patients with revision THA ($\delta = -6.2$; $P = .0126$). Postoperative functional outcome was significantly better in patients with primary THA ($\delta = 8.4$, $P = .013$). Similarly, postoperative pain and stiffness outcomes were significantly better in patients with primary THA (pain: $\delta = 6.4$, $P = .0055$; stiffness: $\delta = 6.7$, $P = .0094$).

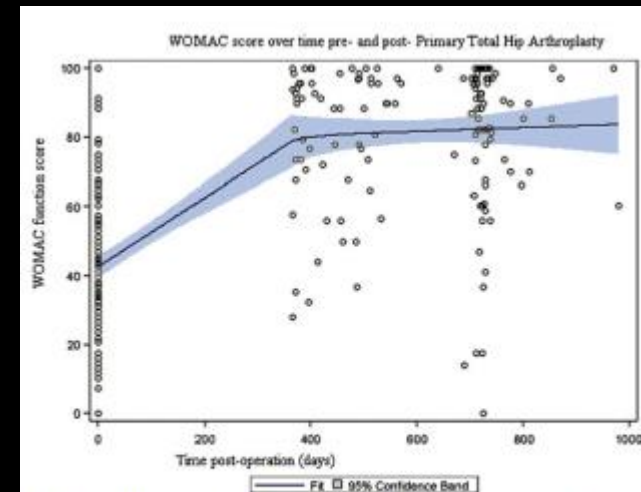


Fig. 1. Western Ontario and McMaster Universities Osteoarthritis Index function scores over time in patients with primary THA.

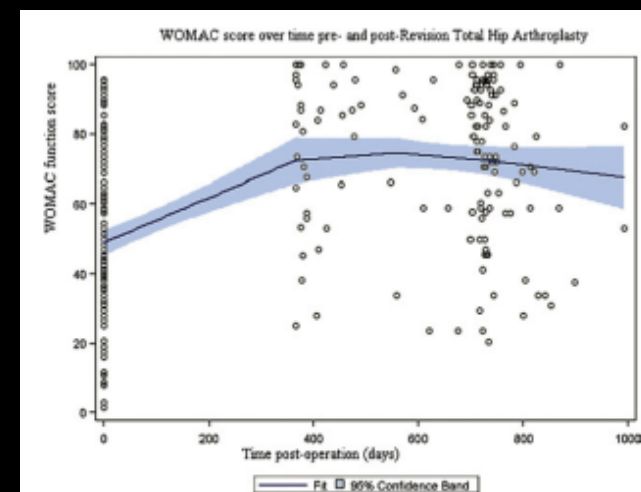


Fig. 2. Western Ontario and McMaster Universities Osteoarthritis Index function scores over time in patients with revision THA.

People who undergo revision arthroplasty report more limitations but no decrease in physical activity compared with primary total hip arthroplasty: an observational study

Martin Stevens, Tsjerk Hoekstra, Robert Wagenmakers, Sjoerd K Bulstra and Inge van den Akker-Scheek

University Medical Center Groningen, The Netherlands

Characteristic	Groups	
	Revision THA (n = 91)	Primary THA (n = 273)
Gender, n female (%)	61 (67)	166 (61)
Age (yr), mean (SD)	70 (12)	63 (14)
Time since surgery (mth), mean (SD)	39 (19)	39 (15)
Co-morbidity		
Charnley Group A, n (%)	61 (67)	193 (71)
Charnley Group B, n (%)	20 (22)	56 (21)
Charnley Group C, n (%)	10 (11)	24 (9)

Outcome	Groups	
	Revision THA (n = 63 to 89)	Primary THA (n = 224 to 271)
Limitations – WOMAC (0 to 100)		
Pain	70 (25)	81 (20)
Stiffness	61 (21)	70 (22)
Physical functioning	59 (25)	72 (22)
Total limitations	63 (24)	74 (20)
Physical activity – SQUASH (min/wk)		
Light household	679 (773)	619 (765)
Intense household	31 (94)	43 (161)
Commuter walking/cycling	9 (50)	29 (116)
Sports	75 (139)	60 (60)
Leisure-time	581 (599)	671 (709)
Work and school	130 (455)	384 (778)
Total amount of physical activity*	1219 (1118)	1613 (1324)
Total intensity of physical activity (min/wk)	2585 (3658)	3738 (4775)

People **reported more limitations** after revision arthroplasty than after primary total hip arthroplasty. However, people after revision arthroplasty **appeared to be equally physically active as** those after primary total hip arthroplasty after adjusting for age, gender, and Charnley group.



Contents lists available at ScienceDirect

Journal of Orthopaedics

journal homepage: www.elsevier.com/locate/jor

Propensity score-matched comparison of physical activity and quality of life between revision total hip arthroplasty and primary total hip arthroplasty

Yuriko Matsunaga-Myoji^{a,*}, Kimie Fujita^a, Yasuko Tabuchi^b, Masaaki Mawatari^c

^a Department of Health Sciences, Faculty of Medical Sciences, Kyushu University, 3-1-1, Maidashi, Fukuoka, Japan

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^c Orthopaedic Surgery, Saga University, 5-1-1 Nabeshima, Saga, Japan

Table 2

Comparison of actual physical activity and health-related quality of life after revision total hip arthroplasty versus primary total hip arthroplasty.

	Revision THA N = 50	Primary THA N = 50	P value
Actual physical activity			
Light PA (min/ wk)	308.4 ± 154.0 (17.3–685.1)	417.3 ± 173.9 (58.5–802.0)	.003
MVPA (min/ wk)	62.2 ± 79.6 (0.1–277.1)	61.0 ± 57.4 (0.2–300.4)	.204
Steps (no./day)	4998 ± 2929 (240–11210)	6865 ± 3038 (734–13106)	.003
Health related quality of life			
Oxford hip score	39.3 ± 8.5 (13.0–48.0)	44.0 ± 3.7 (32.0–48.0)	.011
SF-8 PCS	44.1 ± 11.3 (12.0–58.7)	50.5 ± 7.2 (29.6–59.3)	.003
SF-8 MCS	48.1 ± 11.5 (23.7–62.5)	55.7 ± 6.6 (36.0–63.7)	<.001

Results: Based on propensity scores in the revision THA (68.3 years) and primary THA (67.8 years) groups, light PA, number of steps, and HR-QoL scores 1–3 years after revision THA were significantly lower than those after primary THA ($P < 0.05$). Moderate-to-vigorous intensity PA did not differ between groups ($P = 0.204$). Measured light PA, moderate-to-vigorous intensity PA, and number of steps after re-THA were moderately correlated with HR-QoL scores.

Table 1

Characteristics of propensity score-matched patients with primary and revision total hip arthroplasty.

		Revision THA N = 50	Primary THA N = 50	Std. diff.	P value
Age, years	Mean ± SD	68.3 ± 6.9	67.8 ± 7.2	.053	.923
Sex, n (%)	Female	36 (72.0)	35 (70.0)	.097	.318
Follow-up duration, months	Mean ± SD (Range)	25.1 ± 12.3 (12.0–42.0)	25.2 ± 12.2 (11.0–42.0)	.008	.734
Indication for revision THA, n (%)			N/A	N/A	N/A
Aseptic loosening		19 (38.0)			
Frequent dislocation		11 (22.0)			
Mechanical failure		9 (18.0)			
Infection		6 (12.0)			
Other		5 (10.0)			
Type of revision THA			N/A	N/A	N/A
All-component revision		10 (20.0)			
Acetabular cup, liner & femoral head revision		22 (44.0)			
Acetabular cup & liner revision		4 (8.0)			
Femoral head & liner revision		11 (22.0)			
Femoral stem, liner & femoral head revision		3 (6.0)			
Charlson Risk Index, n (%)					
0		38 (76.0)	38 (76.0)	.000	1.000
1		12 (24.0)	12 (24.0)		
BMI, kg/m ²	Mean ± SD	23.4 ± 2.8	23.3 ± 3.2	.016	.918



Predictors of Health-Related Quality of Life After Revision Total Hip Arthroplasty for Aseptic Loosening

Yuichi Kuroda¹ · Shinya Hayashi¹ · Shingo Hashimoto¹ · Tomoyuki Matsumoto¹ · Koji Takayama¹ · Ryosuke Kuroda¹

Received: 25 December 2019 / Accepted: 19 February 2020 / Published online: 2 March 2020
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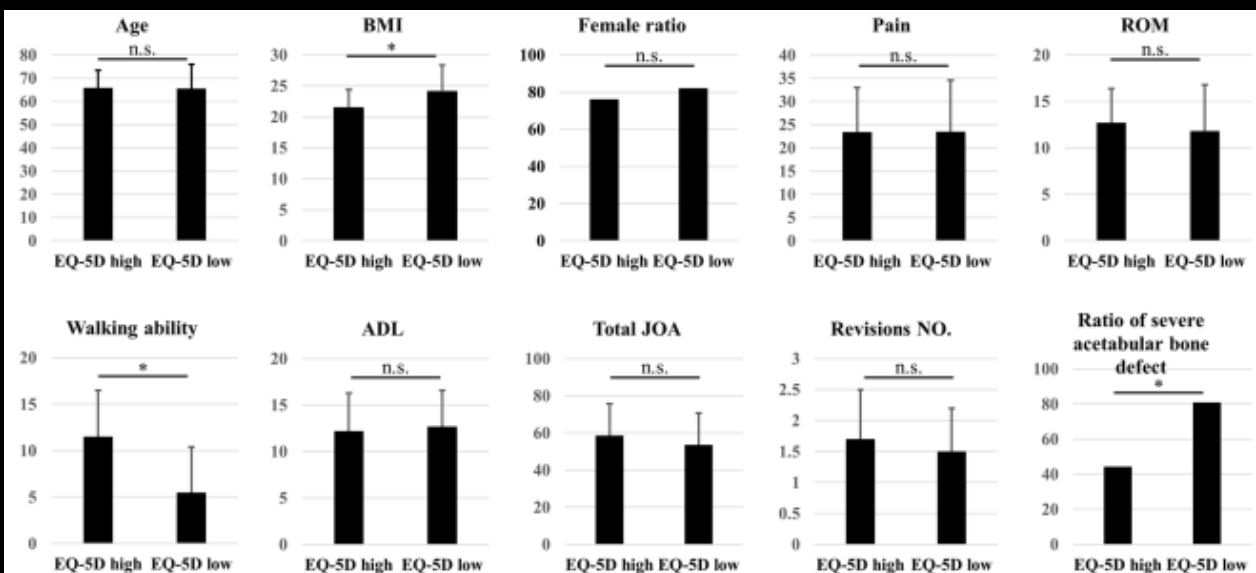


Fig. 1 Comparison of mean values between patients with postoperative EQ-5D utility score ≥ 0.6 points and < 0.6 points. Significant differences between good and poor QOL groups were identified for BMI, walking ability, and severity of acetabular bone defect

Results Significant differences between the good and poor QOL groups were identified for BMI, walking ability, and severity of acetabular bone defect (BMI: 21.5 ± 2.9 vs. 24.1 ± 4.3 , $P=0.0331$; walking ability: 11.5 ± 5.0 vs. 5.5 ± 4.9 , $P=0.0058$; acetabular bone defect: 44.4% vs. 81.0%, $P=0.0103$). The walking ability independently affected the EQ-5D utility score.

Conclusions The present study indicates that a higher BMI, lower walking ability, and more severe acetabular bone defect are predictors of lower QOL after revision THA for aseptic loosening. In particular, the walking ability was the only independent factor. Thus, surgeons should pay attention to the postoperative management of patients with these risk factors.

Table 1 Patient demographic data 1

Variables	Value
Age (years)	65.7 ± 8.9
Male/female (number)	11/40
BMI (kg/m^2)	22.6 ± 3.8
Preoperative JOA score (points)	
Pain	23.4 ± 9.9
ROM	12.4 ± 4.1
Walking ability	9.6 ± 5.7
ADLs	12.3 ± 4.0
Total	56.9 ± 17.0
Postoperative JOA score (points)	
Pain	36.4 ± 4.4
ROM	14.9 ± 3.5
Walking ability	13.4 ± 5.4
ADLs	15.6 ± 3.3
Total	81.8 ± 12.0

The data are expressed as mean \pm SD values

JOA Japanese Orthopaedic Association, BMI body mass index, ROM range of motion, ADL activities of daily living

Variables	Value
Revision no.	
1	25
2	19
≥ 3	7
Revision type (number)	
Acetabular only	35
Femoral only	3
Both	13
Severity of acetabular bone defect (number)	
Mild defect	19
Severe defect	29

LA QUALITA' DI VITA DEL PAZIENTE DOPO LA REVISIONE... PER INFEZIONE

HIP
ISSN 1120-7000

Hip Int 2016; 26 (4): 311-318
DOI: 10.5301/hipint.5000416

REVIEW

Quality of life after staged revision for infected total hip arthroplasty: a systematic review

Luuk Rietbergen¹, Jesse W.P. Kuiper¹, Simon Walgrave², Laura Hak^{1,3}, Sascha Colen^{2,4}

TABLE IV - Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) scores

Author	Date	Design	Age	Treatment	Nr. treated	Nr. success	Success %	FU months	FU Nr.	FU %	WOMAC Pain	WOMAC Stiff.	WOMAC Func.	WOMAC total
Barbari ^ć (35)	2014	retrospective	64	2-stage revision	20	20	100%		17	85%				74
Biring (28)	2009	retrospective	64	2-stage revision	99	88	89%	144 (120-180)	34	34%	89.3	89	76	80.6
Romanò (29)	2010	prospective	65	2-stage revision	40	39	98%	48 (24-72)	39	98%	77.4 (22.8)	71.4 (24.1)	76.6 (21.3)	76
Hsieh (25)	2004	prospective	61	2-stage revision	42	40	95%	55.2 (36-66)	33	79%	88.2 (20.7)	72.1 (25.6)	85.3 (19.6)	84.8
Masri (26)	2007	retrospective	65	2-stage revision	29	26	90%	47 (22-88)	26	90%				54.0
Kappler (32)	2012	retrospective	63	2-stage revision	14	14	100%	40 (4-100)	9	64%				78
Leung (31)	2011	retrospective	64	2-stage revision	38	30	79%	58 (24-123)	27	71%	67.1	64.3	59.5	62
Summary	-	-	63.7*	-	282	257	91%	69.8*	185	65%				73.1*

FU = follow-up; * = weighted mean.

TABLE VI - Short Form 12 (SF-12) scores

Author	Date	Design	Mean age	Treatment	Nr. treated	Nr. success	Success %	FU months	Nr. FU	FU %	PCS	MCS
Romanò (29)	2010	prospective	65.3	2-stage revision	40	39	98%	48 (24-72)	39	98%	35.6 (12.4)	43.1 (13.8)
Kappler (32)	2012	retrospective	63	2-stage revision	14	14	100%	40 (4-100)	9	64%	35	54.0
Sabry (33)	2013	retrospective	63.8	2-stage revision	78	67	86%	58 (24-153)	45	58%	38.9	50.9
Biring (28)	2009	retrospective	72	2-stage revision	99	88	89%	144 (120-180)	34	34%	33.5	53.1
Leung (31)	2011	retrospective	63.5	2-stage revision	38	30	79%	58 (24-123)	27	71%	32.4	47.9
Summary			67.3*		269	238	88%	73.4*	154	57%	35.4*	49.1*

FU = follow-up; PCS = physical component score; MCS = mental component score; * = weighted mean.

Discussions: Patients who underwent 2-stage revision for hip PJI had substantially lower (physical component) (HR)QoL scores, but mental scores were comparable to the general population.

Selected Papers from the 9th International Congress of Arthroplasty Registries
Guest Editor: Ola Rolfson MD, PhD

OPEN

What Are the Long-term Outcomes of Mortality, Quality of Life, and Hip Function after Prosthetic Joint Infection of the Hip? A 10-year Follow-up from Sweden

Peter Wildeman MD^{1,2}, Ola Rolfson MD, PhD^{3,4}, Bo Söderquist MD, PhD^{1,5}, Per Wretenberg MD, PhD¹, Viktor Lindgren MD, PhD⁶

Table 1. Characteristics of patients with PJI within 2 years of primary THA and matched controls who responded to the patient-reported outcome questionnaire

	PJI (n = 148)	Control (n = 512)	p value
Mean age at primary surgery, years ± SD	65.3 ± 10.1	65.3 ± 10.1	> 0.99
Mean age at follow-up, years ± SD	76.4 ± 10.0	76.4 ± 10.0	
Female sex	53 (78)	48 (247)	0.35
Indication for operation			
Primary OA	86 (128)	87 (444)	0.94
Acute trauma, hip fracture	2 (3)	4 (19)	0.44
Complication trauma	1 (1)	1 (3)	> 0.99
Secondary OA	0 (0)	0 (0)	
Sequelae of childhood hip disease ^a	4 (6)	3 (14)	0.41
Femoral head necrosis	5 (7)	4 (22)	0.82
Inflammatory joint disease	1 (2)	2 (10)	> 0.99
Other	1 (1)	0 (0)	0.22
Surgical approach ^a			
Direct lateral	56 (83)	40 (207)	0.001
Posterior	41 (61)	59 (300)	< 0.001
Minimally invasive hip replacement surgery	3 (4)	1 (4)	
Implant fixation ^a			
Cemented	66 (98)	71 (364)	0.25
Uncemented	21 (31)	16 (81)	0.14
Hybrid	2 (3)	1 (4)	0.19
Reversed hybrid	9 (13)	9 (48)	0.83
Resurfacing	1 (2)	3 (13)	0.39
Mean follow-up time, years ± SD	11 ± 12	11 ± 12	0.89
Mean year of operation ± SD	2007 ± 0.99	2007 ± 0.88	0.10

Table 2. Surgical details for the patients with prosthetic joint infection (PJI), 10 to 14 years' follow-up

Surgical details	Patients with PJI
Surgical intervention for PJI (n = 148)	
No reoperation	6 (9)
DAIR	68 (101)
One-stage revision ^a	3 (4)
Two-stage revision ^a	22 (33)
Resection arthroplasty ^a	1 (1)
Surgical approaches at reoperation (n = 148)	
Direct lateral	47 (69)
Posterior	41 (60)
Other ^b	7 (10)
No reoperation	6 (9)
Prosthesis in situ at follow-up (n = 148)	
Original prosthesis ^c	67 (99)
Exchanged prosthesis ^d	32 (48)
Resection arthroplasty	1 (1)
Total number of reoperations (n = 148)	
≤ 1	53 (78)
2	21 (31)
≥ 3	26 (39)
Total number of reoperations, indication ^e (n = 293)	
Prosthetic joint infection	90 (265)
Aseptic loosening	2 (7)
Fracture	1 (4)
Dislocation	3 (9)
Other ^f	3 (8)

Table 3. Patient-reported outcome measures in patients with prosthetic joint infection and controls

	PJI (n = 148)	Control (n = 512)	OR or multiple regression estimates (95% CI)	p value
EQ-VAS, median (IQR)	65 (30)	80 (30)	-9.9 (-13.7 to 6.1) ^b	< 0.001
EQ-5D-index, median (IQR)	0.83 (0.37)	0.94 (0.21)	-0.13 (-0.18 to 0.08) ^b	< 0.001
EQ-5D-SL ^c , % (n/N major problems)				
Mobility	50 (74 of 147)	24 (118 of 498)	3.4 (2.3 to 5.0) ^a	< 0.001
Self-care	22 (32 of 147)	12 (59 of 498)	2.1 (1.3 to 3.4) ^a	0.003
Usual activities	43 (63 of 147)	24 (119 of 498)	2.4 (1.6 to 3.6) ^a	< 0.001
Pain/discomfort	37 (55 of 147)	24 (119 of 498)	1.9 (1.3 to 2.8) ^a	0.001
Anxiety/depression	16 (23 of 147)	10 (50 of 498)	1.7 (1.0 to 2.8) ^a	0.06
Ambulatory aid ^d	65 (96 of 147)	41 (211 of 509)	3.1 (2.1 to 4.8) ^a	< 0.001
Assisted living ^e	21 (31 of 148)	12 (62 of 510)	2.0 (1.2 to 3.3) ^a	0.01
OHS, median (IQR)	36 (19)	44 (13)	-5.9 (-7.7 to 4.0) ^b	< 0.001

Hip PJI has considerable long-term negative effects on mortality, health-related QoL, and hip function. Multiple reoperations of the hip consequently contribute to persisting poor hip function even in the long term, but using a posterior approach for a reoperation rather than the direct lateral approach may help preserve function.

LA QUALITA' DI VITA DEL PAZIENTE DOPO LA REVISIONE... PER FRATTURA PERI-PROTESICA

Arthroplasty Today 29 (2024) 101418



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Original Research

The Effect of Periprosthetic Fractures Following Total Hip and Knee Arthroplasty on Long-Term Functional Outcomes and Quality of Life

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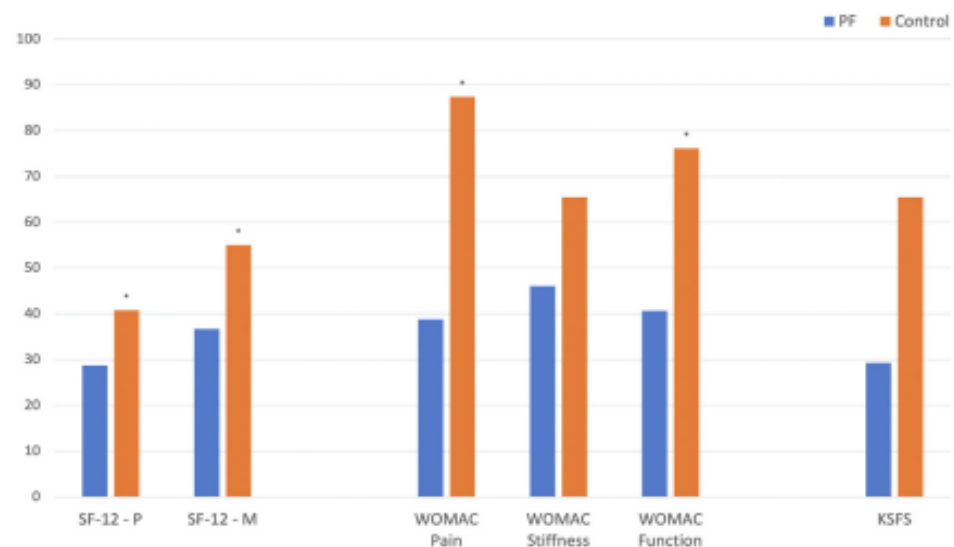


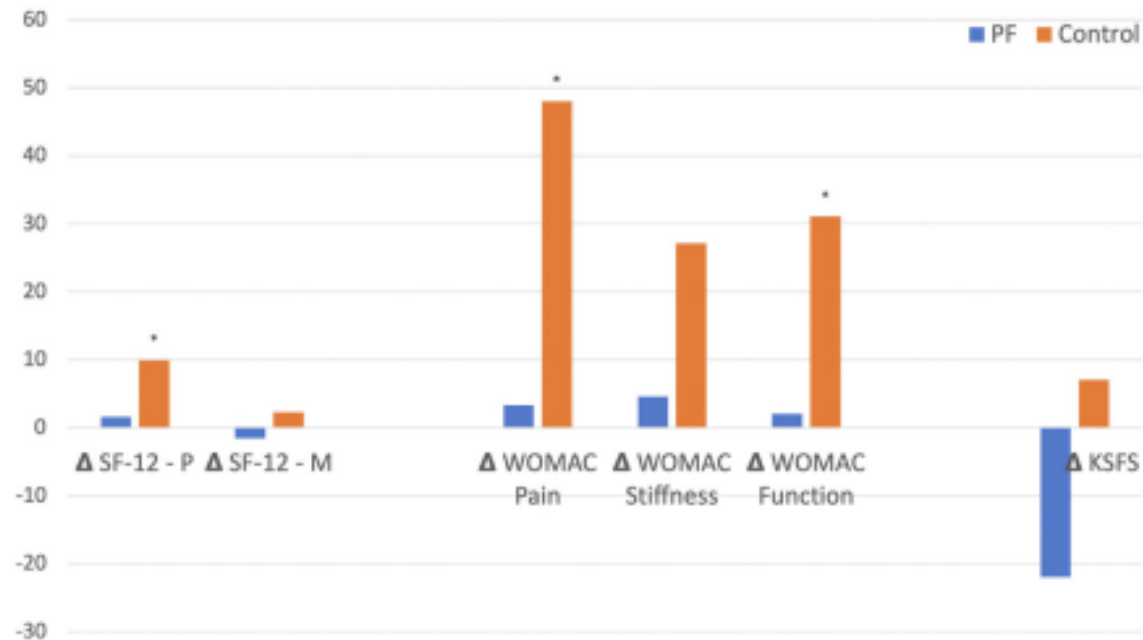
Table 1

Patient demographics and clinical characteristics of the 2 groups.

Variable	PF group mean ± SD n = 17	Control group mean ± SD n = 67	P value
Age	71.0 ± 11.5	71.0 ± 11.0	.98
Gender (%)			.32
F	13 (76%)	43 (64%)	
M	4 (24%)	24 (36%)	
BMI kg/m ²	27.7 ± 4.3	28.7 ± 4.3	.43
ASA	2.7 ± 0.70	2.4 ± 0.55	.066
Original surgery			.41
TKA	6 (35%)	16 (24%)	
THA	11 (65%)	51 (76%)	
SF-12			
P	27.1 ± 5.029	29.5 ± 7.2	.33
M	43.9 ± 11.4	51.2 ± 11.6	.08
WOMAC			
Pain	33.3 ± 23.1	42.8 ± 21.5	.23
Stiffness	20.833	45.0 ± 23.8	.09
Function	40.6 ± 17.2	43.9 ± 22.1	.65
KSFS ^a	50.0 ± 21.75	58.2 ± 21.7	.62

BMI, body mass index.

^a Used only in the setting of TKA.



PPFs following TKA and THA **result in significant deterioration of quality of life**. Secondly, we were also able to **demonstrate a high complication rate** compared to a negligible rate in our matched cohort of uncomplicated TKA and THA patients. PPFs are very severe complications that predispose to further complications, especially in the older population.

TRAUMA SURGERY

Health-related quality of life (EQ-5D) after revision arthroplasty following periprosthetic femoral fractures Vancouver B2 and B3 in geriatric trauma patients

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	Total	Vancouver B2	Vancouver B3	Interprosthetic	p-value
Number	43	56% (n=24)	30% (n=13)	14% (n=6)	
Age	78 ± 9.2	78 ± 8.5	81 ± 7.3	72 ± 9.6	0.118
Sex (% female)	67%	63%	80%	67%	0.646
CCI	5.2 ± 1.7	5.2 ± 1.5	5.9 ± 2.1	4.0 ± 0.6	0.034*

Table 3 Distribution of answers (EQ-5D-5L, EuroQol Health Questionnaire 5D) of the 22 patients during follow-up

	Mobility	Self-care	Usual activities	Pain	Anxiety
1 No problems	13	11	9	8	12
2 Moderate problems	8	7	8	11	10
3 Severe problems	1	4	5	3	0

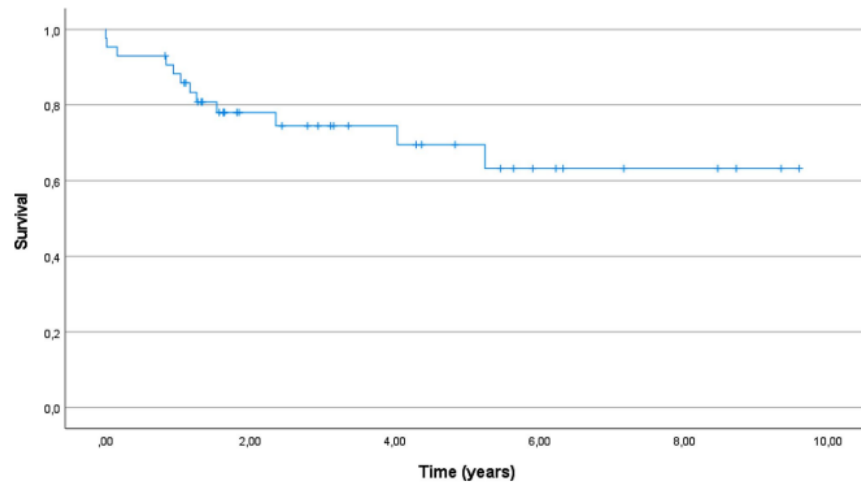


Fig. 2 (a) Vancouver B2 fracture, (b) postoperative imaging after implantation of a long-cemented stem; (c) Vancouver B3 fracture, (d) postoperative imaging after implantation of a modular uncemented stem

Results Between 2008 and 2016, 43 patients could be included. Most patients (63%) were able to walk independently or with a walking aid after one year and amongst the surveyed patients 77% were able to reside at home. Concerning the QoL assessment, a high index of 0.8 ± 0.1 has been reached after one year. Mortality pointed out to be 9% after one year and 28% in general.

LA QUALITA' DI VITA DEL PAZIENTE DOPO LA REVISIONE... L'ATTIVITA' SESSUALE E' ANCORA POSSIBILE?



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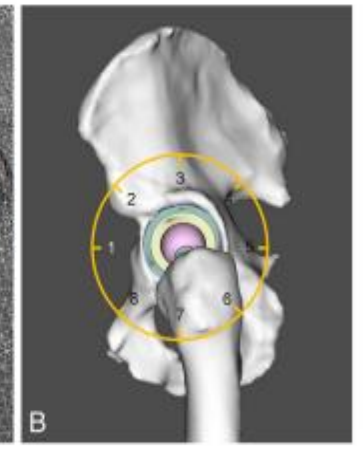
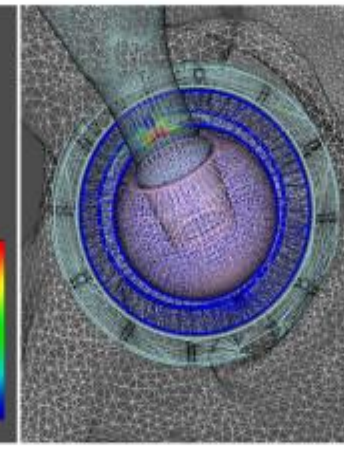
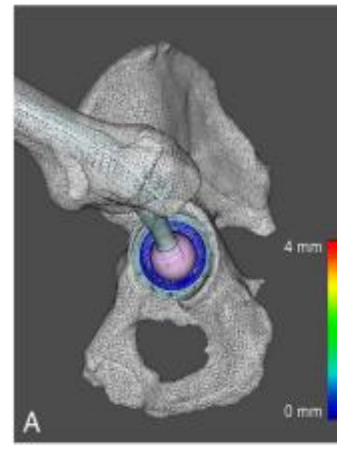
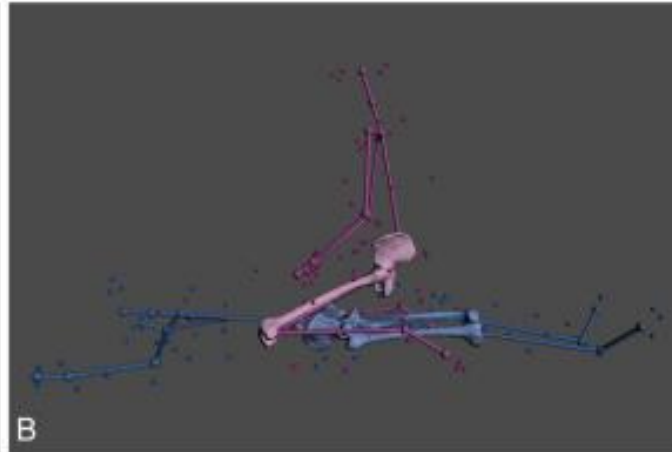
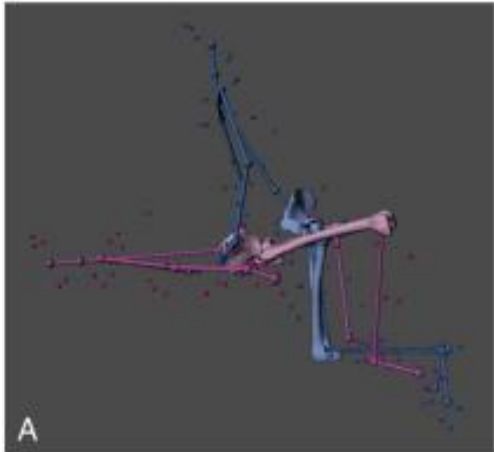
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Sexual Activity After Total Hip Arthroplasty: A Motion Capture Study

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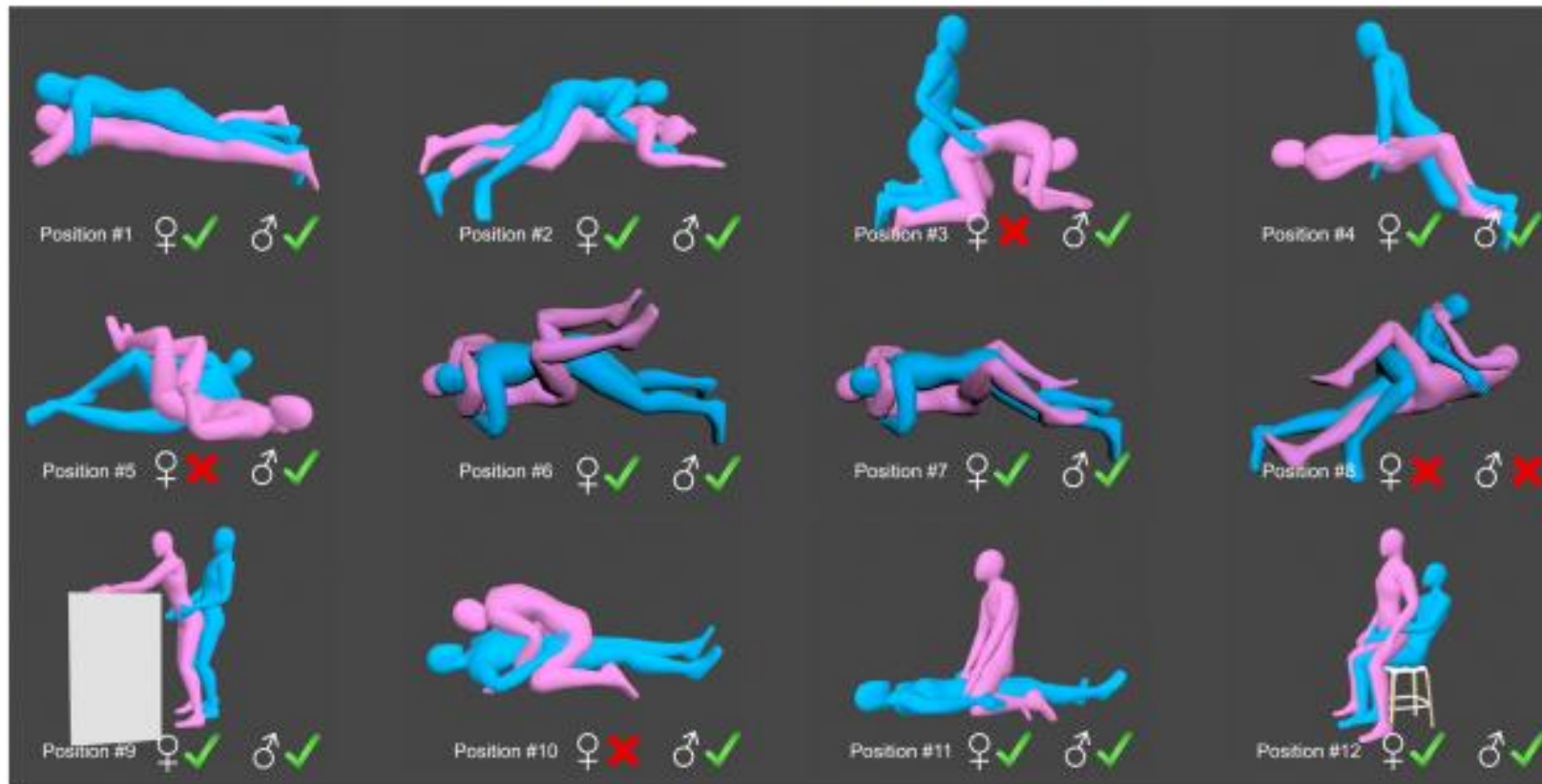
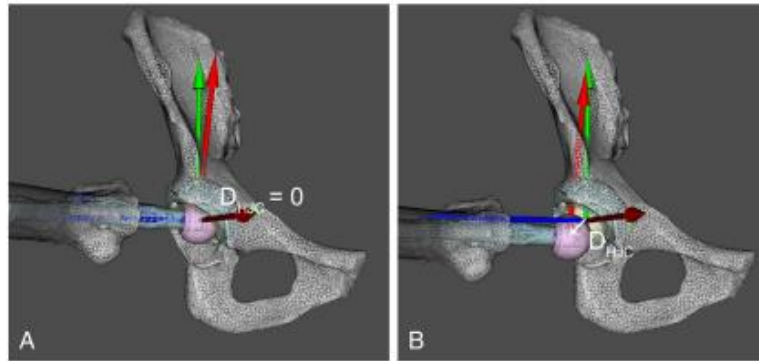


Fig. 6. Sexual positions for men and women recommended after THA. In all images, the man is represented in blue and the woman in pink. A cross next to each symbol means that the position should be avoided; a tick means that the position is allowed.



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Review

Sexual Activity After Total Hip Arthroplasty: A Systematic Review of the Outcomes



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Table 1
Studies in Systematic Review.

Author	Year	Nation	Retrospective or Prospective	LOE	Outcomes Evaluated
Nunley et al [15]	2015	USA	Retrospective	III	Sexual frequency, satisfaction, hip stability during coitus
Wang et al [14]	2014	China	Retrospective	IV	Pain and mobility during coitus, HHS, and satisfaction of patient and partner
Yoon et al [11]	2013	South Korea	Retrospective	IV	Sexual frequency, satisfaction, and concerns after THA
Wall et al [16]	2011	United Kingdom	Retrospective	IV	Sexual satisfaction, pain, and education—surgeon and patient perspective
Laffosse et al [9]	2008	France	Retrospective	IV	Cause of coital difficulties, sexual frequency, and satisfaction
Dahm et al [5]	2004	USA	Retrospective	IV	Education—surgeon perspective
Nordentoft et al [17]	2000	Denmark	Retrospective	IV	% Sexual active pre- and post-THA
Stern et al [13]	1991	USA	Retrospective	IV	Cause of coital difficulties, when sexual activity resumed, comfortable positions
Baldursson and Brattstrom [12]	1979	Sweden	Retrospective	IV	Cause of coital difficulties
Todd et al [18]	1973	United Kingdom	Retrospective	IV	Cause of coital difficulties, relief with THA

LOE, level of evidence; THA, total hip arthroplasty.

Table 4
Sexual Activity Post-THA.

Author	Year	Nation	Mean Follow-Up; (Range) mo	Mean Return to Sexual Activity (Range); mo	N	N Improved Satisfaction	%	N Increased Frequency	%
Nunley et al [15]	2015	USA	28		791	487	61.6	302	38.2
Wang et al [14]	2014	China	NR (12 to —)	3.8 (1.5-6)	247	—	—	—	—
Yoon et al [11]	2013	South Korea	NR (6 to —)	6 (0.8-48)	64	15	23.4	3	4.7
Laffosse et al [9]	2008	France	48 (6-180)	2.2 (0.1-12)	135	47	34.8	24	17.8
Total					1237	549	44.4	329	26.6

THA, total hip arthroplasty; NR, not reported.

TROMBOPROFILASSI: E' DIVERSA SE SI TRATTA DI REVISIONE?

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<https://doi.org/10.1177/1076029618820167>



Original Article



Thromboprophylaxis for Hip Revision Arthroplasty: Can We Use the Recommendations for Primary Hip Surgery? A Cohort Study

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Table 1. Recommendations for Thromboprophylaxis in Major Orthopedic Surgery (Primary Hip Arthroplasty, Primary Knee Arthroplasty, and Hip Fracture) From the *Institutional Guidelines for the Management of Thromboprophylaxis in Orthopedic Surgery*.

Primary Hip Arthroplasty

1. Thromboprophylaxis with both mechanical and pharmacological methods is indicated.
2. During the surgical procedure, use antiembolism stockings and intermittent pneumatic compression devices on the contralateral limb.
3. During hospitalization it is recommended to use:
 - a. Pharmacological prophylaxis:

Enoxaparin	40 mg	Once a day
Dabigatran	220 mg	Once a day
Rivaroxaban	10 mg	Once a day
Apixaban	2.5 mg	Twice a day
Fondaparinux	2.5 mg	Once a day
 - b. Antiembolism stockings and intermittent pneumatic compression devices on both limbs, until the patient has restriction of movement.
4. Continue prophylaxis during 35 days after the day of the surgery.

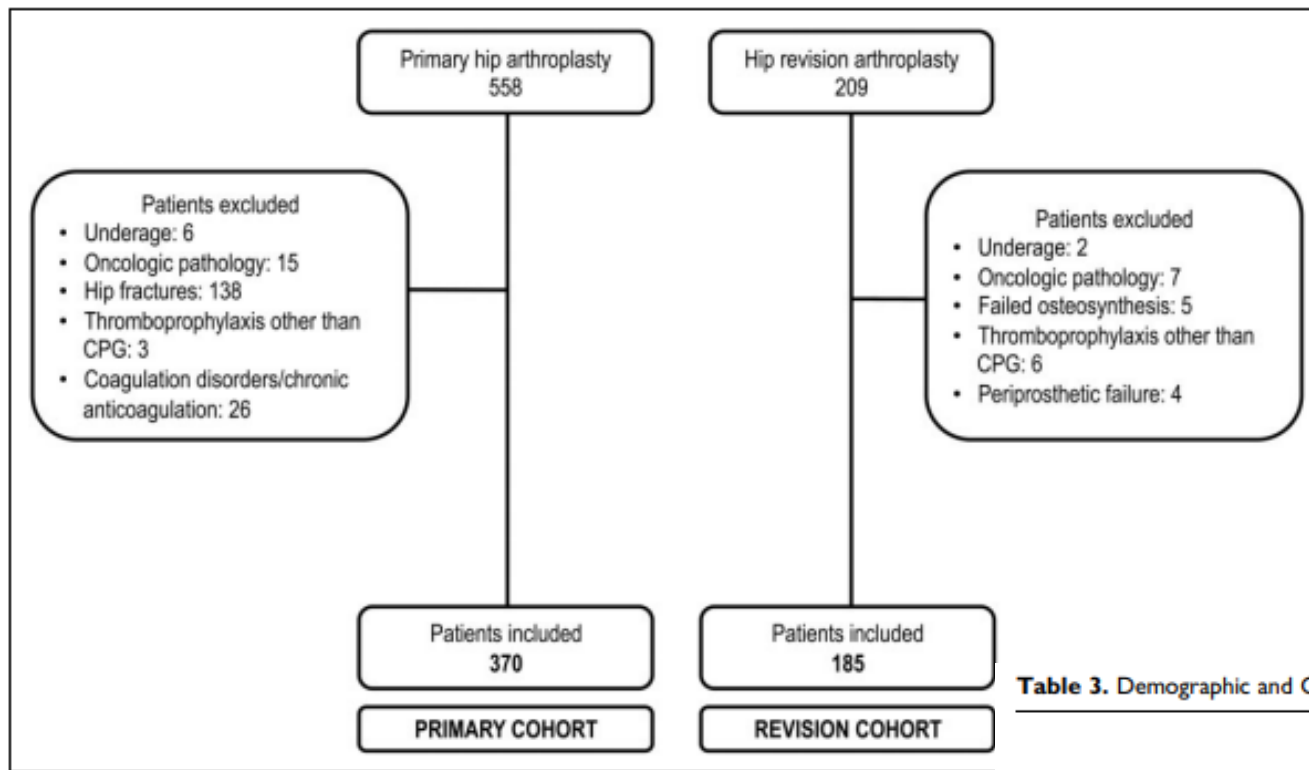


Figure 1. Patient selection flowchart.

Table 3. Demographic and Clinical Characteristics of the Patients Included in the Study.

Variable	Revision		Primary		P Value
	n (N = 185)	%	n (N = 370)	%	
Gender					
Female	112	60.54%	259	70%	.026
Male	73	39.46%	111	30%	
ASA classification					
I	9	4.8%	17	4.59%	.887
II	115	62.16%	182	49.19%	.004
III	59	31.89%	171	46.22%	.001
IV	2	1.08%	0	0%	.219
	Mean	Range	Mean	Range	P value
Age (years)	66.2	30-95	66.1	29-92	.947
Surgical time (minutes)	305	128-645	190	60-400	.000
	Mean	Standard Deviation	Mean	Standard Deviation	P Value
BMI (kg/m ²)	27.71	19.3	25.96	4.2	.245
	Median	IQ Range	Median	IQ Range	P Value
Intraoperative bleeding (cc)	800	400-1500	400	300-600	.000

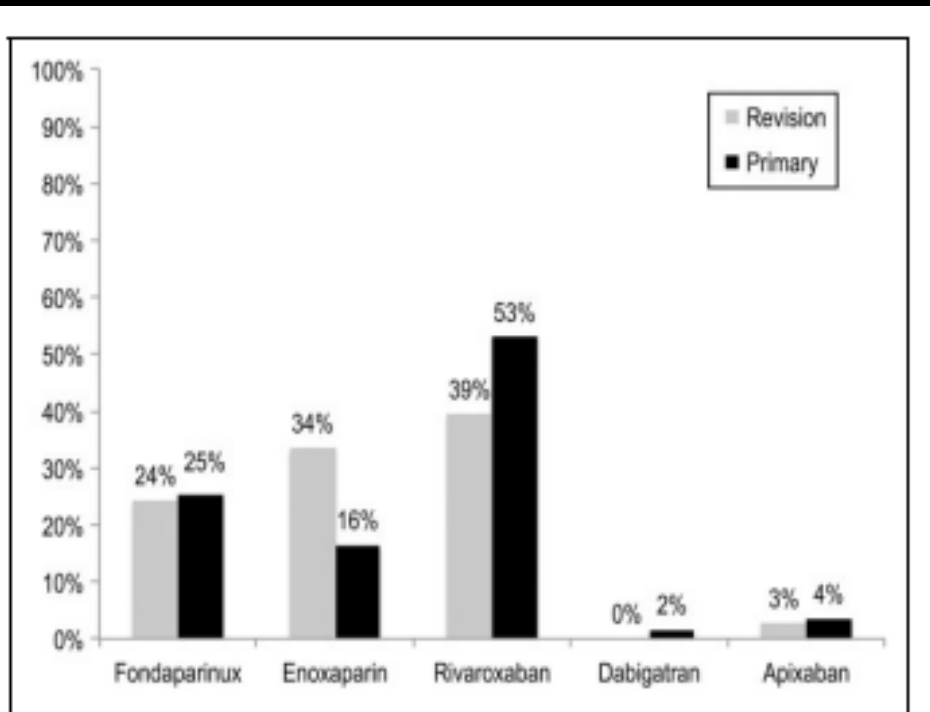


Figure 2. Use of the different types of anticoagulant agents.

Table 5. Prevalence of Overall Thromboembolic Events in the Hip Revision Surgery Group and the Primary Arthroplasty Group and Prevalence at the Different Follow-Ups.

Variable	Revision (N = 185)	Primary (N = 370)	P Value	Adjusted P Value
Hospitalization				
Deep vein thrombosis	0.27%	0%	0.479	.484
Pulmonary embolism	0.54%	0.54%	1.000	1.000
3-month follow-up				
Deep vein thrombosis	0%	0.54%	0.316	.317
Pulmonary embolism	1.08%	0.27%	0.219	.230
Overall	1.62%	1.35%	0.801	

The prevalence of deep vein thrombosis and pulmonary embolism and the presence of major bleeding events were assessed during hospitalization and at 3 months after discharge and compared between groups.

The **overall prevalence of thromboembolic events** in the hip revision surgery cohort and in the primary hip cohort was **1.62% and 1.35%, respectively** (P = .801).

The **38.4% of hip revision patients and 20.3% of primary hip patients** presented **major bleeding events**.

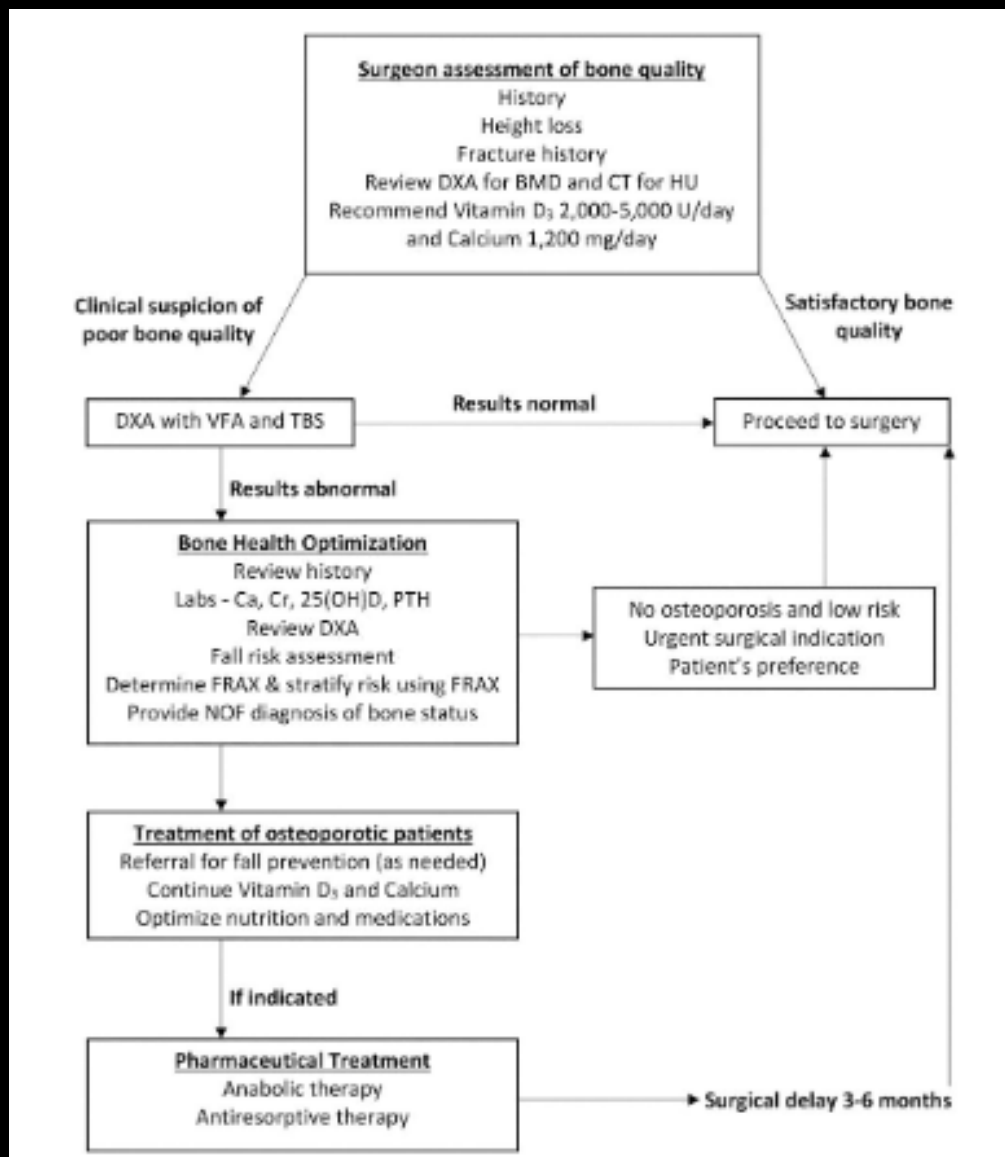
Thromboembolic disease outcomes with the use of a standardized thromboprophylaxis regimen were similar in both cohorts.

Table 4. Distribution of Comorbidities and Related Diagnoses of Patients Included in the Hip Revision Surgery Group and the Primary Arthroplasty Group.

Type of Comorbidities	Revision		Primary	
	n (N = 185)	%	n (N = 370)	%
Neurological	17	9.19	23	6.22
Cardiovascular	113	61.08	197	53.24
Pulmonary	18	9.13	33	8.92
Gastrointestinal	28	15.14	66	17.03
Hepatic	5	2.79	5	1.35
Renal	10	5.41	2	0.54
Endocrine	45	24.32	184	49.73
Hematological (not related to coagulation disorders)	13	7.03	7	1.89
Rheumatologic	10	5.41	12	3.24
Oncologic	17	9.19	22	5.95
Vascular peripheral	11	5.95	17	4.59

PERCHE' IL RISCHIO
DI
SANGUINAMENTO
E' AUMENTATO?

REVISIONE E QUALITA' DELL'OSSO



... per gli adulti di età pari o superiore ai 50 anni che devono essere sottoposti a chirurgia ortopedica, in fase preoperatoria è raccomandato lo screening della salute ossea, inclusa una valutazione del rischio di fratture (FRAX).

Il trattamento pre-operatorio è in grado di ridurre sensibilmente il rischio di complicanze intra e post-operatorie.

Kadri Aamir; Binkley Neil; Hare Kristyn J.; Anderson, Paul A. Bone Health Optimization in Orthopaedic Surgery The Journal of Bone and Joint Surgery: April 1, 2020 – Volume 102 – Issue 7 – p 574-581, doi: 10.2106/JBJS.19.00999

CONCLUSIONI

- ✓ Il numero di interventi di revisione è in costante aumento
- ✓ Un intervento ben eseguito comporta la possibilità di concedere precocemente il carico ed il ritorno precoce alla normale vita quotidiana
- ✓ L'ottimizzazione della qualità dell'osso è pre-requisito essenziale per ottenere i risultati sperati e scongiurare serie complicanze
- ✓ Non sono necessari protocolli di profilassi tromboembolica specifici

- ✓ Il paziente sottoposto a revisione può aspirare a un ottimale ritorno alla normale vita quotidiana
- ✓ Un maggior tasso di insoddisfazione si registra in caso di revisione per frattura o per infezione

GRAZIE