PREOPERATIVE DIAGNOSIS: , Left hip degenerative arthritis.,POSTOPERATIVE DIAGNOSIS: , Left hip degenerative arthritis.,PROCEDURE PERFORMED: ,Total hip arthroplasty on the left.,ANESTHESIA: ,General.,BLOOD LOSS: , 800 cc.,The patient was positioned with the left hip exposed on the beanbag.,IMPLANT SPECIFICATION: , A 54 mm Trilogy cup with cluster holes 3 x 50 mm diameter with a appropriate liner, a 28 mm cobalt-chrome head with a zero neck length head, and a 12 mm porous proximal collared femoral component.,GROSS INTRAOPERATIVE FINDINGS: ,Severe degenerative changes within the femoral head as well as the acetabulum, anterior as well as posterior osteophytes. The patient also had a rent in the attachment of the hip abductors and a partial rent in the vastus lateralis. This was revealed once we removed the trochanteric bursa.,HISTORY: ,This is a 56-year-old obese female with a history of bilateral degenerative hip arthritis. She underwent a right total hip arthroplasty by Dr. X in the year of 2000, and over the past three years, the symptoms in her left hip had increased tremendously especially in the past few months.,Because of the increased amount of pain as well as severe effect on her activities of daily living and uncontrollable pain with narcotic medication, the patient has elected to undergo the above-named procedure. All risks as well complications were discussed with the patient including but not limited to infection, scar, dislocation, need for further surgery, risk of anesthesia, deep vein thrombosis, and implant failure. The patient understood all these risks and was willing to continue

further on with the procedure.,PROCEDURE: , The patient was wheeled back to the Operating Room #2 at ABCD General Hospital on 08/27/03. The general anesthetic was first performed by the Department of Anesthesia. The patient was then positioned with the left hip exposed on the beanbag in the lateral position. Kidney rests were also used because of the patient's size. An axillary roll was also inserted for comfort in addition to a Foley catheter, which was inserted by the OR nurse. All her bony prominences were well padded. At this time, the left hip and left lower extremity was then prepped and draped in the usual sterile fashion for this procedure. At this time, an anterolateral approach was then performed, first incising through the skin in approximately 5 to 6 inches of subcutaneous fat. The tensor fascia lata was then identified. A self-retainer was then inserted to expose the operative field. Bovie cautery was used for hemostasis. At this time, a fresh blade was then used to incise the tensor fascia lata over the posterior one-third of the greater trochanter. At this time, a blunt dissection was taken proximally. The tensor fascia lata was occluded with a hip retractor. At this time, after hemostasis was obtained, Bovie cautery was used to incise the proximal end of the vastus lateralis and removing the partial portion of the hip abductor, the gluteus medius. At this time, a periosteal elevator was used to expose anterior hip capsule. A _____ was then inserted over the femoral head purchasing of the acetabulum underneath the reflected head of the quadriceps muscle. Once this was performed, Homan retractors were then inserted superiorly and inferiorly

underneath the femoral neck. At this time, a capsulotomy was then performed using a Bovie cautery and the capsulotomy was _____ and then edged over the acetabulum. At this point, a large bone hook was then inserted over the neck and with gentle traction and external rotation, the femoral head was dislocated out of the acetabulum. At this time, we had an exposure of the femoral head, which did reveal degenerative changes of the femoral head and once the acetabulum was visualized, we did see degenerative changes within the acetabulum as well as osteophyte formation around the rim of the acetabulum. At this time, a femoral stem guide was then used to measure proximal femoral neck cut. We made a cut approximately a fingerbreadth above the lesser trochanter. At this time, with protection of the soft tissues an oscillating saw was used to make femoral neck cut.,The femoral head was then removed. At this time, we removed the leg out of the bag and Homan retractors were then used to expose the acetabulum. A long-handle knife was used to cut through the remainder of the capsule and remove the glenoid labrum around the rim of the acetabulum. With better exposure of the acetabulum, we started reaming the acetabulum. We started with a size #44 and progressively reamed to a size #50. At the size #50 mm reamer, we obtained excellent bony bleeding with good remainder of bone stalk both anteriorly and posteriorly as well as superiorly within the acetabulum. We then reamed up to size #52 in order to get bony bleeding around the rim as well as anterior and posterior within the acetabulum. A size 54 mm Trilogy cup was then implanted

with excellent approaches approximately 45 degrees of abduction and 10 to 15 degrees of anteversion dialed in. Once the cup was impacted in place, we did visualize that the cup was well seated on to the internal portion of the acetabulum. At this time, two screws were the placed within the superior table for better approaches securing the acetabular cup. At this time, a plastic liner was then inserted for protection. The leg was then placed back in the bag. A Bennett retractor was used to retract the tensor fascia lata and femoral elevator was used to elevate the femur for better exposure and at this time, we began working on the femur. A rongeur was used to lateralize over the greater trochanter. A Box osteotome was used to remove the cancellous portion of the femoral neck. A Charnley awl was then used to cannulate through the proximal femoral canal. A power reamer was then used to ream the lateral aspect of the greater trochanter in order to provide maximal lateralization and prevent varus implantation of our stem. At this time, we began broaching. We started with a size #10 and progressively worked up to a size #12 mm broach. Once the 12 mm broach was inserted in place, it was seated approximately 1 mm below the calcar. A calcar reamer was then placed and the calcar was reamed smoothly. A standard neck as well as a 28 mm plastic head was then placed and a trial reduction was then performed. Once this was performed, the hip was taken to range of motion with external rotation, longitudinal traction as well as flexion and revealed good stability with no impingement or dislocation. At this time, we removed 12 mm broach and proceeded with

implanting our polyethylene liner within the acetabulum. This was impacted and placed and checked to assure that it was well seated with no loosening. Once this was performed, we then exposed the proximal femur one more time. We copiously irrigated within the canal and then suctioned it dry. At this time, a 12 mm porous proximal collared stem, a femoral component was then impacted in place. Once it was well seated on the calcar, we double checked to assure that there was no evidence of calcar fractures, which there were none. The 28 mm zero neck length cobalt-chrome femoral head was then impacted in place and the Morse taper assured that this was well fixed by _____.,Next, the hip was then reduced within the acetabulum and again we checked range of motion as well as ligamentous stability with gentle traction, external rotation, as well as hip flexion. We were satisfied with components as well as the alignment of the components. Copious irrigation was then used to irrigate the wound. #1 Ethibond was then used to approximate the anterior hip capsule. #1 Ethibond in interrupted fashion was used to approximate the vastus lateralis as well as the gluteus medius attachment over the partial gluteus medius attachment which was resected off the greater trochanter. Next, a #1 Ethibond was then used to approximate the tensor fascia lata with figure-of-eight closure. A tight closure was performed. Since the patient did have a lot of subcutaneous fat, multiple #2-0 Vicryl sutures were then used to approximate the bed space and then #2-0 Vicryl for the subcutaneous skin. Staples were then used for skin closure.

The patient's hip was then cleansed. Sterile dressings consisting of Adaptic, 4 x 4, ABDs, and foam tape were then placed. A drain was placed prior to wound closure for postoperative drainage. After the dressing was applied, the patient was extubated safely and transferred to recovery in stable condition. Prognosis is good.