BRITISH HIP SOCIETY

Affiliated to the BOA
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Officers :

President – Graham Gie **Immediate Past President** – Ian Stockley
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Treasurer - John Nolan
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Web page Coordinator – Fares Haddad
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BRITISH HIP SOCIETY
NEWSLETTER
July 2010

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PRESIDENTIAL INTRODUCTION – MR GRAHAM GIE

I hope you are all enjoying this wonderful summer and having time off with your families but it is time again for your executive committee to remind you, through this newsletter, that work goes on and that exciting events are coming up in the near future.

After the driest 1st 6 months of the year in 81 years, another rare event occurs in the UK in 2010, The Combined English-speaking World Orthopaedic Meeting which comes to Glasgow from 12th to 17th September. This event is held only once every 6 years and rotates through centres around the English-speaking world. It is therefore likely to occur in the UK only once during your working career so please make every effort to attend. An excellent programme has been arranged by the BOA & Specialist Societies and has a significant international flavour.

The BHS Meeting to be held on 'The English Riviera' from March 2nd to 4th 2011 promises to be the biggest & best yet. We have an excellent venue with easy access by train (walking distance) & airports within half an hour by road. 'Concept Meetings' will soon be in touch & registration as well as accommodation bookings will be available on-line. Please register early as it does assist with arrangements & late booking (within 2 weeks of the meeting) will incur a 50% supplementary fee. The Association of Care Practitioners will be running their meeting parallel to the BHS Meeting & it is very likely that BORS will be holding a half day meeting leading into the main BHS sessions.

Good data is now being produced by the National Joint Register & I would urge all of you to ensure that your own data is submitted with patient consent. At the Manchester meeting last year, the BHS membership unanimously approved that data entry should be mandatory. I would also urge you check your own position on the funnel plots such that if you are heading towards outlier status, the data can be dealt with locally & issues resolved before the issues becomes a national one.

Finally, your committee are seeking nominations for the positions of Vice-President & Honorary Secretary. To make your society truly democratic & representative, please put forward names of any deserving members for these positions. Orthopaedic surgeons remain significantly under-represented.

I look forward to seeing as many of you as possible in Glasgow in a few weeks time.

Graham Gie FRCSEd(Orth)
President BHS

THE US TRAVELLING FELLOWS 2010:

The BHS is delighted to confirm the names of the North American Fellows who we will be hosting this year:

James L. Howard, MD, Mac, FRCSC
Assistant Professor
Orthopaedic Surgery
London Health Sciences Centre, C9-118
339 Windermere Road
London, ON N6A 5A5
Canada
Email: james.howard@lhsc.on.ca

Hany S. Bedair, MD
Massachusetts General Hospital / Harvard Medical School
55 Fruit Street, Suite 3B
Boston, MA 02114
Email: hbedair@partners.org

Itinerary:

Arrive on Sunday 29 August and travel immediately from London to Exeter to be met by **Graham Gie**. Remain in Exeter until Wednesday 1 September.

Travel to London to be met by **Fares Haddad**. They will spend Thursday 2 and Friday 3 in London.

Travel to Norwich on Saturday 4 September to be met **John Nolan**. They would remain in Norwich until Tuesday 7 September.

During the afternoon of Tuesday 7th September travel to Wrightington to be met by **John Hodgkinson.**

On Thursday afternoon (9th September) travel from Wrightington to Edinburgh where they would be met by **Colin Howie**.

Stay at Edinburgh until Sunday 12 September and spend the next week at the BOA in Glasgow.

Our Fellows are always shown the most generous hospitality in North America. Please engage with our visitors and make them as welcome as you possibly can. It is important that they have the fondest memories of their time with us and the best impression of Orthopaedics in the UK.

COMBINED MEETING IN GLASGOW 2010.

12th Meeting of the
Combined Orthopaedic Associations
12 – 17 September 2010
Glasgow, Scotland

Preparations are well advanced for the 12th meeting of the combined Orthopaedic Associations to be held at the Scottish Exhibition and Conference Centre (SECC): **www.secc.co.uk**. The meeting of the Combined Associations of Australia, New Zealand, US, Canada and South Africa is only held every 6 years and so this year is the once in our lifetime that we will host the meeting in the UK. Please attend and help make it a big success! The BOA is working hard to make the meeting relevant to al surgeons and, hopefully a great success.

Register now www.comoc2010.org

A full programme can be downloaded here:
http://www.comoc2010.org/Monday-13-Sept-g.asp

SUMMARY:

MONDAY 13 SEPTEMBER 2010

07.00	Satellite		Satellite		Satellite	
Room	**Clyde**	**Lomond**	**Alsh**	**Boisdale**	**Carron**	**Dochart**
08.00	**Instructional** Hips ***The Metal Bearing Surface***	**Instructional** Children ***Hot Topics in Children's Orthopaedics***	**Instructional** Elbow/Shoulder ***Difficult Proximal Humeral Fractures***	**Instructional** Military Surgery ***Severe Limb Trauma in War and Conflict***	**Instructional** ***Revalidation***	**Debate**
10.00	Tea, Posters and Exhibition					
10:30	**Symposium** Hips ***Joint Registries***	**Symposium** Children ***Managing flat feet and pes cavus***	**Symposium** Elbow/Shoulder ***Distal Humeral Fractures***	**Free Papers** Military Surgery	**Instructional** AAOS ***Relationship with Industry***	**Free Papers General I**
12.00	Robert Jones Lecture [BOA] N M P Clarke *Paediatric orthopaedics and the Robert Jones Birthday Volume*					
12.45	Opening Ceremony					
13.15	Lunch, Posters and Exhibition					
14:15	Plenary Lecture [AustAO] S Graves *Joint Registries*					

Monday cont…

15.00	Tea, Posters and Exhibition					
15:30	**Charnley Lecture** Hips *Protrusio in young people (Michael Leunig)*	**Free Papers** Children	**Free Papers** Elbow/Shoulder	**Instructional** Military Surgery *The Nerve injuries of war*	**Symposium** *The Bone & Joint Decade*	**Symposium AOA** *Incorporating a culture quality for improving quality and patient safety through education and a paradigm Shift*
16:00	**Free Papers** Hips	**Keynote Lecture** *Pharmaceuticals and bone healing (David Little)*				
16:30		**Free Papers Children**		**Keynote Lecture** Military Surgery *Advances in the management of complex limb nerve injuries (Praveen Anand)*		
17:00				**Instructional** Military Surgery *Regeneration of the wounded*	**Free Papers General II**	
17:30			**Hunterian Lecture** *The Distal Radio-Ulna Joint* (John Stanley)			
18.00	Opening Reception – Science Centre					

TUESDAY 14 SEPTEMBER 2010

07.00	Satellite		Satellite		Satellite	
Room	**Clyde**	**Lomond**	**Alsh**	**Boisdale**	**Carron**	**Dochart**
08.00	**Instructional** Trauma *Minimally Invasive Plate Osteosynthesis*	**Instructional** Hands *Scaphoid Fractures*	**Instructional** Sports Trauma *Causes and treatment of groin pain*	**Instructional** Limb Recon. *Reconstruction: where we are and where we are going?*	**Instructional** Hips *Hip Resurfacing*	**Symposium NZOA** *Funding Systems for Compensation*
10.00	Tea, Posters and Exhibition					
10.30	**Symposium** Trauma *Fragility Fractures*	**Debate** Hands *The Ulnar Corner*	**Instructional** Sports Trauma *Tendinopathy*	**Debate** Limb Recon. *Current issues*	**Symposium** Hips *The Painful Young Adult Hip (10:30 – 11:30) (Free Papers – 11:30 – 12:00)*	**Instructional** Medicolegal *Working in Elite Sport: Pitfalls, indemnity and Ethics for Orthopaedic Surgeons*
12.00	Presentations					
12.15	Plenary Lecture [AOA] S L Weinstein *The evidence base for treating paediatric orthopaedic conditions*					

Tuesday cont…						
13.00	Lunch, Posters and Exhibition					
14.15	Plenary Lecture [NZOA] P Robertson *Proving what we already know*					
15.00	Tea, Posters and Exhibition					
15:30	**Free Papers** Trauma	**Free Papers** Hands	**Free Papers** Sports Trauma	**Keynote Lecture** Limb Recon. ***Post-traumatic reconstruction (Charles Taylor)***	**Debate** Hips ***Hip Arthroplasty – Ignoring the evidence***	**Symposium** **AOA** **DDH – Cradle to Grave**
16:00		**Keynote Lecture** Hands ***Nerve Injuries and the Orthopaedic Surgeon (Stewart Watson)***		**Free Papers** Limb Recon. .		
16:30		**Free Papers** Hands	**Keynote Lecture** Sports Trauma ***Hip arthroscopy in athletics (David Young)***		**Free Papers** Hips	
17:00			**Free Papers** Sports Trauma			**Free Papers** **General III**
17:30	**Keynote Lecture** Trauma ***Restructuring trauma care in the UK (Keith Willett)***					
18.00-18.30	***Meet the Experts - Trauma***			***Meet the Experts - HIP***		

WEDNESDAY 15 SEPTEMBER 2010

07.00	Satellite		Satellite		Satellite	
Room	**Clyde**	**Lomond**	**Alsh**	**Boisdale**	**Carron**	**Dochart**
08.00	**Instructional** Children ***Children's Fractures that everyone needs to manage***	**Symposium** National Joint Registry ***NJR Annual Report***	**Instructional** Education ***Competence Assessment***	**Instructional** Training ***Orthopaedic training around the world – Lessons we can all learn***	**Instructional** Orthopaedics in the Developing World ***Clinical Issues***	**Instructional** Communications ***Patient-Physician Communication***
09:30	**Tea**					
10.00	**Instructional** ***Children Brachial Plexus Hands***	Tea, Posters and Exhibition				
10.30		**Instructional** Hips ***Advances in arthroplasty***	**Symposium** COA ***Canadian Fracture Trials: global vision and leadership***	**Instructional** Training ***Orthopaedic training around the world – international perspective***	**Symposium** Orthopaedics in the Developing World ***The Combined Associations role***	**Instructional** Communications ***Patient-Physician Communication***
12.00	Presentations					
12.15	Orthopaedics in South Africa Mthunzi Ngcelwane [SAOA]					
13.00	Lunch, Posters and Exhibition					
14.00	Free Afternoon					
	Golf – Gleneagles	Golf – Western Gailes	Biking	Fun Run – Pollok Park	Climbing	Walking	Cruise – Loch Lomond

THURSDAY 16 SEPTEMBER 2010

07.00	Satellite		Satellite		Satellite	
Room	**Clyde**	**Lomond**	**Alsh**	**Boisdale**	**Carron**	**Dochart**
08.00	**Free Papers** Knees	**Instructional** Foot & Ankle ***Foot Update***	**Instructional** Spine ***Cervical and lumbar radicular pain***	**Debate** Academic Orthopaedics	**Symposium Pensions UK**	**Symposium SAOA** ***Infections in Orthopaedics***
10.00	Tea, Posters and Exhibition					
10.30	**Instructional** Knees ***Anterior knee pain***	**Debate** Foot & Ankle ***The frame in the treatment of pilon fractures***	**Keynote Lecture** Spine ***Natural history of idiopathic scoliosis (Stuart Weinstein)***	**Symposium** ***Professionalism in Orthopaedic Surgery***	**Instructional COA** ***Bone Substitutes***	**Instructional** ***Education Committee***
11:00			**Debate** Spine ***Kyphoplasty & vertebroplasty in osteoporotic fractures***			
12.00	Presentations					
12.15	Howard Steel Lecture B Bryson An Even Shorter History of Nearly Everything					

Thursday cont…						
13.00	Lunch, Posters and Exhibition					
14.15	Plenary Lecture [AAOS] J Callaghan *Why did we leave Charnley Total Hip Replacement?*					
15.00	Tea, Posters and Exhibition					
15:30	**Keynote Lecture** Knees **Adrian Henry Lecture** ***Challenging the dogma in Total Knee Replacement and osteoarthritis*** **(Dr Johan Bellemans)**	**Free Papers** Foot and Ankle	**Free Papers** Spine	**Free Papers** Research	**Free Papers** General IV	**Free Papers** Tumours
16:00	**Symposium** Knee ***Prosthetic alternatives to Total Knee Replacement***	**Naughton Dunn Lecture** Foot & Ankle ***The Cavus Foot (Paul Cooke)***				
16:30		**Free Papers** Foot and Ankle	**Keynote Lecture** ***Spine Posterior Element Anatomy and its Influence on Lumbar Spine Disease and Surgical Treatment (Peter Robertson)***		**Keynote Lecture** General Orthopaedics ***"A comparative effectiveness trial planned care path versus a traditional approach to hip and knee arthroplasty in Alberta Canada" (Cy Frank)***	
17:00			**Free Papers Spine**		**Free Papers** General IV	**Free Papers** VTE
17:30				**Keynote Lecture Research Pseudotumours and hip resurfacing (David Murray)**		
18.00-18.30	***Meet the Experts - Knee***		***Meet the Experts - Spine***		***Meet the Experts – Foot and Ankle***	
19.30	Gala Dinner & Ceilidh – Kelvingrove Museum					

FRIDAY 17 SEPTEMBER 2010						
07.00	Satellite		Satellite		Satellite	
Room	**Clyde**	**Lomond**	**Alsh**	**Boisdale**	**Carron**	**Dochart**
08.00	**Symposium** British Orthopaedic Directors Society ***The best, the worst, the future***	**Instructional** VTE ***Venous thromboembolism in orthopaedic and trauma surgery***	**Instructional** Training ***Opportunities in further training for SAS grade***	**Debate** Tumours ***Endoprosthetic replacement vs allografting***	**Instructional** Computer-Aided Surgery ***Gold standard or fake jewellery?***	**Instructional**
10.00	Tea					
10.30	**Symposium** BODS ***The best, the worst, the future***	**Instructional** VTE ***Venous thromboembolism in orthopaedic and trauma surgery***	**Instructional** E-learning ***A world view on E-learning***	**Instructional** Tumours ***Bone and soft tissue sarcomas***	**Instructional** Computer-Aided Surgery ***Robot Wars***	**Instructional**
12.00	Plenary Lecture [COA] R Bourne *The impact of evidence-based medicine on Orthopaedic Surgery*					
12.45	Closing Ceremony					
13.15	Lunch					
14.15	**Close of Meeting**					

ACCEA - CLINICAL EXCELLENCE AWARDS

The BHS is registered as a nominating body to recommend members of the Society for Clinical Excellence awards.

A panel has been appointed to review applications and to arrange the BHS nominations in ranking order. The panel consists of 4 members of the Society plus one lay person and will change annually. It is the President (Graham Gie) / the member at large (Andy Hamer) / a Senior award holder (Martyn Porter) / a senior member of the BHS (Keith Tucker) and a lay person (Trish Phillips).

The panel uses the same criteria as the ACCEA ranking the nominations. Please see more information at http://www.dh.gov.uk/ab/ACCEA/index.htm

Nominees of the BHS in the past have not been as successful as we would have hoped at gaining higher awards. As a nominating society the BHS is allowed to support 6 Bronze/ 3 Silver and 2 Gold nominations.

The officers of the Society would request that anyone seeking support should submit their applications, fully supported by CV and the relevant ACCEA form completed to the Hon Secretary by the 31st October 2010 [please submit by email to jtimperley@mac.com] The panel can then consider the applications and prepare citations well before the closing ACCEA date on Friday 10th December 2010.

The British Hip Society is also now a registered nominating body in Scotland. The Scottish Clinical Excellence Awards system is different from that in England, Wales and Northern Ireland. Any Scottish members of the British Hip Society who are applying for Clinical Excellence Awards and would like the support of the Hip Society should also submit their applications to the Secretary of the British Hip Society

APPLICATIONS OPEN UNTIL 31/12/10

British/European Travel Awards

Applications are invited from senior SpR's, Hip Fellows and junior Consultants to apply for a £1500 [max] grant towards travel and accommodation to facilitate a visit to an Orthopaedic Centre of their choice in the year 2011. Two awards are available. The closing date is 31st December 2010. Applications should be sent with a CV and details of the proposal to the Hon Sec. John Timperley@mac.com. Applicants will be interviewed in Torbay at the Annual British Hip Society Meeting 2011.

BHS travelling Fellows to the USA 2011

Dedicated hips surgeons who are senior trainees or in their first 5 years of consultant practice who would like to visit several centres of excellence in the USA and Canada should e-mail the Hon Sec. (jtimperley@mac.com). The Fellowship is courtesy of the American Hip Society, over a 3 week period and will take place in late summer/ early autumn 2011 Please include your CV. as an attachment and a brief statement saying why you would like to take part in the Fellowship, what you hope to gain from it and what hip interest and experience/ research you have been involved with that you can present on the tour. The closing date is 31st December 2010. Interviews will take place of the short-listed candidates at the BHS meeting in Torbay (March 2011).

THE McMINN BURSARY

This bursary, funded by Derek McMinn, is to support orthopaedic trainees who wish to study for an MD. The basis of the study should involve the aetiology or treatment of diseases of the hip.

Applicants for the 2012 bursary should submit, their CV to the Secretary of the BHS, John Timperley (Jtimperley@mac.com) by the 31st December 2010, with details of their proposed study. The name of the proposed supervisor and the institution where the study is to take place plus an outline of the costs involved, the name of three referees, together with the proposed date on which the study is to start should be included. Applicants will be interviewed in Torbay at the Annual BHS meeting in 2011.

APPLICATIONS FOR MEMBERSHIP OF THE BRITISH HIP SOCIETY

Ordinary membership of the Society is open to surgeons and scientists who have a special interest in the hip joint as demonstrated by either their research or publications in this field or by the presentation of a paper to the society. A membership proposal form can be found on:
http://www.britishhipsociety.com/printJoin2.htm
Conditions of membership can be viewed at:
http://www.britishhipsociety.com/join2.htm

Please print out the form, get it signed by a proposer and a seconder (both of whom must be members of the society) and send it with an up-to-date CV to the Honorary Secretary: The British Hip Society, British Orthopaedic Association, Royal College of Surgeons, 35-43 Lincoln's Inn Fields London WC2A 3PN United Kingdom. Applicants are required to be members of the BOA.
Please note that applications received after 31st December 2010 will not be considered at the AGM in 2011 and will need to wait until the following year.

NOMINATIONS FOR ELECTION OF THE VICE PRESIDENT OF THE BHS

Nominations are invited from the ordinary members for the position of Vice President of the Society. Nominees must be proposed and seconded by ordinary members. The nominee must give written consent before his or her name can go forward. A ballot will be held at the annual general meeting if it is necessary. The vice president is elected for a term of one year and then succeeds as the President Elect.

NOMINATIONS FOR ELECTION OF HONORARY SECRETARY OF THE BHS

Nominations are invited from the ordinary members for the position of Honorary Secretary of the Society. Nominees must be proposed and seconded by ordinary members. The nominee must give written consent before his or her name can go forward. A ballot will be held at the annual general meeting if it is necessary. The Honorary Secretary is elected for a term of three years.

NOMINATIONS FOR ELECTION OF WEBSITE CO-ORDINATOR

Nominations are invited from the ordinary members for the position of website co-ordinator. Nominees must be proposed and seconded by ordinary members. The nominee must give written consent before his or her name can go forward. A ballot will be held at the annual general meeting if it is necessary. The successful nominee is elected for a term of three years.

Please send all nominations for these position on the BHS Executive to: John Timperley (jtimperley@mac.com) before 10th February 2011.

REPORT FROM IAN STOCKLEY – PAST PRESIDENT:
BHS Meeting Sheffield 2010

Dates: 24-26th February 2010

A record number of delegates attended the annual scientific meeting of the society in Sheffield this February. On Wednesday afternoon, Johan Witt and colleagues held a master class on acetabular osteotomes. This again was a great success and I'm very appreciative of all the preparatory work done by the faculty to ensure that this interactive and practical session ran smoothly. Registration was oversubscribed and I

think with the interest in non arthroplasty management of hip pathology growing at such a pace, the executive will have to consider where to hold this part of the programme in future meetings.

The following morning Adrian Carroll and Brian Mock ford chaired the emerging hip surgeon's forum. Although I have never been allowed to attend this session, delegates who did commented on the discussions being provocative and educational. Certainly worth getting out of bed for!

As the morning progressed, more delegates arrived and the main auditorium was virtually full for the NJR update chaired by Martyn Porter and Keith Tucker. The emotive topic of outliers was discussed and hopefully the audience were reassured with what they heard on the ways outlying data is interpreted and subsequently acted upon. We as a society fully support the NJR and expect full collaboration from all our members.

After an excellent lunch, the first topic in focus session was on the thorny issue of HRG and reimbursement chaired by Bob Kerry. Two dry but instructive presentations by Department of Health colleagues were followed by an entertaining and informative talk by Darren Fern on how to get the most money for your efforts.

The free paper session on the Thursday afternoon chaired by Derek Pegg and Martyn Porter focused on issues relating to metal on metal resurfacing arthroplasty and in particular adverse reactions to metal debris. We do not know the answers yet! One presentation needs special mention. Becky Andrews, Medical student from Sheffield gave an excellent presentation of her research, 'Effect of cobalt and chromium ions on the formation and function of human peripheral blood derived osteoclasts in-vitro. All three adjudicators, Gordon Bannister, John Hodgkinson and.... thought it worthy of merit and so we awarded her a discretionary prize, the President's prize, last awarded in 2003.

After a quick beer, we held the AGM. Professor Gordon Bannister was elected President for 2012-13. The McMinn Bursary was split between George Grammatopoulos from Oxford and David Langton from the North East. Paul Lee, Birmingham and Henry Wynn Jones from Wrightington were awarded the European Travelling Fellowship for 2010. We look forward to receiving their reports in due course.

The question of whether the BHS adopts charitable status was raised by John Nolan. There are definitely some positive benefits for the society but no firm decision could be made without further information being available.

Our society benefits from being an affiliated society of the BOA and the executive firmly believes that any member of the BHS also needs to be a member of the BOA.

The society dinner was held in the Great Hall at Cutlers' Hall. We had a very amusing and entertaining after dinner speech from Andrew Raftery, recently retired consultant transplant and general surgeon.

A session on outcomes in hip surgery chaired by Steve Krikler and Mukesh Hemmady opened the meeting on Friday morning. In this session Henry Wynn Jones gave his presentation, 'High early failure rate with a large head metal on metal hip replacement: the importance of MRI imaging' and was subsequently awarded the McKee Prize. This being awarded to the best presentation by an orthopaedic trainee as judged by our panel of three.

I chaired the second Topic in Focus session, which was themed on infection. It was good to bring back old friends like Lars Frommelt from the Endo Klinik and Jay Parvizi, now at the Rothmann Institute in Philadelphia but my first house officer when I was appointed as a consultant in Sheffield in 1991. Lars explained to us, some of the

survival mechanisms of bacteria and how clever they are in beating us! Jay's excellent presentation on 'smart implants' was based on his research looking at modifying the implant surface to kill bacteria. The final speaker was Rob Townsend, my bacteriology colleague in Sheffield who gave a rather worrying presentation on the emergence of super bugs and the relative lack of new development work in the field of antimicrobials, primarily due to cost.

A presentation from Pramod Archan and Sanjeev Patil on their experiences as BHS/AHS travelling fellows must have encouraged young consultants in the audience to apply for this fellowship in the future. The experience gained is unique and we are indebted to our American colleagues for their hospitality.

My Presidential Guest lecturer, Jean Pierre Vidalain from Annecy had a torrid time getting to Sheffield and an even worse journey home, having to spend the night at Liverpool airport! However, his presentation:'Hydroxyapatite and hip arthroplasty; what have were learned over 25 years' was worth his journey. Hydroxyapaite is certainly magic powder.

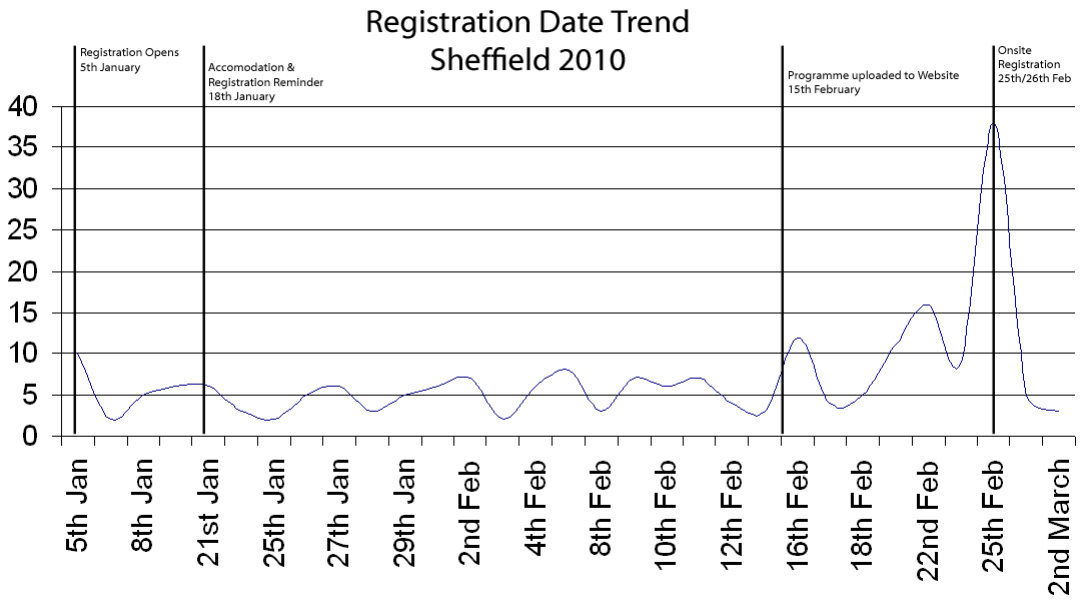
The third Topic in Focus session, chaired by John Timperley and Martyn Porter, was on the old chestnut of polyethylene acetabular components, uncemented or cemented? The evidence presented was quite clear in that the wear rates and survival of cemented cups beats the current polyethylene uncemented cups.

Our final free paper session, chaired by Marcus Bankes and Martin Stone was themed on 'aspects of hip surgery'. Sadly numbers in the audience were dwindling at this stage and I do think we need to look at finishing times for future meetings to try and avoid the presenters in the final session speaking to a skeleton audience.

Ninety two posters were on display and were judged by a panel of Bannister, Gie and Phillips. The winner of the best poster was: 'What is the financial cost of treating periprosthetic hip fractures?' produced by JRA Phillips from Nottingham.

My final act as President was to hand over the Presidency to Graham Gie. Graham needs no introduction and I know he will serve you well as president of this society. It has been a great personal honour to be your president and I would like to take this opportunity of thanking the BHS executive and Claire Wilson at the BOA for all their help and support throughout the year.

It was great fun hosting the meeting in Sheffield and I acknowledge the help of my colleagues in Sheffield, particularly Andy Hamer and our secretaries Kathryn and Liz. However, it is also very stressful when it comes to hotel reservations, catering and organising the dinner! We obviously look at previous meetings and make an educated guess as to possible numbers for the next meeting but you don't make it very easy for the host when you don't commit to your attendance! We all now have to give six weeks' notice to our Trust so why, if you are planning to come to the meeting, not commit at that stage? Hotels are on your back, wanting to release rooms; chefs want final numbers for the dinner two weeks prior to the event. It's a nightmare! Look at the enclosed chart, showing registration numbers against time, produced by Claire Wilson. I'm sure we can improve and make Graham's job easier for Torbay next March!



JOINT ACTION- REPORT FROM PETER FOY

'*Sheffield, where **everyone** matters*'

Sheffield Council
The strapline for Sheffield City council is, *'Sheffield, where **everyone** matters'*. It could not have rung more true for me than the time I spent at the British Hip Society meeting on 25th and 26th March 2010 at the Mecure Hotel. Thank you for your invitation to attend.

Joint Action
Joint Action, as you are aware, is the fundraising and research part of the BOA, not a separate charity. We share the same charity number and incorporated company number as the BOA, so all our risks are minimised and will prevent any reoccurrence of the *'Wishbone'* scenario. We pride ourselves as being the only UK charity that specialises in raising and distributing funds for all areas of the musculoskeletal spectrum and our current research portfolio stands at £1.4 million.

BHS Meeting
The British Hip Society meeting in March gave me a unique insight into the specialist world of Hip Surgery, not just from reading the ground-breaking abstracts around the coffee lounge area, but meeting the members who perform these now-commonplace, yet still life-changing operations and hearing the passion behind the stories of what attracted them to Orthopaedic and hip surgery in particular. Hearing the stories of the patient's lives you've turned around

and given back their former sense of mobility. Understanding the very real issues that stand in the way of delivering the clinical excellence that you all so strongly believe in.

Orthopaedic Research
From the outside to the population at large, trauma and orthopaedic research is not as emotive a topic as say Cancer. Although when we look at the numbers, Cancer affects around 1 in 5 of the UK population. For Orthopaedics, 1 in 2 of us in the UK is going to need the services of an orthopaedic surgeon at some point in our lives. One of the most cost-effective ways of funding our research is by approaching those people who have been directly or indirectly affected by the cause, our past patients. These people's lives have been changed so much, that they wish to show their appreciation in whatever way they can, usually financially. This is why The Orthocard™ scheme was introduced as a primary source of donor acquisition for Joint Action. A legitimate way to obtain, hold and use patient contact data for charitable fundraising purposes.

One of my prime reasons for attending your meeting was to recruit more distributors for our Orthocard initiative, the free patient implant verification card that is given to all patients at point of discharge and assists them by:

Alert	the paramedic services in case of accidents
Inform	GP's or Dentists concerned with Antibiotic Prophylaxis
Assist	Airport security staff to facilitate passage through security checkpoints
Indicate	An easy point of reference for any future revision work for patient notes

Orthocard Distributors as a result of the BHS meeting in Sheffield
Dr Gray's Hospital, Perth Royal Infirmary, Ashford & St Peter's NHS Trust, University College Hospital, Mount Vernon Hospital, Medway Hospital, The Queen Elizabeth The Queen Mother Hospital, Queens Hospital, University Hospital of South Manchester, Nuffield Hospital Hampshire, The Harrogate District Hospital, Craigavon Area Hospital, Scunthorpe General Hospital, Chichester Hospital, University Hospital Aintree Hospitals NHS Trust, Addenbrookes Hospital, Basildon Hospital, Shepton Mallet Treatment Centre, Chapel Allerton Hospital Orthopaedic Centre, Crosshouse Hospital, Southampton General Hospital, Warrington & Halton Hospitals NHS Foundation Trust, Nuffield Health Hospital, Leeds, Countess of Chester NHS Foundation Trust, Freeman Hospital, The William Harvey Hospital, Gloucestershire Royal Hospital, Sunderland Royal Hospital, The Glenfield Hospital, Manchester Royal Infirmary, BMI Cavell Hospital, Northampton General hospital, Calderdale and Huddersfield NHS Trust, Woodend Hospital, Westshore Medical, Ipswich Hospital NHS Trust, Southern General Hospital, The Cumberland Infirmary, St George's Healthcare NHS Trust, Northern General Hospital, Thornbury Hospital, Wrightington Hospital, Royal Derwent and Exeter NHS Trust, Royal Bolton Hospital, RNOH Stanmore, West Suffolk Hospital, Norfolk and Norwich University Hospital, Chesterfield Royal Hospital NHS Foundation Trust, Trafford Healthcare NHS Trust, Royal Hampshire County Hospital, Northumbria Healthcare NHS Foundations Trust, Eastbourne District General Hospital, Wirral University Teaching Hospital, Royal Blackburn Hospital, Southport NHS Trust, Spire Bushey, Royal Cornwall Hospitals Trust, Ormskirk District General, Hospital, Yeovil District Hospital NHS Foundation Trust, Gwynedd Hospital N H S Trust.

If you don't see your name on the list above and wish to become a distributor of the Orthocard™, then contact Peter Foy at the BOA secretariat for more details. 0207 405 6507

TREASURERS REPORT – MR JOHN NOLAN

The BHS finances remain in good shape. Income has increased slowly as the membership of the society continues to expand. A profit was realised at last year's BHS meeting in Manchester and the surplus funds have enabled the BHS to maintain its commitment to fund both European and American travelling fellowships for members of the society as well as to hosting Travelling Hip Fellows from America every two years.

A change in corporate tax regulation has meant that the BHS has had to consider applying for charitable status and the membership approved moves towards the change of status, at the AGM in Sheffield in March, when details of the full annual accounts were reported.

BHS Meeting in Torbay. March 2-4th 2011

We are pleased to formally confirm that the 2011 British Hip Society Annual Meeting will be taking place at the Riviera International Conference Centre (RICC), Torquay from 2nd - 4th March 2011. Why not arrange for your family to come down and explore the South-West after the meeting?

The RICC is centrally located with many hotels nearby within walking distance. Full details on all accommodation options will be available once we go live with the online registration system, in September 2010 - further details will be sent to you in due course. The final date for submission of abstracts will be 30th November 2010 and successful authors will be informed by 31st December 2010.

Topics in focus:

1. Management and Recommendations for Long Term Follow Up – Organiser/ Chairman Gordon Bannister.
2. Periprosthetic Fractures – Organisers/Chairman Andy Hamer and Fares Haddad

3. Impaction bone grafting esp. in the treatment of periarticular acetabular lysis

At the Annual General Meeting the Executive positions open fro election will be decided by the votes of the membership. In addition important changes to the BHS Constitution will be discussed and voted upon. Make sure you are there so that your views can be aired!

***Please Note*:** The annual meeting of the BHS is becoming increasingly popular as the membership expands. Unfortunately a large number of delegates are registering on site and this is causing significant administrative problems when booking venues etc. To encourage members to register early there will be a deadline for early Registration and payment of the advertised registration fee. Members who register on-site or two weeks prior to the meeting will be required to pay a 50% supplement by cheque at the time of registration. Please book as soon as you know you can attend the meeting!

BHS WEBSITE – REPORT FROM FARES HADDAD

The BHS website has remained in its current format since 2006. Over this time, a member's area has been created and I am glad to report that we have 120 members registered for access; we want more members to access it however. With the help of Nic Wardle who is an expert in this area, we are planning some enhancements in the coming year.

The content is currently relatively limited but I would like suggestions on what members would like to see in this area. There is also a forum which does not get much use, and I would like members' views as to whether they wish it to remain.

Annual Meeting registration is our area of focus for this year and we plan to make online registration a feature. Our plan is to use Paypal to enable users to pay for the meeting; its use could also be extended to paying for subscriptions if this was felt desirable by the membership and the executive. We hope to hear from the membership would be useful to determine whether an online submission system for abstracts would be welcomed and if the current format of the website is meeting the expectations of all those that visit it.

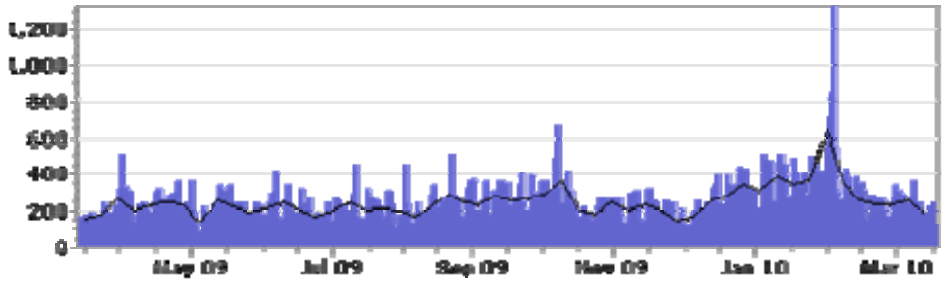


Chart of number of hits the website sustained in the last year

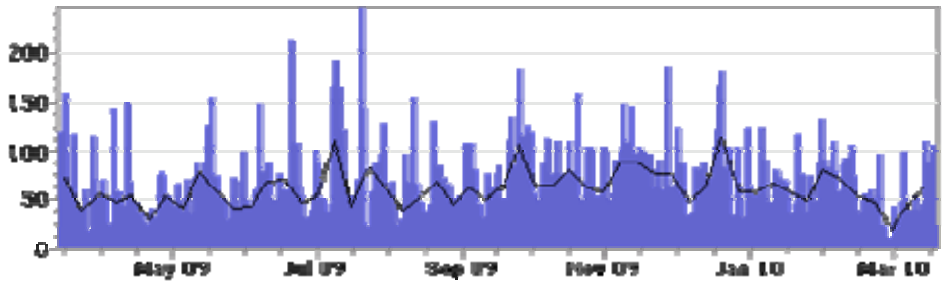
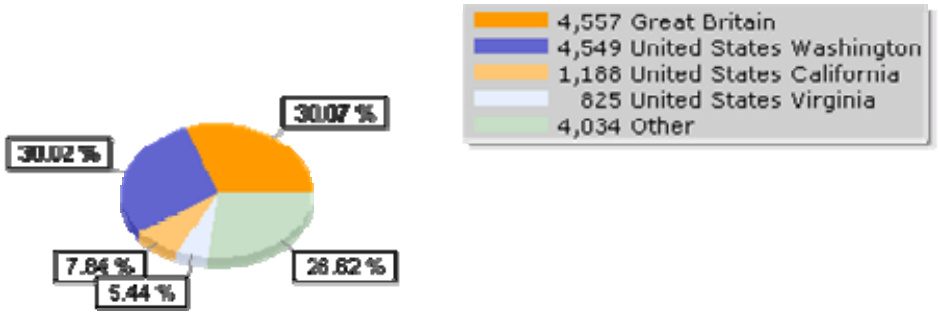


Chart of how long the sessions (time spent on site) lasted (average in seconds) in the last year

It can be seen from the statistical analysis of the site that we are accessed fairly consistently throughout the year – with the obvious spike of activity around the annual conference run up. Bandwidth has never been an issue and to date I haven't been made aware of any technical issues with accessing the site. Our web hosts provide significant redundancy and load balancing to prevent these issues, and our package can be extended to allow streaming media (at a further cost) if this was wanted.
We are also attracting an encouraging spectatorship from around the world as can be seen in the graph below:



Pie chart depicting location (and number of sessions) of access in the last year (April '09 to April '10)

In this time of instant access and "on the go" websurfing via smartphones I hope that the website can be adapted to improve members access to the society and maintain contact and education between our members and visitors to the site.
Email contact is becoming by far the most convenient and reliable method of keeping our members up to date, and if the whole society could be encouraged to register with the members area then facilitating this would be much easier.
I plan to send out a short questionnaire asking for the membership's opinion on the points raised above and asking for any further suggestions.

FIPO – REPORT FROM FARES HADDAD

THE BHS continues to work closely with FIPO (The Federation of Independent Practitioner Organisations) which is a medical organisation

representing the majority of the medical professional's organisations in Britain that have private practice committees. FIPO was formed in 2000 to provide an overarching body for the many specialist and other medical committees acting on behalf of the profession in the independent sector. FIPO will thus provide guidance, policies and co-ordination to these medical organisations.

Many members have recently been concerned by attempts by insurance companies to fix fees, divert patients and restrict approval for newly appointed consultants. A survey has recently been sent out to most of you in order to gauge the scale of the problem. For example, many consultants have received a letter from PPP suggesting that they should comply with a new fixed fee schedule issued by PPP and which is similar if not exactly the same as the schedule enforced on newly appointed consultants for the last 18 months or longer. Broadly speaking the fee reimbursements are lower than current BUPA and other insurance rates. FIPO is currently estimating the number of consultants who have been approached by AXA PPP and it appears to be between 18 - 20%.

The letter sent to these consultants' states that they should give patients an estimate of their potential fees and FIPO would agree that this is appropriate. However, there is also the implication that PPP will make patients aware of their potential shortfall which will, of course, be increased if the consultant fails to agree to charge at this new low rate of fees as the reimbursements to the patients will fall under this new schedule if they insist on seeing this consultant of their choice.

Consultants are concerned that this will penalise some patients and at the same time they do not wish to break the traditional contract they have with the patients who are ultimately responsible for their own fees.
Consultants are also concerned that patients may be diverted to alternative specialists at preauthorisation. This may not always be clinically appropriate and it may destroy continuity of care as patients are diverted from consultants who have treated them previously.

Anaesthetists are being targeted as well and so there is a threat that clinical teams (surgeon and anaesthetist) may be broken.

All professional bodies have made it clear that patients should have the right to see the consultant of their choice and that they should not be diverted for any reason by the insurer. We hope that these types of restrictive networks do not take root because if they do then continuity of care and choice for GPs and patient will be significantly restricted.
There are thus many implications to such initiatives and FIPO has responded by issuing a guidance letter to all consultants, and some guidance to GPs who may not be aware that their referrals are being diverted. You can find out more at info@fipo.org.

Metal On Metal Hip Replacement and Hip Resurfacing Arthroplasty :
What does the MHRA Medical Device Alert mean?
–LETTER FROM JOHN SKINNER, GRAHAM GIE and PETER KAY

You will be aware that the MHRA (Medical and Healthcare Related Devices Agency) has been investigating the incidence of adverse events associated with metal on metal (MOM) hips. An Expert Advisory Group was set up to investigate the incidence and extent of problems and to establish guidelines that would help and advise surgeons and patients. The clinicians on the group are all members of the Hip Society and include John Skinner, Martyn Porter, Keith Tucker, Paul Gregg and Peter Kay. The NJR, BOA and MHRA were all represented and Jan van der Meulen acted as statistical adviser. The NJR was used to find cases of revision of MOM and HRA . A report has now been submitted to the MHRA and the MHRA has released a Medical Device Alert for all MOM bearings.

The key points are that excellent results are reported with MOM hip resurfacing arthroplasty (HRA) and THR from many centres. It is accepted that MOM bearings have a higher incidence of painful joints. There are a small but significant number of patients who develop pain and significant tissue damage.

It is felt that pain with MOM bearings should be investigated as we are still uncertain which patients are likely to progress or develop serious soft tissue reactions. These reactions (variously referred to as ALVAL, Pseudo tumour, effusions, bursae ,tissue necrosis and ARMD (adverse reaction to metal debris)) are rare and probably have an incidence of somewhere between 1 and 9 per thousand devices implanted. It is possible that the incidence is higher in some areas and more frequent with some devices than others. The MHRA feel that there is insufficient evidence to highlight one particular device at this stage and it is fair to say that adverse reactions have been reported with all MoM devices.

The advice on a practical level is straight forward and probably just represents best practice for patients by their surgeons. It is likely that there will be media interest as the MHRA is briefing the press and that there will be a high level of enquiry by patients to trusts, hospitals and surgeons.

As the advice stands it does not constitute a formal recall of all patients. It means that all patients should probably be contacted by letter and told of the Alert. Patients can be reassured that in the absence of pain or symptoms, the serious soft tissue reactions/tissue necrosis are rare.

If patients are anxious then they may be offered a blood test to measure cobalt and chromium levels. The main purpose of this is that low levels are reassuring and strongly predict not having an adverse outcome or soft tissue reaction. Slightly elevated levels or very high levels are less certainly understood but probably correlate with high wear at the bearing. Ultimately in the presence of pain, high cup inclination angle and elevated metal ions then revision should be considered. It can be argued that in the presence of pain and high inclination angles revision should be considered anyway.

It is likely that Cobalt and Chromium levels may be useful for screening but they are not well understood at present. High levels may start as low as 7 ppb for either metal. High levels have a higher correlation with revision, pain and soft tissue reactions, but the correlation is not absolute in the short term. It may be that longer follow up will clarify this.

The alert mandates follow up at least annually, for the first five years and then as per locally agreed protocol thereafter. It may be that life-long review is appropriate for

some components. Not all patients will require in person follow up. It may be that postal questionnaire or phone call is all that is required in asymptomatic stable joints and those with proven provenance. Patients should be warned to contact the surgeon/ hospital if symptoms change or function or hip scores deteriorate.
All revisions should be documented in the NJR and several centres are happy to analyse the implant for cause of failure.
It should be noted that there are several other causes of failure including impingement, psoas/adductor tendonitis, failure of fixation of components, femoral neck fracture or resorption/AVN, neurological, referred pain from spine, sacrum or adnexae, hernia. These are not generally associated with the soft tissue reactions that have triggered the MHRA intervention.
It seems that we as the Orthopaedic Profession will be called on to reassure investigate and manage the patients through this difficult time. We believe that there remains uncertainty as to the incidence of this problem and that although fluid collections around these implants may be common, severe reactions are thankfully rare. If they occur, the surgery may be complex as the soft tissue damage reported can be severe.
Pain in patients with mom bearings should be investigated and if it is associated with features such as high component inclination angles, high metal ion levels, soft tissue reactions then this should be taken seriously. It does seem to be a progressive condition and early revision in selected cases may be sensible.
It will be a long time before we know whether this is an overreaction but we all agree that patient safety is paramount. In the current climate of uncertainty the advice to follow up our patients seems sensible and may even facilitate good practice with PCT/Insurance company support.

Details of Blood collection techniques:

Measuring cobalt and chromium Ions

Chromium and cobalt and other metals present in surgical implants are usually measured by inductively coupled plasma mass spectrometry (ICPMS) using either quadruple (QICPMS) or high resolution mass spectrometry (HR-ICPMS). Both are capable of accurate analysis, but only HR-ICPMS instruments will allow the measurement of some other metal ions such as titanium and nickel. Electro thermal atomisation atomic absorption spectrometry may also be used, but is less common now in the leading trace element analysis laboratories.

Blood samples for trace element analysis must be collected in trace element free tubes. Tubes are available with either EDTA anticoagulant for the analysis of whole blood samples or with no additive for the analysis of serum samples. There is a small difference in results obtained from whole blood and serum, but both can be used to assess release of metals from implants. The primary advantage of whole blood for the surgeon is that samples can be sent to the laboratory without the need for separation of serum, a step which may allow potential for sample contamination. Some laboratories may advise against the use of stainless steel needles for sample collection, but the

amount of contamination introduced via this route is usually low relative to the amount of chromium and cobalt released from high wear joints.

Synovial fluid samples should be collected into the same blood collection tubes or into sterile plastic ‘universal’ containers. Urine samples should be random collections voided directly into a plastic universal container, although in rare circumstances a timed 24-hour collection may be appropriate. In this case the laboratory should be contacted for advice before sample collection is commenced. In all circumstances glass and metal-containing containers must be avoided.

Trace element assays are available from the Supra-Regional Trace Element laboratories. In all cases the samples must be referred to the analytical laboratory via the local clinical biochemistry laboratory. Most laboratories will be unable to accept referrals from individual surgeons. All laboratories use QICPMS. HR-ICPMS is also available at London (Imperial College).

All laboratories participate in the national QC programme TEQAS, run from the School of Molecular and Biomedical Sciences, University of Surrey. This includes assessment of chromium and cobalt. Most laboratories will also participate in other international EQA schemes.

SAS Trace Element Laboratories

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Guildford Trace Element Laboratory Centre for Clinical Science School of Biological Sciences University of Surrey GUILDFORD GU2 7XH Tel:+44 (0)1483 689978 Fax:+44 (0)1483 689979 Director: Dr A Taylor Deputy Director: Dr C Harrington	Southampton Trace Element Unit Division of Laboratory Medicine Southampton University Hospitals NHS Trust Mail Point 804 Southampton General Hospital Tremona Road SOUTHAMPTON SO16 6YD Director: Dr V Walker Tel: (0)23 8079 6419(Office), +44 (0)23 8079 (Laboratory) Fax: +44 (0)23 8079 6339
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NICE guidelines on VTE prophylaxis

JBJS EDITORIAL: NICE and venous thromboembolism by Rober Atkins.

The original guidance issued by the National Institute for Health and Clinical Excellence (NICE) concerning venous thromboembolism (VTE) and surgical patients in 2007,1 caused concern among orthopaedic surgeons. In this issue, Treasure et al2 outline the efforts made by NICE to address our concerns. This involved recruiting an orthopaedic advisory group which was approved by the Council of the British Orthopaedic Association (BOA).

The group was heeded by NICE and they have changed the guidance. As "those who cannot remember the past are condemned to repeat it",3 we should reflect on the errors of process which caused the problems with the initial guidance. In so doing, we must include the House of Commons Select Committee Report 2004- 20054 which led up to the guidance from NICE.

Firstly, there was an inflation of the problem in relation to orthopaedic surgery. The Office of National Statistics recorded that, in 2008, pulmonary embolism was the primary cause of death in 3047 cases.5 Treasure et al2 quote a figure of 25 000, and reference the Select Committee Report.4 However, that document offers no primary reference and the high figure is an estimate of total population deaths derived from modelling exercises6 (Cohen AT, personal communication 2010). As Treasure et al2 agree, this is not an orthopaedic problem. Also, as admitted by Treasure et al,2 there was concern that historical data might overestimate the rates of VTE today, due to profound changes in anaesthetic and orthopaedic practice, driven by the determination of the orthopaedic community to minimise problems from VTE.

Secondly, asymptomatic and symptomatic calf-vein thromboses were often conflated, a problem seen throughout the haematological literature. The latter may carry a high risk of a post phlebitic limb,7 while the former may be benign.8 The new guidance from NICE rightly states that the clinical importance of asymptomatic calf-vein thrombosis must be investigated.9

Thirdly, there was an assumption of a linear relationship between the rates of asymptomatic calf-vein thrombosis and symptomatic events. The evidence shows a clear historical association between reduction both of the rate of asymptomatic calf-vein thrombosis and of symptomatic events.10,11 To extend this to a linear relationship is mathematically naive, since it attaches importance to the ability to draw a straight line through two points. To further assume a relationship of precise proportionality is probably erroneous and certainly contrary to logic in lower limb orthopaedic surgery because it implies that pulmonary embolism arises only from a venous thrombosis which develops in the calf and extends proximally. This ignores the contribution of primary damage to the proximal femoral veins due to manipulation of the limb in hip surgery or as a result of tourniquet trauma.

Finally, the original guidance1 combined clinical groups in which orthopaedic surgeons would intuitively believe that the risk of VTE would differ and it merged results from passive and active mechanical methods of prophylaxis.

As Treasure et al2 correctly point out, orthopaedic surgeons are very conscious of the risks of VTE and the lack of intellectual rigour described above reduced the confidence of orthopaedic surgeons in the original guidance.

This confidence was most severely damaged by the tacit assumption that low-molecular- weight heparin (LMWH) was not associated with bleeding complications since none was noted in prospective studies. The contrary clinical experience has been

reported12 but it is easy to criticise the methodology of a postal survey. Nevertheless, when 95% of surgeons report bleeding problems with LMWH of such severity that 50% abandon it, this expert opinion should be given significant weight, particularly when the study was organised by one of the members of the THRiFT group, upon whose opinion the thrombologists rely heavily.13 This decision to downgrade specialist opinion is surprising, since NICE, in my experience, goes to great lengths to capture specialist opinion and balance it against level one evidence. Treasure et al2 assure us that this matter is accounted for in the modelling of the new guidance. Professional concerns were weighed lightly due to "perception bias".4 The suggestion is made that orthopaedic surgeons would not know if the patient suffers a thrombotic complication and would be less concerned with this than with bleeding. By accepting these assertions, those originally chosen to represent orthopaedic surgery failed in their duty. The reality is that orthopaedic patients are followed up until the risk of VTE has passed and the surgeon will be aware of such problems. Clinicians are just as concerned and responsible if a patient has either a thromboembolism or a bleeding complication and they try to balance the risks.

Conversely, haematologists and chest physicians can be accused of perception bias. They do not see the large majority of orthopaedic patients who escape significant VTE and they are not competent to comment on the side effects of prophylaxis. This bias is likely to be greatest for intensivists or chest surgeons who are only involved in rare, life- threatening problems. If applied correctly, perception bias implies that VTE prophylaxis must be led by the specialist orthopaedic surgeons who will have responsibility for the entire therapeutic journey of patients. There would therefore be no place for haematologists, general surgeons or chest physicians to guide orthopaedic practice.

Our lesson is in the 1997 postal survey.12 Then orthopaedic surgeons recognised a problem with LMWH and reacted by modifying practice. This was their prerogative as independent practitioners. Today, the regulatory framework is different. The government has put in place systems which direct our practice. The BOA has been slow to react and in future, must have stronger oversight of those speaking on its behalf. Whoever represents the BOA to NICE must report directly to the executive. NICE has not been faultless with respect to orthopaedic surgery and its worst moment arguably was the production of guidance on osteoarthritis without an orthopaedic surgeon on the development group.14 My belief is that both NICE and the orthopaedic community have learned that their mutual isolationism is unproductive. I think the new VTE guidance is workable. It requires risk assessment to determine the method of prophylaxis. In patients at risk, this would range from active mechanical methods where the risk of bleeding outweighs the benefits of chemical prophylaxis, to a combined regime in the cases at highest risk. Prophylaxis should continue as long as a risk analysis justifies it. NICE advocates serial risk assessments and careful monitoring of adverse events. These will be time consuming and expensive but if the very active policy advocated by NICE is to be safe, the expense must be borne. There is a considerable amount of work to be done. The specialist societies must produce the risk assessments, for only they will have the direct knowledge to do so. The NICE guidance ought to ensure that orthopaedic surgeons are at last given all the tools to combat VTE in orthopaedic surgery.

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What does the NICE guidance mean practically in THR?

- The key to using the guidance is to carry out a **risk assessment** and **discuss the risks** with all patients.
- ***Clearly document the assessment, and the options discussed for every case*.** This could be on a proforma with the consent form.
- High risk patients should be offered chemical prophylaxis for a minimum of 4 weeks.
- Routine cases with no extra risk factors should be counseled about the balance of risk:
    - i.e. The relative risk reduction for VTE phenomenon is 0.8 if chemical prophylaxis is prescribed. However, this is offset by an increased risk of stroke or GI bleed of 1.56.
    - the available data quoted to assess risk after THR is outdated and based on 10-14 days of hospital stay.
    - Chemical prophylaxis will reduce the rate of asymptomatic DVT but will increase the rate of symptomatic bleeds.
- If, on the basis of the information given, the patient decides against chemical prophylaxis document this and detail the routine prophylactic measures agreed on your Unit: e.g. early mobilization, Footpumps, TED stockings, Aspirin.
- **It is good practice to allow the informed patient to decide upon their treatment as it carries risk. It is not enucumbent on you to prescribe chemical thromboprophylaxis if these steps are followed with adequate documentation.**
- It is important that a risk assessment is carried out every 48 hours. If the risk changes (e.g.complication leading to bed rest), them chemical prophylaxis should be considered again.

VTE Prophylaxis - Risk stratification in hip arthroplasty – Graham Gie

Risk/benefit profile for hip surgery, to include primary & revision thr, pelvic & proximal femoral osteotomies & open hip debridement surgery

General risk factors for use of pharmacological prophylaxis (PP)
Use of drugs which interact with pharmacological prophylaxis, such as nsaid's, aspirin, clopidogrel.

General risk factors for the use of mechanical methods
These are poor or insensate skin.

Risk factors for population undergoing procedure:
The general risk factors
Surgery on the hip joint with a total anaesthetic and surgical time > 60 minutes
Active malignancy or cancer therapy including chemotherapy and radiotherapy
Personal history of VTE
Inherited Thrombophilia
First degree relative with a history of VTE
Obesity (BMI>30Kg/m2)

Pre-existing illness: cardiac/respiratory/metabolic/endocrine/inflammatory disorders
Varicose veins with Phlebitis

Factors reducing risk for the procedures:
Young age

Specific VTE risk for procedures above
Moderate to high

Duration of risk
4 to 6 weeks

Risk factors for use of chemical thromboprophylaxis:
The risks in total hip replacement are of poor wound healing, oozing and consequent infection. Deep infection has devastating consequences, requiring further surgery (often 2 or more further operations), increased mortality risk & long-term patient dissatisfaction with outcome of the surgery.
Poor wound healing / wound ooze may delay mobilisation, which in turn may increase the risk of VTE.

Literature
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Risk benefit profile for arthroscopic hip surgery

The general risk factors
Surgery with a total anaesthetic and surgical time > 90 minutes
Active malignancy or cancer therapy including chemotherapy and radiotherapy
Personal history of VTE
Inherited Thrombophilia
First degree relative with a history of VTE
Obesity (BMI>30Kg/m2)
Pre-existing illness: cardiac/respiratory/metabolic/endocrine/inflammatory disorders
Varicose veins with Phlebitis

Specific VTE risk for the procedure:
Low

Duration of Risk
1 to 2 weeks

Risk factors for use of Chemical Thromboprphylaxis
Low

OTHER NEWS/Reminders:

Updates NICE Guidleines

Selection of prostheses for primary total hip replacement. Can be downloaded from:

http://www.nice.org.uk/guidance/index.jsp?action=byId&o=11386

Download the BHS Hip Replacement Booklet - A Guide For Patients compiled by Mr John Nolan, this provides a standardised source of information for your patients. Download at http://www.britishhipsociety.com/docs/BHS%20Hip%20Replacement%20Info%20Booklet.pdf

The Annual Evidence Update (AEU) on Hip Fracture was released on 27 July 2009 . The information from NHS Evidence can be found here: http://www.library.nhs.uk/trauma_orthopaedics/viewResource.aspx?resid=321130&code=a0fec8a401901685acf0a5ebcac46a26

National joint Registry:

The National Joint Registry needs your feedback. Please let us know what you think of the latest report and in particular what you want out of future NJR report. We look forward to hearing from you as soon as possible. Email: jtimperley@mac.com

The following to statements were unanimously approved by the membership of the British hip Society at the last annual meeting in Manchester 2009:

"The British Hip Society considers it mandatory that all surgeons undertaking primary and revision hip arthroplasty in England, Wales and Northern Ireland must try to ensure patient consent and enter full data on the National Joint Registry"

"Poor compliance with the consenting process should be considered as an indicator of poor performance"

John Timperley
Hon Secretary BHS
July 2010

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