

**BROADCAST TRANSCRIPT** 

# 396 - Hip Surgery

# With Steven Bruce and Mr Jonathan Hutt

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## Steven Bruce 00:00

Good afternoon. Welcome to today's lunchtime learning. We're actually going to talk about the hip, and I have Mr. Jonathan Hutt joining me to bring us up to date on a whole range of issues. Jonathan, being a consultant orthopaedic surgeon who specializes in the hip, also closely involved in innovative techniques and in advanced joint preservation. So Jonathan, good afternoon to you. Thank you for joining us.

## Jonathan Hutt 01:32

Good afternoon. Thanks very much for having me.

# Steven Bruce 01:36

well, I'm taken by the pictures of, I think the late Queen on the wall behind you. Were your personal friend.

## Jonathan Hutt 01:42

Sadly, I can't claim responsibility for the pictures behind me, but I do actually get asked, for those who recognize it, that's obviously polo going on behind me. I do get asked if I play polo or treat a lot of polo players, and only one of those is true. But it turns out that riding horses in the way that they do to play polo isn't actually particularly good for your hip joints,

## Steven Bruce 02:00

Okay. Well, my wife's a great horse rider, but fortunately, doesn't play polo, so she might survive a bit longer. You're obviously at the forefront of everything to do with the hip given the amount that you lecture and the fact that you're involved in innovation and so on. What are the current trends in hip surgery? Are you seeing more hip replacements needed, or fewer?

## Jonathan Hutt 02:24

Interesting question then. I mean, I think probably if I give you a brief overview of my practice, it is a little bit more unusual. So half of my practice is what we term hip preservation surgery, and I'm sure we'll discuss a little bit more about that, and that's really non arthritic hip conditions. The other half is in is in hip replacement. But as a result of that, my hip replacement patient is obviously very slightly in age compared to what you might expect. So, I treat a lot of younger patients, including teenagers who need hip replacement surgery. So you've got that end of the spectrum and versus, you know what most people will have in their hip practice, which is the normal sort of aging population and general degeneration in

the hip I think that, I think there's a couple of things about that. I mean, I don't think I would say that we are seeing a higher level of conditions leading to people needing hip replacements, but I think we have an understanding now with modern hip replacement and new technology, really, the benefits that it can give are more predictable and have a greater longevity, and therefore it is reasonable to offer patients hip replacement at a different stage in their journey than you might have done say, 15-20, years ago, when you perhaps couldn't really rely on the implant to last as long. And perhaps the surgery wasn't quite as predictable at that point. So it's quite likely that we're doing more hip replacements as a result of both that in the growing population and possibly the growing aging population too.

## Steven Bruce 03:47

Yeah, that was going to be my follow up as if, as I imagined, the number of hip replacements has increased. What's the cause of that? I mean, is there an unhealthier population giving rise to the degeneration of the hip? Or, as I think you're intimating there, you've got younger people needing hip replacements because of the greater stresses being put on them. I don't know, maybe by professional sport or otherwise. How long do the hip replacements last? Because that used to be one of the concerns,

## Jonathan Hutt 04:13

I think again, that's a question that's quite difficult to answer with, full level of fact, because I think that modern generation implants and bearings have not been around for quite long enough for us to have that level of kind of feedback, predominantly from the registry data. But, perhaps a decade or more ago, you might have told patients that their hip replacements would only last, 10-15, years. I think I routinely tell patients that unless something intervenes, you can expect your initial implant to last for a good 25 years. And obviously within that when we say that point, we're not saying that everyone's hip replacement fails at that point, quite a significant proportion will obviously go on for much longer than that,

## Steven Bruce 04:54

And so your younger patients, what is a Younger patient for you these days, are we talking people in their 20s or older?

## Jonathan Hutt 05:03

I mean, the youngest hip replacements I've done in the last few years have been in a 12 year old. So, there are rare situations in which, you know what you might term pediatric or adolescent hip replacement is required. I mean, I'd stress, they're pretty rare. I mean, even in, my practice, we're talking about a handful during the year at most, I guess other age group would be more in that, 20s to 40s, where you might not expect, people to have problems which would lead to the need for hip replacement. Certainly it isn't by any means, numbers wise, as significant. But practice such as mine that does form a reasonable proportion of my workload,

# Steven Bruce 05:41

but presumably those people are the ones probably engaged in sport, possibly at a high level, who are putting much greater demands on that replacement. Does that mean that they might not reach the 25 year lifespan

## Jonathan Hutt 05:56

I get? I think in that category of patient, you've got a variety of different issues. I mean, mainly because of my work UCLH, I see a lot of patients who've been treated for young malignancy, and they'll have often developed a vascular necrosis of the hip due to the treatment. That's guite a big proportion, actually, of our patient load there. Then you've got the other proportion, perhaps with missed or not fully treated childhood hip disorders, who will obviously develop arthritis earlier in life, and then you've got, like you say, you do have a proportion of patients who have simple degenerative disease that gets them in earlier life for reasons that may or may not be related to the way they play sport and the way they move. I think it's guite an interesting guestion to suggest about whether the person's activity level actually really makes a difference to the longevity of their joint replacement. I actually a bit of a believer in that the more active you are on your joint replacement, the more likely you are to keep it for a long period of time, because you're not only then using the joint, but you're also using the muscular envelope and keeping that in good shape, you're loading the bone properly, so you're not going to be running into trouble from that perspective. And actually, I haven't looked through a lot of the literature recently for a chapter I wrote on this exact topic. actually, in a soon to be published book. And my general takeaway message was that the limitations on activity after hip replacement are largely placed by us on the patient, rather than based on real world data of what is happening. And again, with bearing surfaces really being far more reliable than they used to be, I don't think there's a logic in telling someone that you should be overly protective of your hip replacement over and above, maybe avoiding injury. And so I think that I have strange barriers that I still will tell patients, one of which is contact support, for example, not because of the replacement itself, but because of the unpredictability all the people around you,

## Steven Bruce 07:50

right? Yeah. So what then is, if that's the case, what is the general reason for revising a hip replacement?

## Jonathan Hutt 07:59

Well, I think again, that's changing. So, if you look at the reasons for, revision replacement, a decade ago, it was all bearing where osteolysis, so loss of bone from reaction to bearing where we then had a big space of, as you probably were aware of, metal on metal, hip replacement issues, which caused a similar problem from, reaction to debris generated from the bearing surface. But modern bearings, and I put these in the context of ceramic, ceramic, or, ceramic, what we might call modern polyethylene bearings, really shows very minimal levels of of wear. And so these aren't going to be the failure mechanisms that we see. So we tend to see two spike problems. So you would see an initial spike, perhaps from things such as dislocation, or, early fracture after hip replacement, which, you know may or may not be slightly more technique related. And then you will see another state of what I tend to tell my patients is, I don't think your hip replacement will fail, but you will perhaps start to fail around your hip replacement as you get older. So as your bone weakens, naturally, the implants might start to work themselves loose a little bit, or perhaps we're seeing a higher proportion, I think of revision surgery or redo surgery due to fracture. Again, as people get older, and I think, there is a higher propensity for that mechanism to kind of predominate. Again, it's also true that we don't really have a handle on what is going to be the predominant method of

failure, because you have to almost go 20-25, years post whatever stage you're at, in your in your implants, to figure that out.

# Steven Bruce 09:41

Yeah, I suppose that's slightly reassuring for a surgeon, because in 25 years on, maybe people won't be holding you responsible when the hip wears out.

# Jonathan Hutt 09:49

Well, maybe not. Unfortunately, due to rapidly raising retirement age, I'll probably still be here in 25 years.

# Steven Bruce 09:56

Yes, I suspect some people who go on the NHS waiting list now we'll still be waiting then as well. What is the waiting time like for hip replacement surgery?

# Jonathan Hutt 10:08

Well, I think it is quite geographical. I suspect on the people listening to this call in various different areas of the UK, for example, will have a very different experience if you turn up to your NHS hospital, and that, I think, is one of the great shames, really, I think, in certain areas. And I'd certainly count, our local area here in some of the other hospitals I used to work out in the South West, waiting times are in the good, sort of four to six months zone, from the moment you put on it till surgery, which is not that bad. It's perhaps not as ideal as you'd want it to be, but there are certainly parts of the UK where the wait is up to a year or more, and so there's still wide variation going on.

# Steven Bruce 10:51

I guess it's seldom regarded as being a life threatening condition, and people can wait, even if they have to wait in a fairly sedentary manner, then that's not the end of the world. As far as the prioritization, the triage of NHS patients is concerned,

# Jonathan Hutt 11:10

I suppose, if you were to put it up against a number of other more critical conditions, that would probably be correct. I think, though, that, there's quite a lot of data that has come out, that actually does show that if you delay somebody's joint replacement significantly, you actually will impact their outcome. And there's no doubt going to be an element of defunction in their muscular envelope, and otherwise that contributes to that, I think that, there's also an understanding that actually, simple arthritis can be incredibly painful and incredibly distressing to live through. So whilst in theory, you can wait in terms of the operation, actually the sort of effect that has on you, sort of, from a physical mental health perspective, and also from an ultimate outcome is there, and so it still should remain a relatively pressing issue. Yeah,

# Steven Bruce 12:04

I suppose we ought to just have a quick look at why people should refer to you in the first place, or to another surgeon for hip replacement, and you know clinically whether we should be suggesting this earlier than perhaps we would have done in the past, and typically, a few

years ago, you wouldn't be told to go for replacement of anything unless it was so unbearably painful that you couldn't carry on.

# Jonathan Hutt 12:31

I think there's definitely a changing threshold. I think that has to be sensibly put into the context of what might be normal non operative management of hip arthritis. And so there's a couple of things that come into that. I mean, obviously, there's the longevity of the symptoms, there's the severity of the symptoms, there's the overall effect on that patient's function and quality of life. And ultimately, that's the driver for any form of intervention, no matter what it would be, and it isn't logical to jump too many steps in the ladder. But equally, I think it's not also logical to keep going at something that isn't providing, the potential benefits that you might hope for. So I guess what I'd say to people on that perspective is it's clearly, if I see somebody in that situation, an it's unusual in private practice, you might see somebody who hasn't seen anyone else for their arthritis and had any treatment at all, really, and I would certainly not going to suggest immediate surgery for the vast majority of those patients. So it's really about educating them about the process and then usually packaging them off for a period of physiotherapy style interventions, relatively mild pain relief and so on and so forth. I guess there is a number of factors that I would bring into all of that. And, I think that both talking from an age perspective, a bit like we were just discussing. I think often I find that in the wider world that doesn't have such a narrow practice focus that I do. that people are still wary of offering joint replacements to younger patients, even in the setting of relatively significant pain and dysfunction. And I think that's definitely something that we need to debunk to a certain extent, because hip replacement, isn't an age related operation. It's a kind of symptom and function related operation. The same balance of judgment will apply whether you're 20 or 70. I mean, obviously there are potential consequences to having joint replacement at a younger age, and that has to come into the conversation, but it certainly shouldn't be a barrier to it either. And then I guess it's just about, understanding what that patient is going through and whether you're making progress. I think that's the key point. if you're if your patient is managing to do the things they want to do with minimal amounts of pain and discomfort, there isn't a huge rush to do much about that, because, they can carry on doing that for as long as they like. Right? But if they're finding that they are being progressively more limited, and you know that may be slightly different for patients in their 40s or 50s than a patient in their 70s or 80s, you know they are having to, make their life smaller and make their activities less as a result of significant hip pain, then, and it isn't getting better, and this isn't manageable with non operative features, then it is worth a discussion about whether now is the time to consider more invasive procedures, if you like. Because, we know the outcomes from hip replacement are really good. We know we can get people back to doing high levels of activity for long periods of time. And I often find myself in conversation with my younger patients, saying it's not logical to me that you must suffer significant pain during your young life when you've got family commitments, social commitments, you're working hard just to have a hip replacement when you retire. we need to be getting these people back to doing the things we want to do within reason.

# Steven Bruce 15:57

it's a little bit of a challenge, though, isn't it, because if we're talking about degenerative problems leading to hip replacement, that degeneration takes place slowly and progressively

over time, and people lose track of the function that they've lost over that time, and maybe they'd be better off complaining about things as soon as it became difficult to walk the 10 miles that they've been Doing previously per day, or whatever it might be, and maybe that's education that we need to be bringing into our own practice as physical therapists here.

# Jonathan Hutt 16:29

Yeah, I think, I think there's a healthy middle ground there. Isn't there, because the other thing I stress to my patients, regardless of the operation and what I'm treating, is, we're trying to look at what I think I can actually improve. And certainly, if you're talking about someone for whom removing their pain will only give them a marginal gain in terms of their life, then obviously that feels not enough for hip replacement. But equally, you shouldn't be so dysfunctioned by your hip that you can't do anything before we consider it. So somewhere in the middle is that kind of conversation, and it is a very personal conversation. I think patients react differently to it, and whether they have that conversation with me or with one of the therapists, it doesn't really matter. We should all be talking about it in the same way.

# Steven Bruce 17:12

How accurately do you think you're able to predict the success of any individual's hip surgery?

# Jonathan Hutt 17:21

Again, I think if we're just talking about hip replacement, I think you can, in a situation where you've got clear hip symptoms, clear radiology findings, and you can then predict, I think, with reasonable efficiency, most of vast majority of those patients will get the pain relief they need after surgery in the absence of a complicating factor. And I think that's probably what is going to cause a poorer outcome. We don't see quite as much, if you like, technically well done surgery in hip replacement that doesn't have the outcome you'd expect. You might see that in knee replacement surgery a little bit more, for example, we don't tend to see that to quite the same level in hip replacement surgery, although clearly it does occur from time to time, right?

# Steven Bruce 18:14

And what about the non degenerative reasons for hip replacement? What was the problem with the 12 year old that you mentioned earlier on? What were you looking for there? And again, I'm thinking this in the context of my colleagues, the people watching when they get somebody of that age who might present to them thinking, this is a simple physical therapy problem, when actually there's something more serious underlying.

# Jonathan Hutt 18:35

Yeah, I mean that, and that's a good point. And I think that when I talk to therapists about hip problems in young patients. I often stress that early and simple imaging can be extremely helpful in really delineating what the underlying problem is, even if it doesn't necessarily deviate them from whatever treatment pathway they're following. So I mean, I would argue, I mean, the patient I was talking about actually had bilateral hip dysplasia as a young baby, and attempted treatment, which hadn't worked and had led to a vascular necrosis with both hips, and she was extremely disabled by it. So you know that that was the reason, in her

case, to her so often, the much younger patients do have a history of either structural disorders of the hip that can be systemic, or childhood hip problems such as per phase or Sufi or things like that, which can intervene. But it's also true that there are some young hip disorders which are worth picking up early because they have consequence. And I see and treat a lot of what I might term adolescent and young adult hip dysplasia, which is, I think, a slightly different phenomenon from what you might pick up at birth that can lead to quite significant hip pain and early arthritis and is worthy of early investigation in the setting where the symptoms aren't set. As you might expect, there's a long tradition of non arthritic hip problems being treated as groin strains or similar, for a long time, because I think not just amongst, obviously GPs and therapists, also amongst orthopaedic surgeons who don't treat it very often, a lack of recognition of the potential underlying anatomical anomalies. And so part of my role is not only if patients are sent to me, it isn't the case that I will then offer them surgery. I will often investigate them, try and understand the underlying biomechanics if they think they're relevant, and then often package that patient's problem up in a slightly different way to go back to the therapist, because not every hip problem will need the same approach. And sometimes you understanding whether there is instability in the hip, such as dysplasia or, for example, impingement, which is perhaps a more recognized phenomenon amongst amongst the listeners, there is a very different approach to those sorts of things I'm sure that they would take and therefore understanding what's going on will help everyone in their treatment pathway.

# Steven Bruce 21:04

Hannah has just sent in a question, following up on your comments about the effects of delaying surgery. She's interested to know if there's, if there's a source that she could go to to find out more about specifics in that regard,

## Jonathan Hutt 21:21

I couldn't quickly the literature sitting here, but I can certainly look up there's a bit of two or three relevant papers published on that fact that I can certainly dig out and pass on.

## Steven Bruce 21:31

That would be helpful. As I said to you earlier on, before we went on air, I'll send out an email either later today or tomorrow, with any reference information as well as your contact details for those who might want to refer to you, if you can, that will be great. Thank you. We got a few other specific questions coming in here as well. Natalie has got a particular problem. She says, Do you have any suggestions about how a patient can facilitate the MSK triage? Because in her area, patients seem not to be progressing to get onto any waiting list at all, despite severe levels of pain and restricted mobility, is that something you've seen across the board are GPs reluctant to refer onwards,

## Jonathan Hutt 22:11

I think it probably where she is is a reflection of a lot of changes that have happened in The UK, where MSK referral pathways tend to be deviated away from orthopaedic surgeons being a first point of contact from the GP. That's not a usual pathway. Certainly where we work, we have, a physio referral section, and I think it runs very differently in different regions. And I do think times that can become and I think it's not just necessarily an attitude problem. I think it's a logistics problem of moving people through the system in a sort of, a

way that seems logical and potentially progressive, that people get stuck in that system a little bit without the opportunity to say, I've been sent here, may have been investigated. We've tried some non operative management. I now need to go and, see what else I can do about it, but they seem to get stuck at that point. So there are definitely bottlenecks in the in the process.

## Steven Bruce 23:08

I think, I hope, I hope these problems are less than I imagine, but I think the audience would support me in saying that there's a perceived resistance on the part of GPs to act on requests or suggestions by osteopaths and chiropractors. We're seen as being outside the system, and I suspect a lot of GPs have no idea of the level of training that osteopaths and chiropractors go through, and that's certainly not true of all of them, and it's not a criticism of GPs, More about what they're told about us. Are there criteria, NHS guidelines, which say under these circumstances they should be this patient should be referred for an orthopaedic consultation.

## Jonathan Hutt 23:55

I'm not aware of what I would call strict guidance in each particular situation, just thinking through my patients. But I guess I mean, I would certainly follow what I might describe as a logical progression. So, short term symptoms very rarely need to see you know me, initially, I'm not going to be able. I'm not going to make decisions on short term symptoms. I think you look for significant, either progressive symptoms or symptoms aren't responding to other forms of treatment that you might expect to get better in a period of time. If you're finding that your patients are in that zone, then that really should be an indicator, certainly for more investigation and potentially for onward referral. Now, I think it depends on which systems you work in in the UK, how much freedom people have to do things themselves in terms of investigation, but that would be my usual onward referral, thought and like I said before, it doesn't necessarily mean that they're then going to go to a different pathway, but they then might come back with more information to everyone,

## Steven Bruce 24:58

I don't know if Natalie saw the show that we ran a few days ago, but one of the one of the things that came out of that show was that GPs, being as busy as they are, they quite like to be told what it is you want them to do, rather than asked for an opinion. And maybe it's helpful to say these are the factors that I'm taking into account. This is what I would need to screen this person with possible view to referral. And please, would they do that? Can I assume that x ray is your initial first screening tool?

## Jonathan Hutt 25:32

Always, I think X ray, when it's properly interpreted, gives you an absolute wealth of information, either in, obviously in arthritis, it just gives you the answer straight away. But in non arthritic hip disease, it also gives you an awful lot of information. The slight problem you might have with that is, particularly when you get X rays referred from primary care, you may then not get them seen by either an orthopaedic or a musculoskeletal radiologist who's got sufficient experience to pick up some of the subtler problems. And they often, for example, mild dysplasia might get reported as normal. And so again, that can be slight bottlenecks in the system that it's difficult to know how to how to overcome that, but I think, it's definitely

there. I would certainly agree that, it seems to be, move or was certainly to go via MRI as your first investigation. But whilst MRI is very helpful, it almost always shows up labral tears and things like that. It's not really the label tear that interests us. It's the mechanism behind it, and the MRI in its current form does not really provide much structural information to kind of hang your hat on in terms of the biomechanics.

## Steven Bruce 26:44

How difficult would it be for a physical therapist to gain enough knowledge to be able to look at an x ray and just form an opinion about those mild dysplasias you were talking about? We can be I'm not suggesting we can become radiologists overnight, of course, but

## Jonathan Hutt 27:03

When we discuss this with orthopaedic trainees, who will obviously be seeing a lot of patients through clinic, but may not have, again, lots of experience. it's not very difficult to point out a couple of particularly obvious areas that you can measure on an x ray that will give you a, broadly speaking, an idea about where they fit in the categories. And that will pick up a lot of things, pick up a lot of the mild pathology you miss if you don't look specifically for it. And again, we also encourage people, my hip colleagues, who don't treat the disorders and so on, to, obviously, engage in understanding of them. But also, if they are not seeing something or the patient is still in pain, to remember that hip pain in young patients is not a normal phenomenon, and it should always be investigated if it proves recalcitrant.

## Steven Bruce 27:53

I've got a couple of questions about hip replacement failure here, one from Robin, one from HG, Robin wants to know what the clinical findings we should look for in hip replacement patients, that would suggest to us that they ought to look for revision. And HG is being more specific. He says he's got a patient who had a new hip 15 years ago. It was a metal hip. The patient was called back regularly for tests to see if the prosthetic was shedding shards. Obviously, you mentioned that earlier on. What's the consequence of this failure? What do they need to look out for now? And I guess he's saying, Well, how serious could this be if there are shards that aren't picked up?

# Jonathan Hutt 28:38

Yeah, so probably, if I take those questions one at a time, I tell my patients at a year post op, I don't need to see you again for your hip replacement unless there's a problem, because you will know if there's a problem. In general now we have better bearing surfaces. You don't get this silent wear and silent bone osteolysis that we used to see. So really, your patient is going to be symptomatic if there's a problem. So they will generally have a recurrence of pain around the hip. They may start to develop symptoms of instability, of subluxation of the joint, if not frank dislocation, which is a pretty obvious sign that there might be a problem. And they may start to get bone overload symptomatic patient to present with a failing hip replacement with modern implants. And actually, even in the setting where people develop pain, quite often, it isn't the implant that's the cause of the pain. they may be getting due to various changes. as life goes on, they may be getting some muscular discomfort around around the joint instead, and that could normally be fairly simply sorted out with regards to

the sort of metal hip replacement problem. I think the important aspect is that these patients, do need to be monitored, not that regularly, but they do need to be investigated and monitored.

And the problems that you get related to the metal debris, if you like, and their body's reaction to the metal debris, more importantly, are really what leads to the issues. So the adverse reaction to metal debris, the AR MD (Adverse Reaction to Metal Debris) patient, you will get a variety of different things happening, but fundamentally, you're getting an inflammatory response that's causing damage to bone and soft tissue, and it can be very extreme. I mean, it can be, when in my previous job, when I worked in St George's, I did a lot of redo hip basal surgery. I did a little bit less of that now with the bulk of the other stuff that I do, but we saw a lot of those types of patients, and they can have extremely severe destruction of their muscular envelope and also of the bone surrounding their hip replacement, which can make both reconstruction and ultimate functional outcome, really very difficult to achieve a good a good outcome, which isn't said, of course, that it's inevitable in all metal hip replacements, and if the patient has been appropriately investigated with cross sectional imaging, really is the key one here. So we tend to test metal ion levels, but on their own, they're not necessarily that helpful. But in conjunction with soft tissue metal reduction 3d imaging, such as MRI, you can very clearly see if there are, so called pseudo tumors, which are like pockets of usually fluid or solid mix causing problems and destruction in either the bone or the soft tissue. And that's really more likely to be a trigger for, discussing redo surgery in the setting of symptoms.

# Steven Bruce 31:40

Perhaps we can move on to, I think, what is more your area of preference at the moment, which is joint preservation. Hannah's already asked about this. She's also getting fed up with me going down fox holes of my own. She wants to when it's appropriate, and what is meant by it, especially in younger people.

# Jonathan Hutt 31:58

So I will move away slightly from what I would term the sequelae of young hip disorders in childhood. So, there is a subsection of what I do that's related to patients who are diagnosed in their paediatric life with either dysplasia, slipped epiphyses, Perthes, or other things like that. So if we then talk about the other mechanical problems you run into, essentially, for me, they fall into two camps. One is impingement, which perhaps, you hear a little bit more about, and the other is instability, and there are a variety of different causes of both of those. So, if we're going to be stereotypical, your impingement patient is likely to be a young male patient, usually quite sporty. I think a lot of these are problems of active individuals rather than sedentary individuals. So they'll, they'll be football players, rugby players, tennis players, whatever it might be, but they'll be quite active. In general, it's activity related pain, and they'll generally get discomfort at the end range of motion or after periods of activity. And what you would then find as a clinician seeing them is they tend to have slight restrictions of motion. So as you bring their hip into flexion, you lose a lot of internal rotation, that, and the more extreme manoeuvres are where you start to generate pain in the joint because you impinge them. But then outside that range of motion, the hip is actually not terribly uncomfortable. And there are a number of causes, for that, which we can discuss. But the instability patient is normally slightly different. So that would be classically young female. They're often a little bit hyper mobile to a greater or lesser extent. Again, they'll often

be quite active, but they'll often be, dancers and gymnasts, and things like that, where the extra mobility that they have in their hips is actually a benefit, to their chosen sport and activity. And they'll present in a very similar way in terms of their pain distribution. But what you'll find, again, when you examine them, is not only more generalized signs of, say, hypermobility, but you'll also notice the hip maintains its range of motion a great deal better. And although they'll have more end range motion pain, it will be, at a wider range of rotation, for example. And again, there are different causes for that, and you'll see that spectrum amongst males and females as huge amounts of crossover. Obviously, I'm just those are a good example of the sort of extremes of both

# Steven Bruce 34:27

So what's then, your advice if you want to preserve these joints? Obviously, you're not going to say to a high level dancer, stop doing your dancing.

# Jonathan Hutt 34:40

Yeah, it's a good point. And I think that is as much about managing patients expectations as it is about treating their pain. So I think actually, instability is an interesting one to discuss in that regard, because, again, a lot of the patients I will see, I'll see ballet dancers. I'll see dancers often, various stage in their careers and Instability is caused by a number of things. So it's basically caused by the hip not being well contained, which is partly due to their general hypermobility, because they'll have more motion in general. And it's also due to acetabulum, or what people might classically call dysplasia, and also due to rotational changes in the thigh bone, so they will often have more ante torsion in their femur, and that combination stops the hip starting off like this, and generally means it's kind of coming out of the front and causing problems and instability pain. Now surgical treatment of that is different from impingement, and generally involves operations to move the bones around, osteotomy surgery to more contain the hip joint. Now, of course, the risk of that is that you then lose that range of motion that you've had. So you've got to be quite careful when you're planning that sort of surgery in order to not disadvantage the hip in the future. So again, you know not go in too far too soon. What you would tell that patient is you would have to appropriately investigate and really understand that biomechanical problem. And then pass them back to their therapy team and say, Look, this patient's got instability problems because of the following things. And they would say, Okay, well, in which case, let's, let's make sure we work on the general stability, the core stability. Let's not overload all that anterior musculature that's working hard to keep the hip stable and see if we can settle things down, and keep people doing their activity that way. Because not only is surgery a relatively big deal in that situation, but also has consequences for where they are in the stages of their career, particularly if they're looking at going into things professionally. That said, even after that surgery, patients can then return, because you've kept their hips so you've not replaced it, you've still got their own joints, and if you've positioned it correctly, they should be able to go back to a very high level of activity. And I've, I've got patients who've, go back to things like CrossFit. I had one who did an Ironman only last week, he was telling me. So, these patients can go back to very high levels of activity, but you obviously wouldn't treat them unless their symptoms were significant in the first place.

## Steven Bruce 37:15

I have a consultation for you to carry out here, sent him by Jo. Apparently, she's got a 58 year old male patient with a three year history of polymyalgia rheumatica, for which he's been on steroids. He's got severe, bilateral hip pain, extremely restricted range of motion. MRI shows grade four chondral loss. Would that be due to long term steroid uses? Her question is what would your advice be on managing it? Apparently he's still waiting for an orthopaedic consultation, despite being referred by rheumatology.

## Jonathan Hutt 37:46

Chondral loss equals osteoarthritis, advanced osteoarthritis. So he's got bilateral arthritis. Now that may or may not be related to his steroid use, obviously, that long term could potentially lead to partial AVN (avascular necrosis) of the of the femoral head, and if you lose the structural integrity of the subchondral bone supporting the cartilage, that is a risk factor for developing secondary degenerative changes. But the picture you paint there is a gentleman who's got secondary degenerative changes and reasonable restriction. It sounds like he needs a hip replacement.

## Steven Bruce 38:17

Would you do them both at the same time?

## Jonathan Hutt 38:21

So it depends a little bit on the patient. I do a reasonable amount of bilateral surgery, because I do quite a bit of anterior hip replacement. The patient's lying flat on the bed. You can drape both hips at the same time. It only it decreases your general operation time, and it's relatively easy to do. I think you've got to pick your patients correctly, though, because the rehabilitation is a little harder, and obviously the operating time is longer. Potential for blood loss is greater. So if patients are on the younger side, fit and healthy, can put up with a reasonable physiological disturbance from surgery. They will benefit from it because they only have one slightly longer period of rehab versus two shorter ones, but additively, would be longer. And equally, if patients have quite significant hip deformities, so they've stuck in various flexion, rotation positions, and that's the same on both sides. That's another reasonable relative indication to do them both at the same time, because it makes their rehabilitation less challenging, if they've got to then try and rely on a less good hip while they rehab the replaced side. So that would be another, another reason why. I mean, it's definitely not that common to do it that way around, but I find myself doing it slightly more now than I used to.

# Steven Bruce 39:38

You talked there about your anterior approach to hips. And Mandy sent in a question a few minutes ago asking about whether anterior is preferable to posterior hip replacement. I have read that you can have minimally invasive posterior replacements as well as the anterior approach, which is, I think, was developed for that very reason. What's your opinion on the two approaches?

## Jonathan Hutt 40:01

So I was trained as a posterior hip surgeon in the UK. Essentially, you are largely, these days, trained in posterior hip surgery. So a lot of what people do, and I guess their attitudes towards it, are formed strongly by that. I'm a bit of an anomaly in the UK. I mean, I know

you've had an anterior hip surgeon on before, but I think we kind of all know who the other ones are, because we are, at the moment, a small proportion of UK surgeons, just as out of interest, If you look across at the other major orthopaedic nations, such as Australia, Europe in general and America, they are very much moving towards anterior replacement surgery, and they've been doing in Europe for decades now, and so it's not an unusual thing to do. I think that the term invasive is often very poorly defined in orthopaedics, and can mean anything from the length of the scar to the amount you disturb during the operation. It's probably the second one of those that's more important. And I guess the reason I was attracted to the anterior approach, it was largely a surgical curiosity that led me there, because I wasn't being obviously pushed into it. Basically don't cut any muscles during the anterior approach. And so It's a way into the hip that doesn't involve dividing any muscles. Whereas no matter what your posterior approach to the hip is, you have to divide some muscles in the slightly abnormal may to a greater or lesser extent. I guess my, my experience with it has been that in the main, and it isn't, across the board, but in the main, I find patients are up on their feet quicker and more comfortable quicker. They're back to normal life quicker. So it's that early stage rehab that it seems to have a quite a significant impact on and in fact, there's multiple RCTs that demonstrate that. In fact, they also demonstrate that in the longer term, functional outcomes, at least as we explore them at the moment, don't seem to differ hugely between the two. And so my take on that which is slightly different from the posterior surgeons, is that that means it's a good approach, because I get the early benefit without any downside. And the equivalence, to me, is not a reason not to do it, because I can see some benefits to it as well. I think it's, it's largely a philosophical question in the UK, I think that there's a lot of resistance to it at the moment, and I don't really understand that, because I don't go around telling people to do it instead of something else. I just that's what I do in my practice, and I find it helpful. I also, as, again, as a young hip surgeon, in terms of my patients, I'm thinking about their next operation as well. And we do know that revision surgery does have worse outcomes in terms of complication risks and longevity. And I just wonder whether, if we, go to use an approach initially that causes very little disturbance, and then have a sort of a native surgical plane for the second one, whether there might be some benefits there in the long term. I can't prove any of that. That's just my personal feel.

## Steven Bruce 43:03

I was going to ask you, actually, how many times can you revise a hip replacement successfully?

## Jonathan Hutt 43:20

Yeah, that's a good question. I mean, I think that you want to do it as few times as possible. I think again, it's that thing that Patients often come and they say things like, my my first one's going to last me 10 years, and I can only have two or three, and I'm never quite sure whether where they get that information from. In theory, we have reconstructive techniques that vary from the very simple to the extremely complex bone loss implants. You could have as many as you wanted, really, but there's definitely going to be a law of diminishing returns if you're having either frequent surgery or more progressively more complex surgery in terms of what is needed to get a stable hip construct.

## Steven Bruce 44:02

of course, if they last 25 years, I guess most people are never going to need more than two are they?

## Jonathan Hutt 44:08

Well, I mean, that's the hope. And I think, I think, I think there is, can't say it particularly boldly, but I still think there are patients whose hips I'm going to be replacing in their 30s and 40s who won't need another hip replacement. I'm sure that's going to be case.

## Steven Bruce 44:21

That's very encouraging. Bertrand has sent in an interesting thing here. He says he's got a patient who's given him a very wooly description of a dark area around his hip replacement and that it needs to be redone. And he got the impression that it was around the femoral shaft, but it might not be. Is that something you've heard of before - you're looking very puzzled!

## Jonathan Hutt 44:44

I don't know if that's any sort of selective interpretation of symptoms or of the what he's taken away from someone's description of his imaging, but I don't know what that might be. No, sorry.

## Steven Bruce 45:00

It's not fair to ask you that when there's no patient in the room, and we don't really have a good description what was going on, but it was intriguing.

Claire asks if the reason hip resurfacing is generally not done on women because they have shallower hip joints.

# Jonathan Hutt 45:17

The main reason it's not done on women is because the implants were removed from the market. it wasn't due to the shallower side of things, but quite naturally, you might expect, women's hips are slightly smaller than men. And what we found was with almost with all makes the metal on metal bearings in smaller sizes were much more prone to these metal on metal problems, and therefore they were taken off the market completely, which disadvantages women who no longer have access to it. One of the trials I've been involved in recently was of ceramic resurfacing, and we're actually hoping to trial another ceramic resurfacing next year at UCH, and that, I think, probably has some legs in it. There's nothing commercially available yet, but we're very close to it at the moment. And I think that when that does happen, particularly for the female patient, actually will be a potential good option, almost more so than for the more restriction of motion anatomy. You know my experience, admittedly quite small during the trial, it was only 20-30, patients on my side, the younger women who had, arthritic problems and suitable anatomy, did extremely well after that operation,

# Steven Bruce 46:31

Perhaps that answers the question already that Andre has sent in saying, When do you consider resurfacing versus replacements or alternatives?

## Jonathan Hutt 46:40

Actually, I don't resurface Patients with metal on metal bearings. It's a personal thing. I've seen enough of the bad side of metal hips to not particularly want to do that. Stuck in a little bit of equipoise about whether resurfacings are functionally better than hip replacements. I don't think the data is that strong in younger patients. I think there's potential for a smaller group of more active or loading patients who may find they do better in the margins with hip resurfacing. But I found that anterior approach ceramic hip replacements have been really good in my younger cohort. So I'd need to prove that somehow before I actually took it back up again.

# Steven Bruce 47:26

John's asked if you've ever come to a conclusion on why hips tend to degenerate on one side, rather than both

## Jonathan Hutt 47:38

truthfully, no, but because I think it's quite unusual to see, let's say you take a morphology that's particularly prone to potential joint replacement, like large amounts of impingement, for example, or even hip displasia. It would be another good example. You do see some patients for whom it seems to affect them only on one side rather than the other, and I actually think that might be for two reasons. One is, I think that, again, in the active patient who does sport, they probably use their hips very differently depending on the sport that they play. So they're going to move differently on either side, which may put more stress on one side than the other. Equally, I think in the younger patient, what you tend to see is a sort of initial, quite significant injury to the joint for some reason, which then leads on to degeneration. So I think you can have a situation where you start to disturb the joint itself with a fairly significant cartilage injury, which maybe goes unnoticed or misdiagnosed, but that will then start a cascade problem that in the absence of it on the other side won't cause a similar issue. I mean, this is all guesswork.