

Relieving Painful Hip or Knee Arthritis

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- Undergrad - Carroll College - Helena, MT
- Medical School - University of Washington
- Residency - University of New Mexico
- Fellowship in Joint Replacement - Coon Joint Replacement Institute, St. Helena, CA
- First Surgeon with Fellowship training specifically in Robotic Joint Replacement

Medical License: CO and MT
Disclosures: Consultant for Stryker Robotics

Boulder County Fair circa 1990







About my practice...

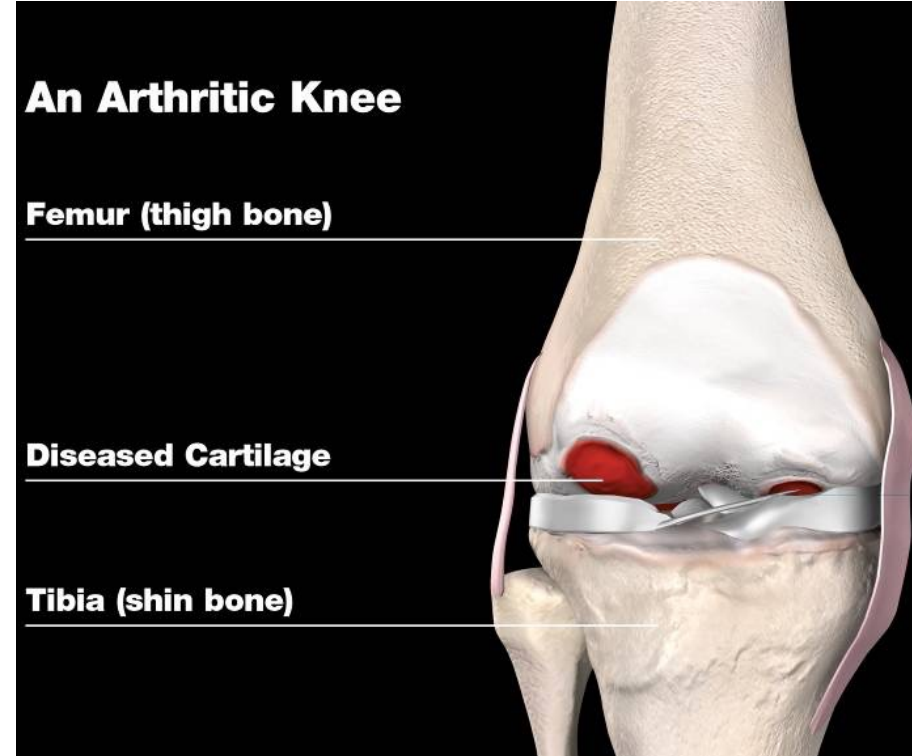
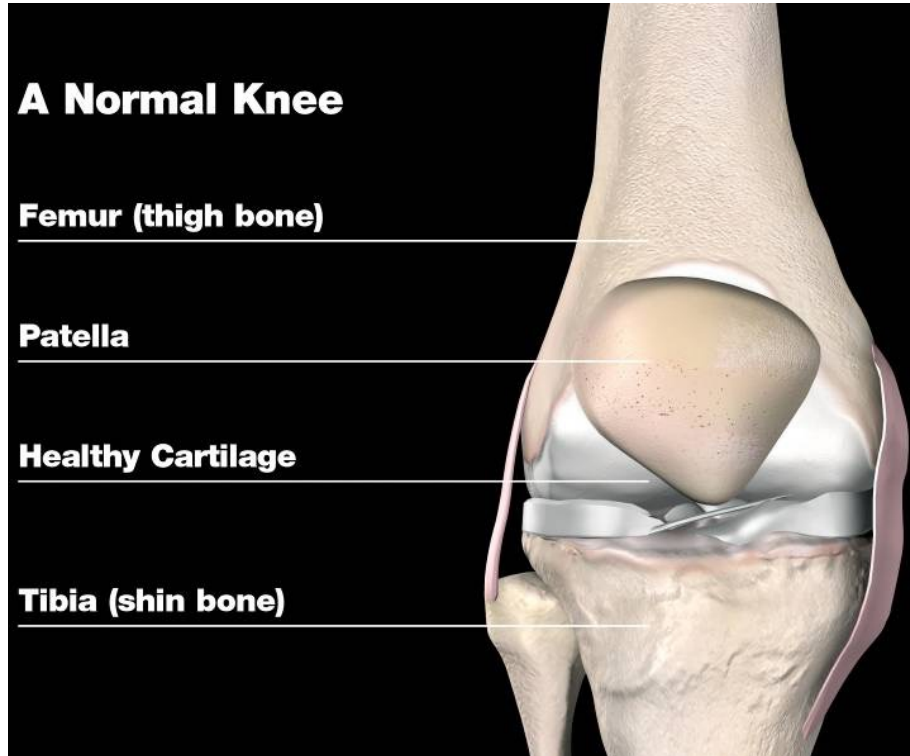
- Focus on minimally invasive surgical techniques combined with advanced technology
- 99% of cases done under spinal anesthesia
- Avg LOS: TKA 1 days, THA 1 days
- 91% of patients discharged to home with outpatient PT
- Now doing Outpatient Surgery Center

Lowest Complication Rate in Boulder



Boulder Centre
for Orthopedics

What is Arthritis?



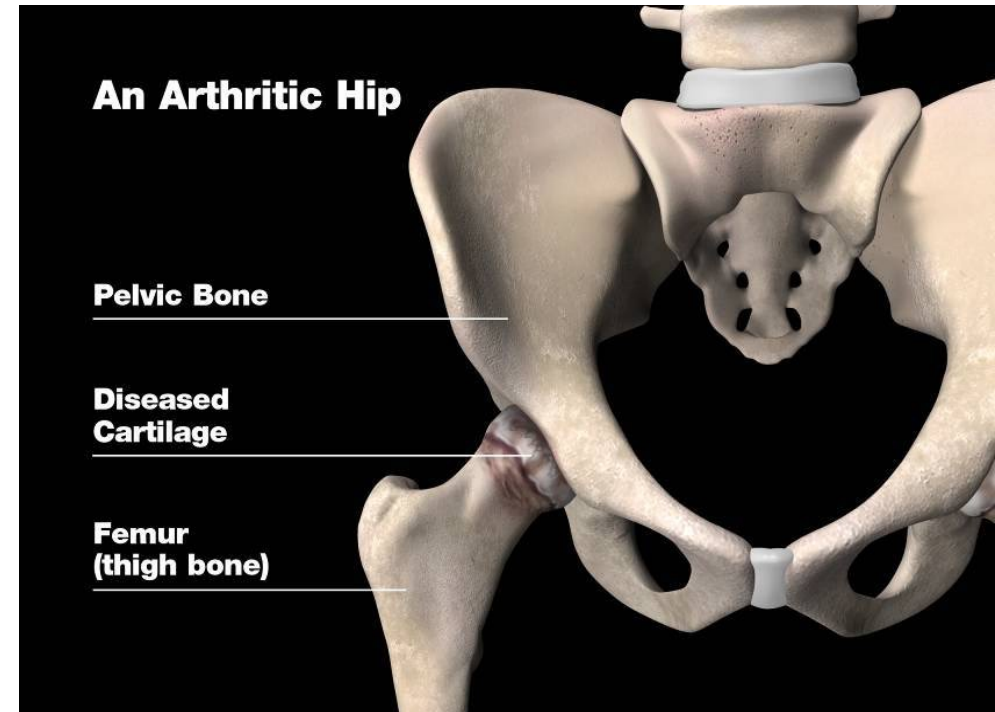
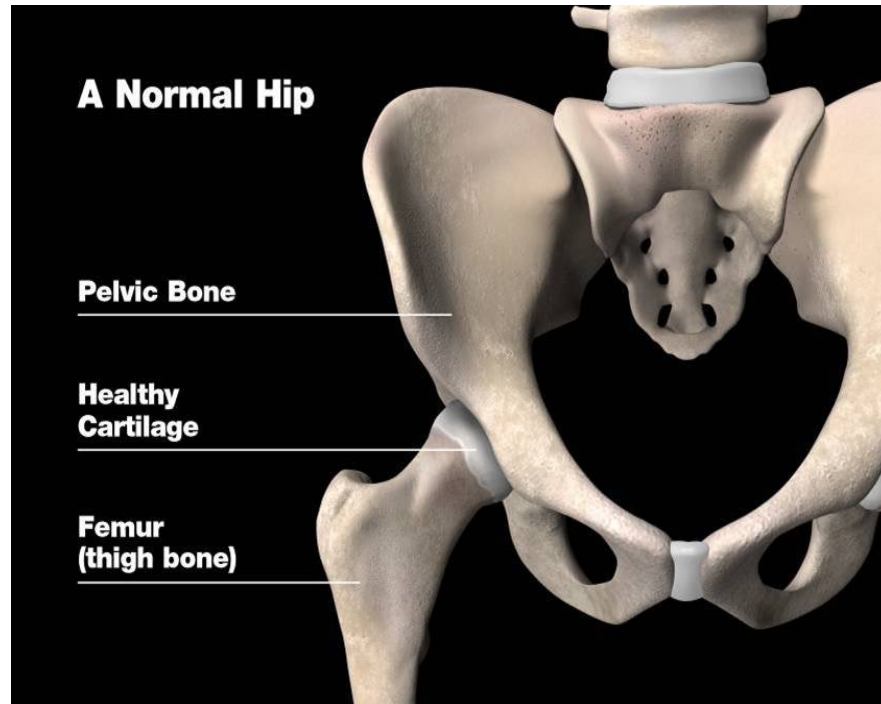
Osteoarthritis - Worn out articular cartilage

**Inflammatory Arthritis - Systemic process
ex: Rheumatoid, Psoriatic, etc.**





Hip Stages



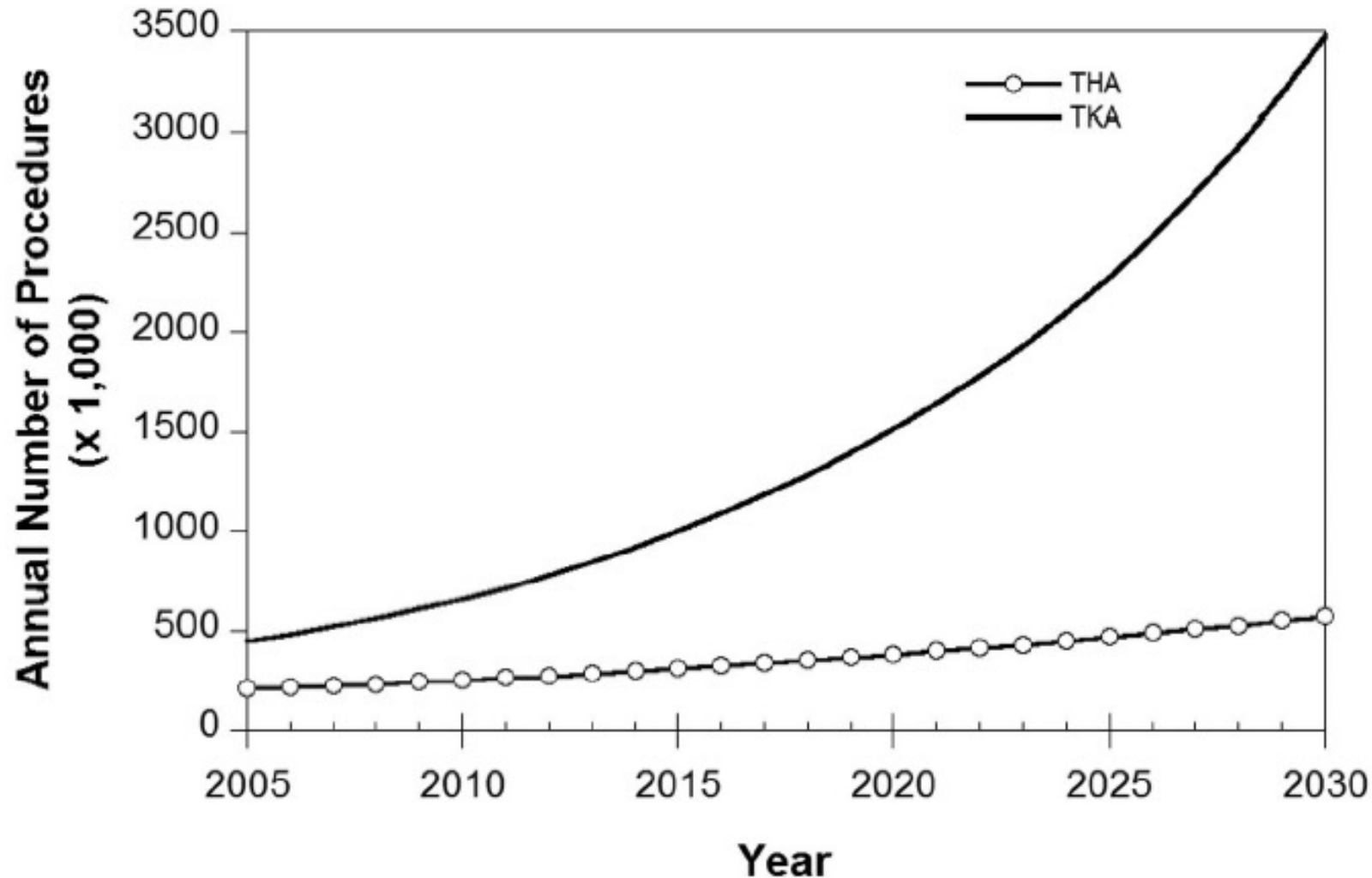
X-ray Showing Arthritis



Other Causes of “Hip Pain”

- Bursitis: Lateral/Side pain. Worse when you lay on that side
- Back pain: Can radiate down to hip and cause hip pain symptoms
- Hernia: Abdominal opening causing pain in the groin

Primary Hip and Knee Replacement Projection 2005-2030



Patients are getting both younger and older. They have different expectations.

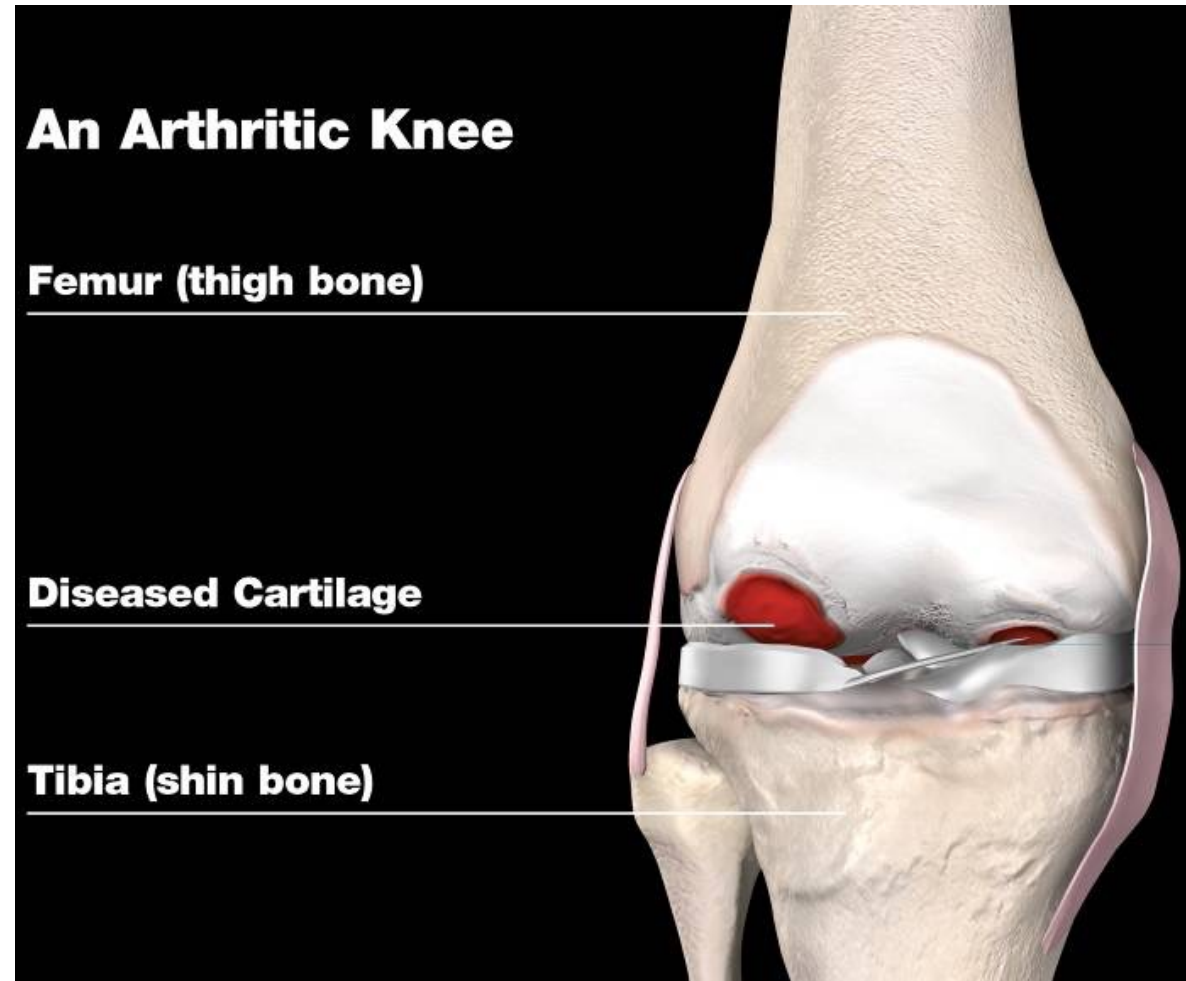
- Want to maintain their quality of life and active lifestyles

Patients are often better informed today.

- Internet allows access to more information
- **BUT BEWARE THE INTERNET (and Stem Cells)**

How Can I Avoid/Delay a Joint Replacement?

- Rest, ice, and heat applications
- Medications for inflammation and pain
- Lifestyle modification
- Physical therapy
- Joint fluid supplements
- Knee arthroscopy
- Total joint replacement



Intervention	AAOS (Rating)^a	VA/DoD (Grade)^b
Weight loss	Recommended for patients with a BMI ≥ 25 kg/m ² (Moderate)	Recommended for patients with a BMI ≥ 25 kg/m ² with a goal of losing $\geq 5\%$ body weight (C)
Exercise/physical therapy	Self-management programs, strengthening, low-impact aerobic exercises, and neuromuscular education; engage in physical activity consistent with national guidelines (Strong)	Manual therapy (B) Aquatic therapy (C) Walking aids (EO)
Oral medications	Nonsteroidal anti-inflammatory drugs (NSAIDs) or tramadol (Strong) Unable to recommend for or against the use of acetaminophen, opioids, or pain patches (Inconclusive)	Acetaminophen (≤ 4 g daily) or oral NSAIDs are first-line therapy (B) Topical capsaicin may be considered as first-line or adjunctive therapy (C) Duloxetine or tramadol may be offered as an alternative/adjunct to oral NSAIDs (B) Non-tramadol opioids may be considered for patients with contraindications, inadequate response, or intolerable side effects with non-opioid therapies or tramadol (C)
Intra-articular injections	Unable to recommend for or against the use of intra-articular corticosteroids, growth factor injections, and/or platelet rich plasma (Inconclusive) Cannot recommend using hyaluronic acid (Strong)	Corticosteroid injection may be considered (C) Insufficient evidence to recommend for or against the use of intra-articular hyaluronate/hylan injection; however, it may be considered for patients with inadequate response to nonpharmacologic measures and an inadequate response, intolerable adverse events, or contraindications to other pharmacologic therapies (I)

^a AAOS rating: Strong, the work group recommends; Moderate, the work group suggests; Inconclusive, the work group is unable to recommend for or against.

^b VA/DoD grade: B, USPSTF recommends service. High certainty that net benefit is moderate or moderate certainty that net benefit is moderate to substantial; C, recommends selectively offering or providing service to individual patients based on professional judgment and patient preferences. At least moderate certainty that the net benefit is small; I, current evidence is insufficient to assess the balance of benefits and harms of the service; EO, expert opinion.

Source: Data extracted from National Guideline Clearinghouse.

RICE and NSAIDs

Rest, Ice, Compression, Elevation

Ibuprofen, Aleve, Tylenol, Celebrex

Topical compounds

Glucosamine



Avoiding high impact activities,
i.e., running, jumping

Weight loss: Goal BMI < 40



Cortisone

Visco-supplementation

Platelet rich plasma (PRP)

Stem Cells



“Chicken Shots”- Hyaluronic acid injections

**Covered by most insurance in knees
but not hips*



PRP: Platelet Rich Plasma

Injections of concentrated blood products to enhance healing

**Not covered by insurance, expensive*



The Promise of Stem Cells

Obtain stem cells, concentrate them and inject them into the joint to decrease inflammation and promote healing.

**Not covered by insurance, very expensive*



My Future?



The Dustbin of History

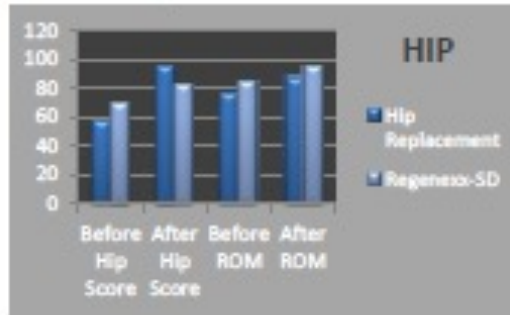
Regenexx-SD vs. knee and hip replacement?

Data Collection

This data was collected by Regenexx network physician Mitch Shelinkop, M.D. As an orthopedic surgeon, he collected knee and hip replacement data in 2007. He also used the same methods to collect data on the Regenexx-SD procedure for knee and hip arthritis. Regenexx had no involvement in the data collection nor it's preparation.

What does this mean?

The Harris Hip Score and hip range of motion improved in both hip replacement and Regenexx-SD patients. While hip replacement patients saw greater improvements, given that the Regenexx-SD patients had a dramatically less invasive injection, the risk/benefit ratio is good.



73% of Regenexx-SD hip patients returned to sporting activities!



The Regenexx-SD procedure is a same day bone marrow stem cell procedure that isolates the fractions of bone marrow that have the most stem cells.



Caution! This is a comparison trial, which is not the same as a drug company style controlled trial.

How does a major surgery compare to an injection of stem cells?

What does this mean?

The Knee Society Assessment Score and the Function Score improved in both knee replacement and Regenexx-SD patients. Regenexx-SD knee patients saw greater post procedure levels in both measures. Given that the Regenexx-SD patients had a dramatically less invasive injection, the risk/benefit ratio is excellent.



Details: Hip-94 THA surgeries performed in 2007, mean age of 62 years, mean BMI of 30. 38 Regenexx-SD procedures performed in 2012, mean age of 51 and BMI of 26. 24 THA patients were available for follow-up at one year and 18 Regenexx-SD patients were available at 1 year. Harris Hip Score administered to both groups by the same technician and clinician. Knee-111 knee TKA knee surgeries performed in 2007, mean age 67 years, mean BMI of 32. 37 Regenexx-SD procedures performed in 2012 with a mean age of 55 years and a BMI of 27. At one year there were 71 TKA and 26 Regenexx-SD patients available for follow-up. Knee Society Assessment Score and Knee Society Function Score administered to both groups by the same technician and clinician.

Knee Society Assessment Score

- TKA

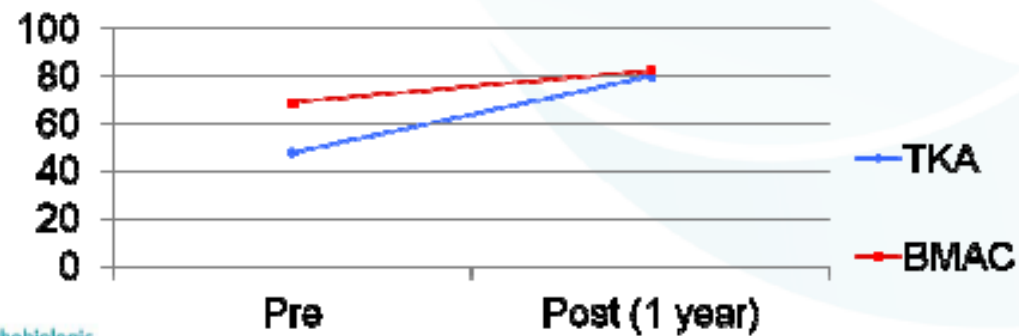
- Pre op 48

- Post op 80

- BMAC

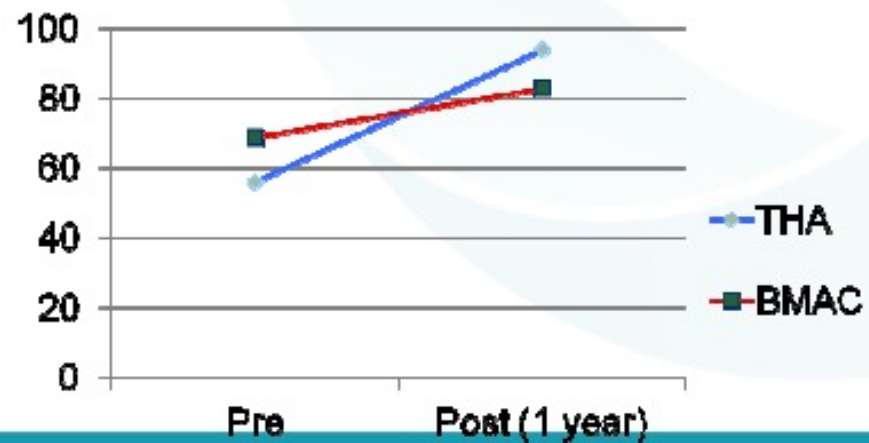
- Pre op 69.08

- Post op 82.44

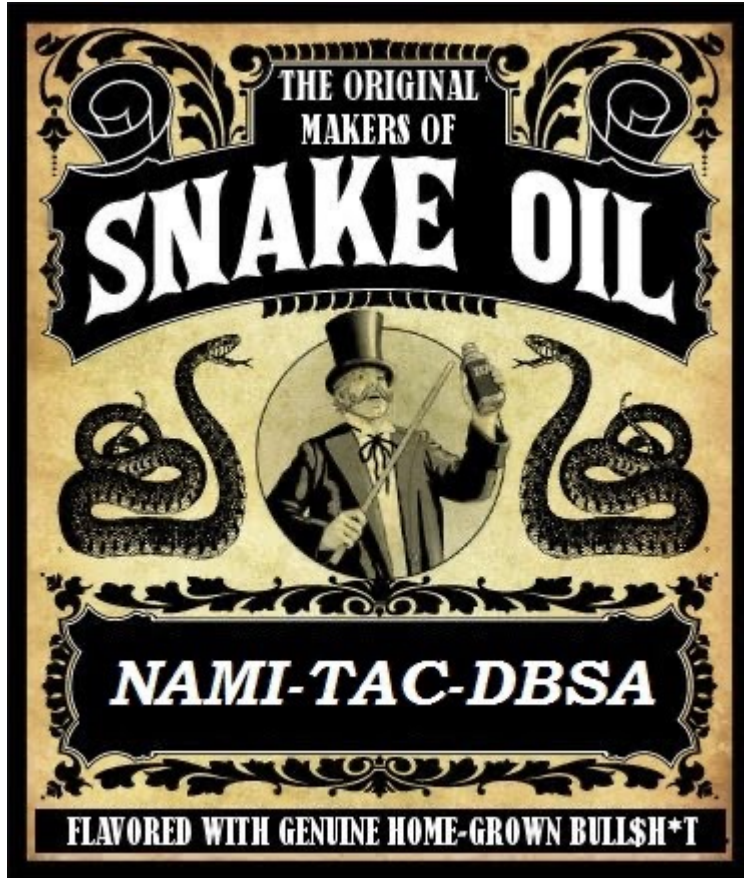


Mean Harris Hip Score

- THA Preop (101) 56
- THA Post(24) 94
- BMAC Preop (28) 68.75
- Post BMAC (18) 82.89



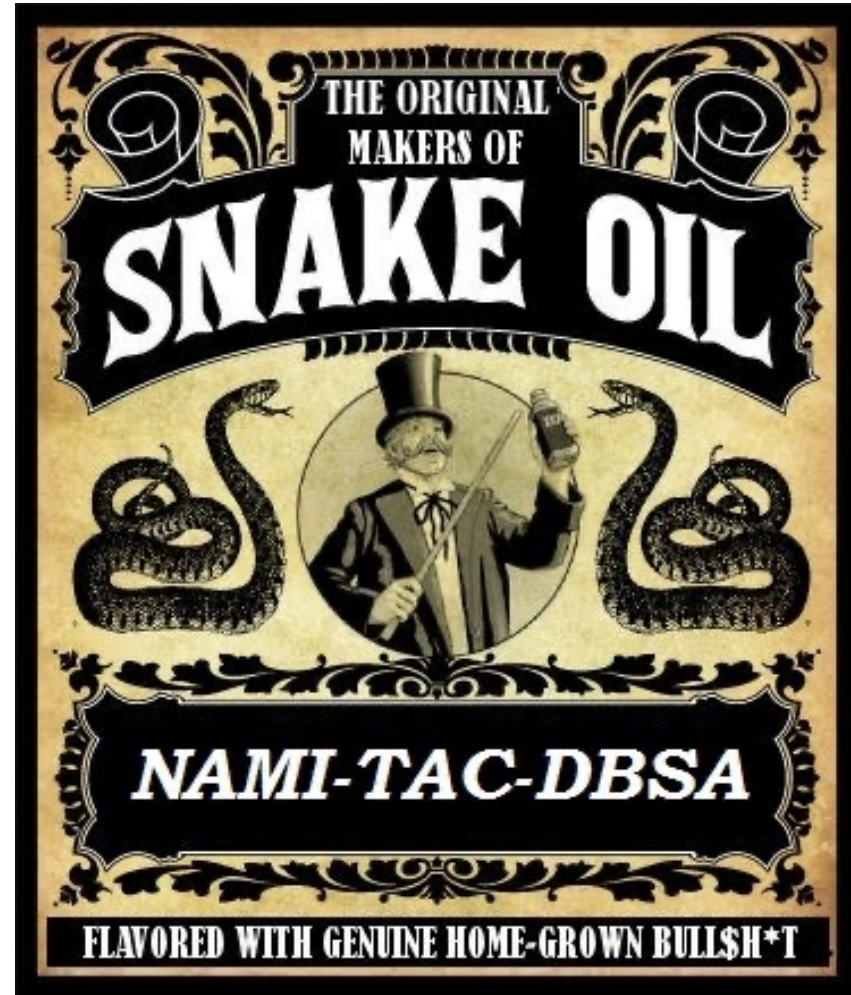
Stem Cells = Snake Oil?



STEM CELLS?



The Dustbin of History



- Surgery is a difficult decision
 - Duke Study: 88% pts decline Joint Replacement
- OA is a degenerative disease
- Better outcomes are reported in patients who had a total joint operation earlier in the disease process¹
- At 2 years post-operation, patients who chose surgery earlier in disease process vs. those who waited¹
 - Had improved function
 - Had reduced pain

1. Fortin PR, et al. *Arthritis Rheum.* 2002;46:3327-3330.

- Improvements in hip and knee replacement materials
 - Success rates >90% ¹
- Partial vs. total knee replacements
- Minimally invasive procedure techniques
- New designs

1. American Academy of Orthopaedic Surgeons.
<http://orthoinfo.aaos.org/topic.cfm?topic=A00389>, accessed Dec. 15, 2010, and
http://www.niams.nih.gov/Health_Info/Hip_Replacement/default.asp#8.

What is Mako?



Computer Navigated, Robotic Arm Assisted



- Damage and pain isolated to one compartment of the knee, usually medial or lateral.



- Damage and pain isolated to one compartment of the knee, usually medial or lateral.



- Can also be isolated to the patella femoral joint.

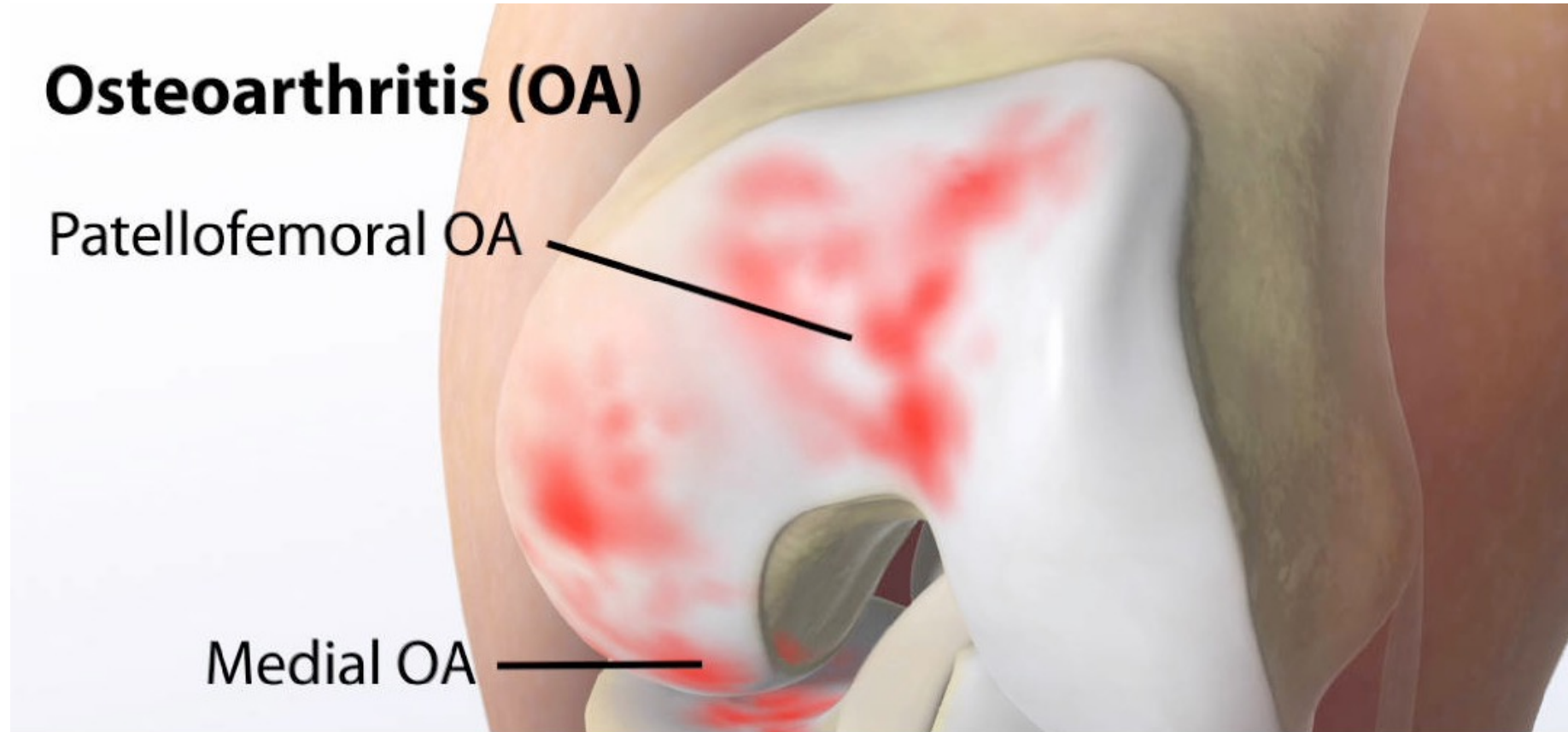


- Occurs in 2 of the 3 compartments of the knee, most commonly the medial and patella femoral.

Osteoarthritis (OA)

Patellofemoral OA

Medial OA



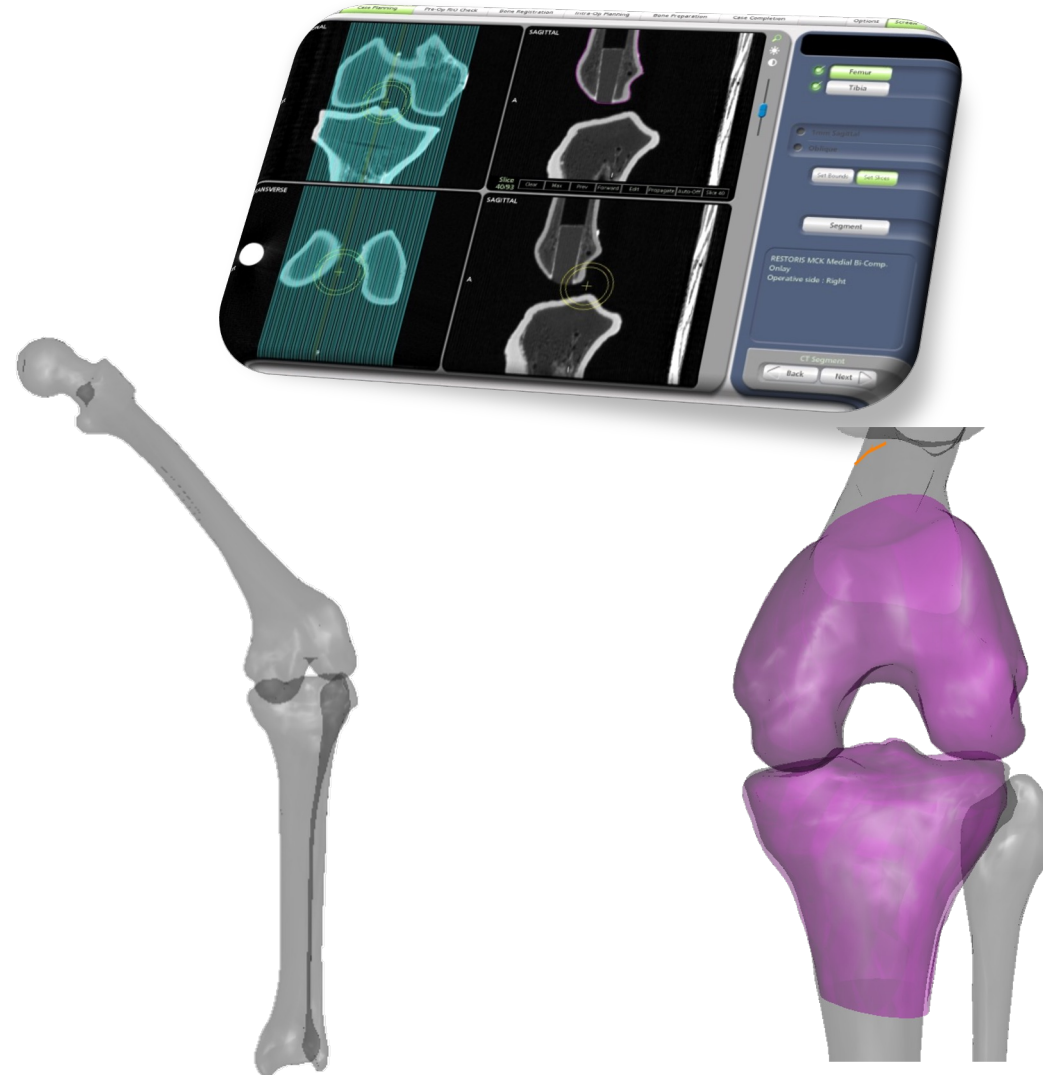
Mid-stage Arthritis

- Occurs in 2 of the 3 compartments of the knee, most commonly the medial and patella femoral.



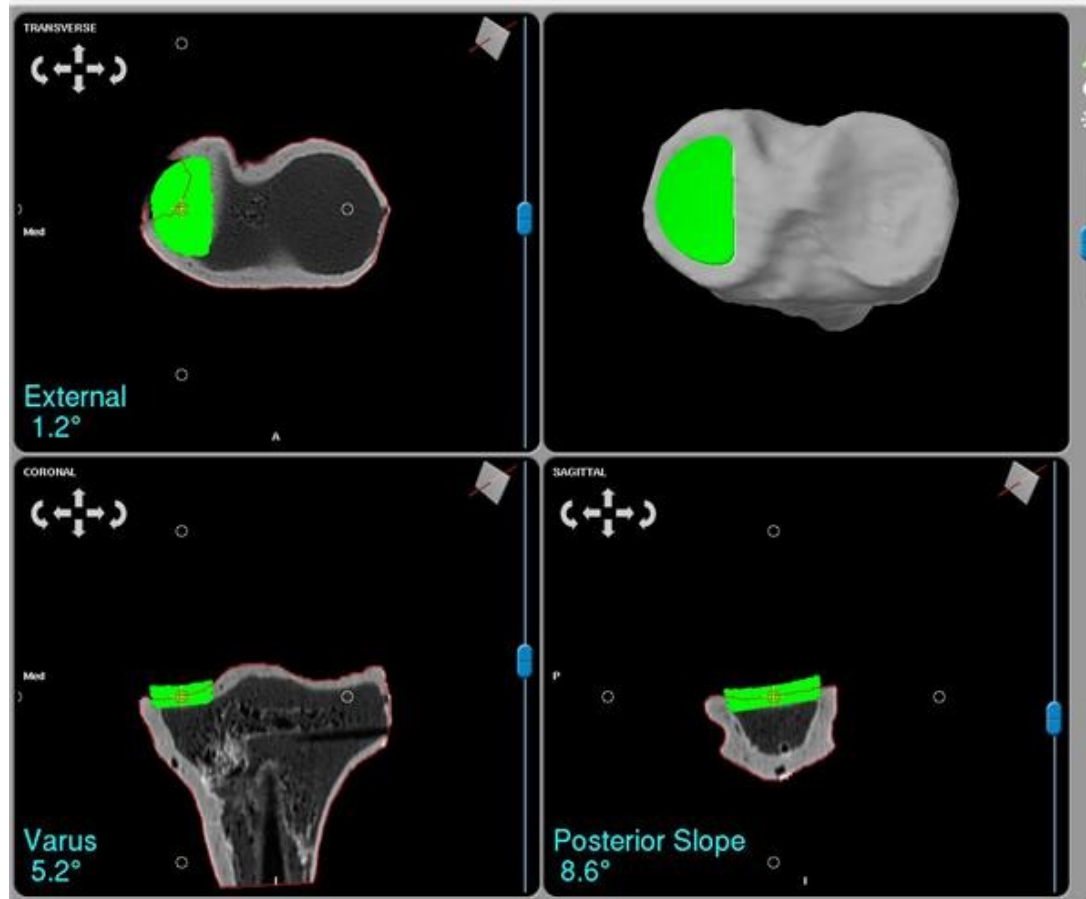
Makoplasty Procedure

- The patient must have the correct indications for the procedure.
- A CT scan is then performed to make a 3D model of the patients knee.

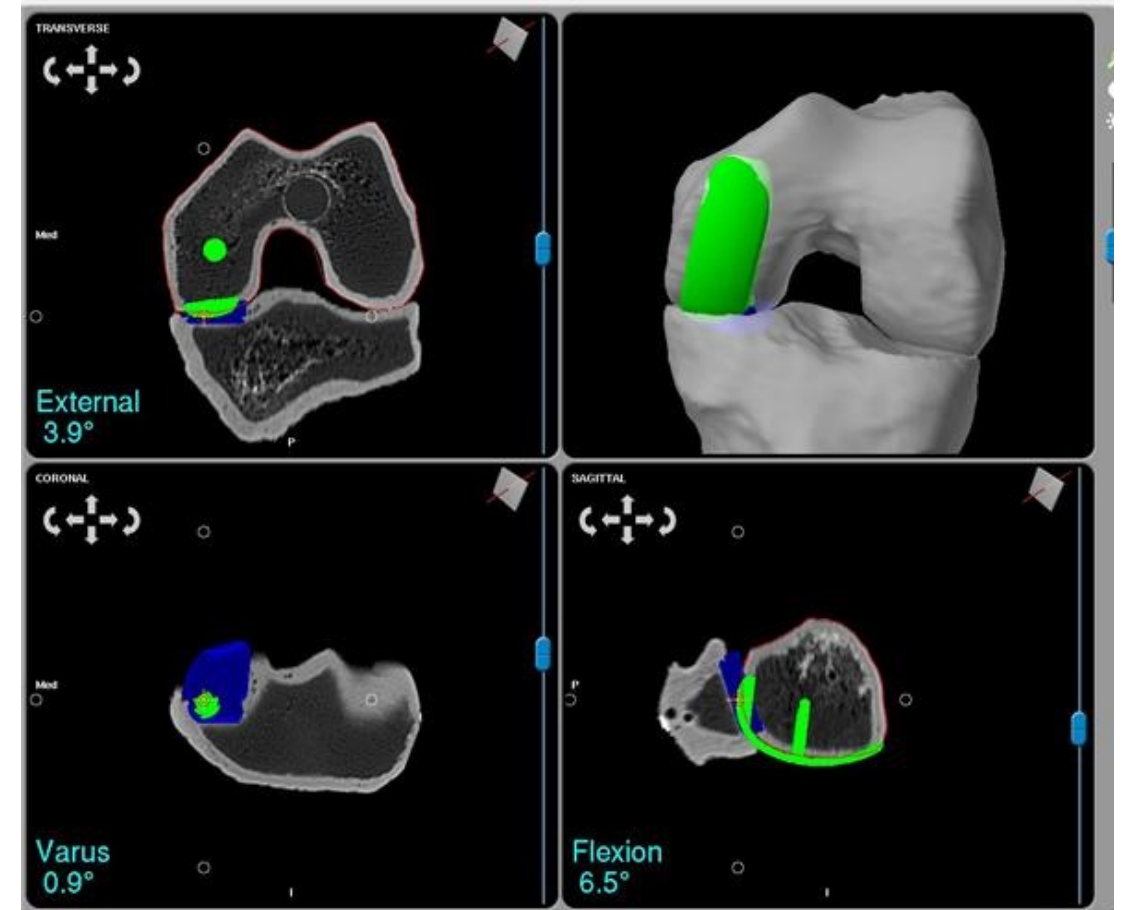


Makoplasty Procedure

The model is then used to plan for the placement of the components.



We are able to plan to 0.1 degrees and 0.1 mm.

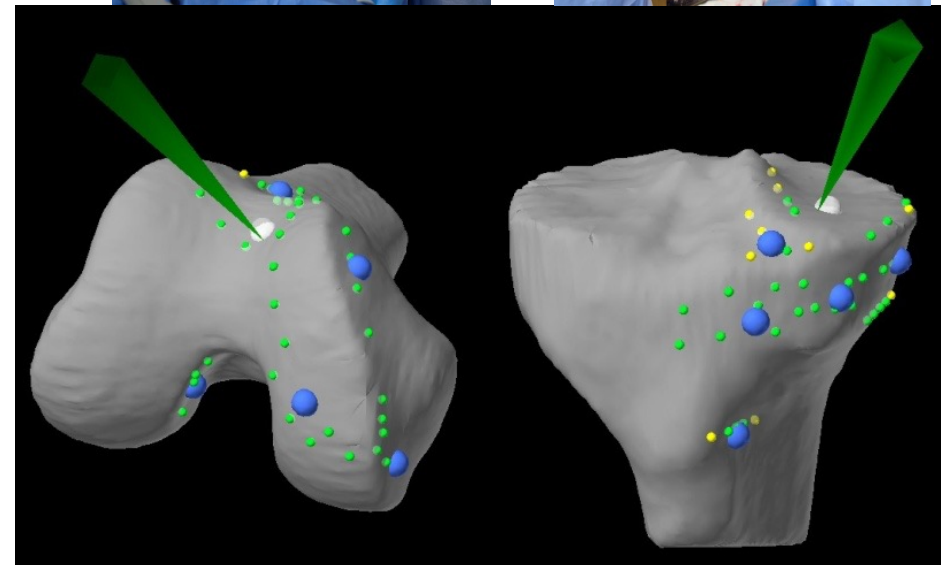
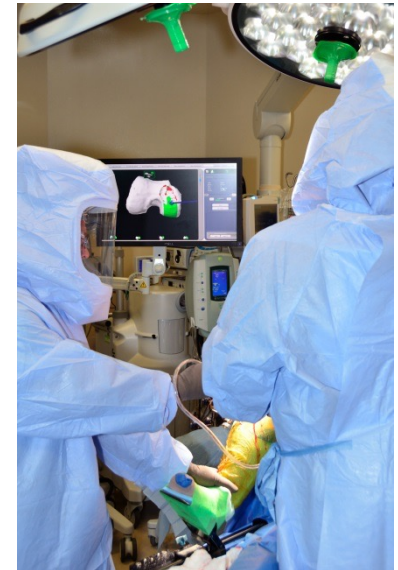


Robotic Process (cont.)

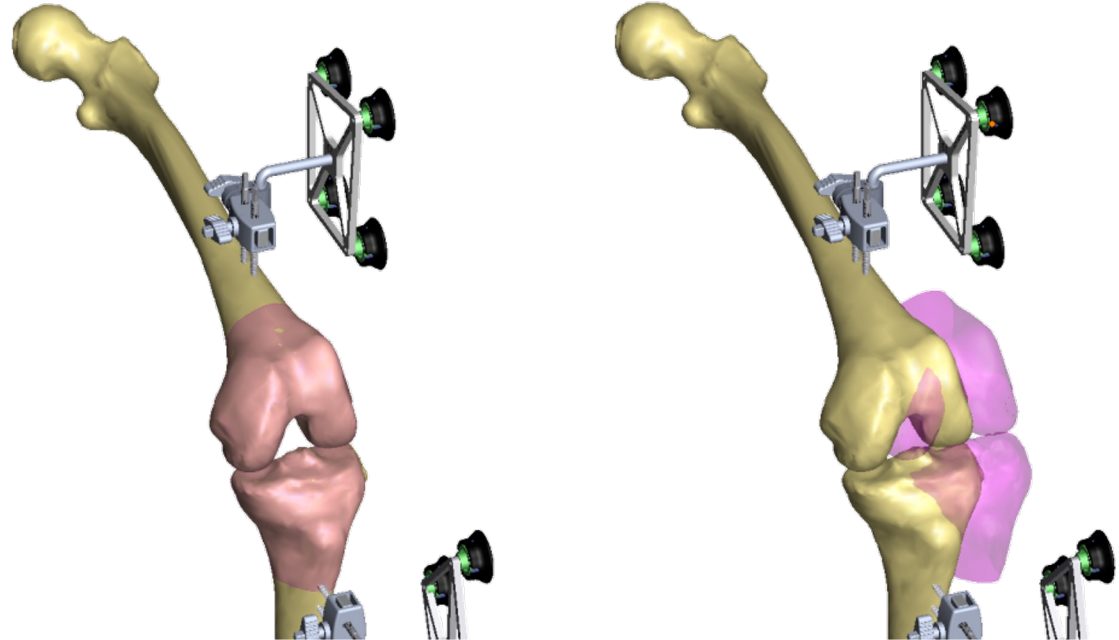
- Then a pin is placed into the distal femur and proximal tibia for placement of tracking device.
- Center of hip is then found.



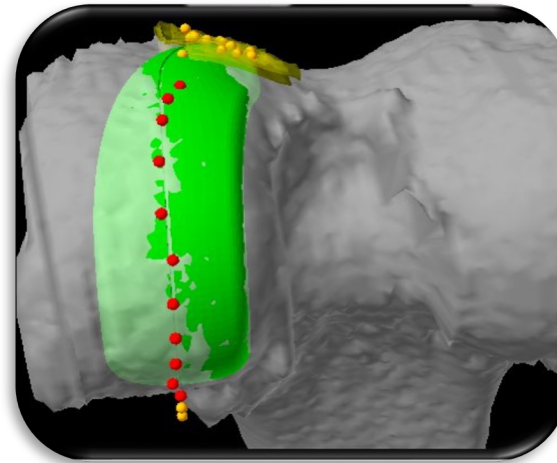
- Anatomic landmarks on the femur and tibia are used to calculate the position of the knee in space.
- This information is then combined with CT and pre-op plan.



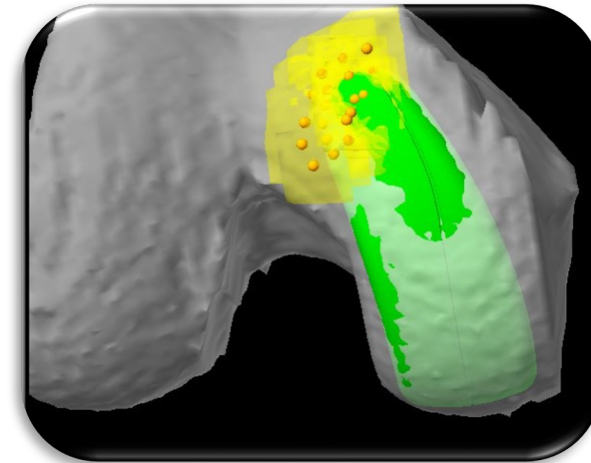
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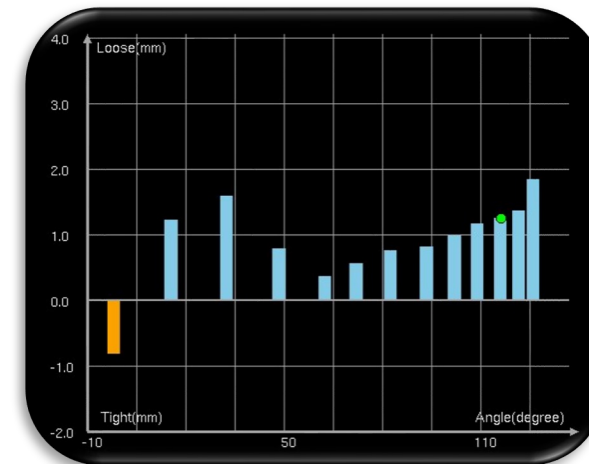
- After obtaining anatomic landmarks, evaluation of coronal and sagittal alignment, flexion and extension laxity and ROM can be measured.
- Infinitely personalized process.



Implant Tracking



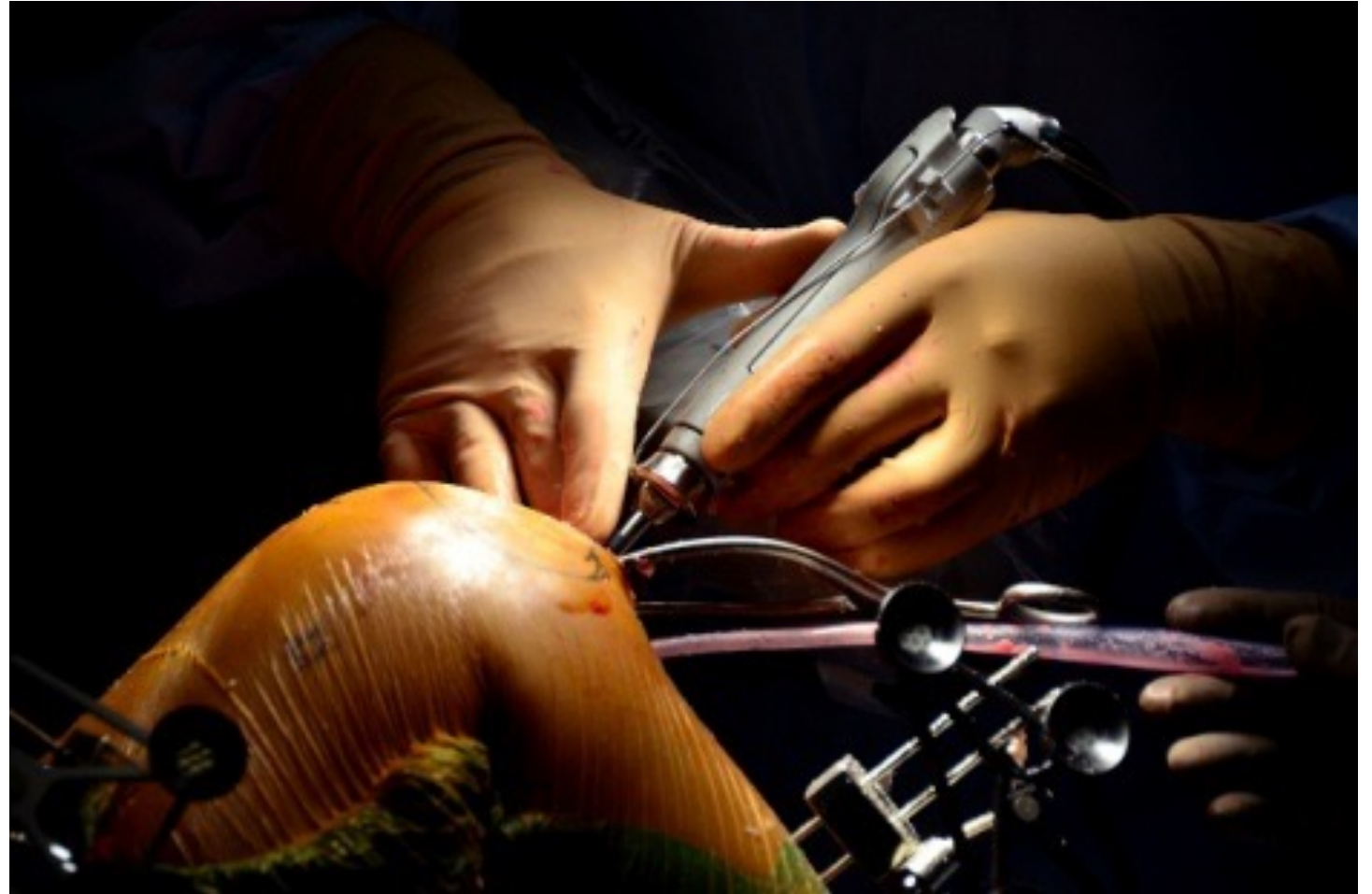
Cartilage Mapping



Joint Balancing

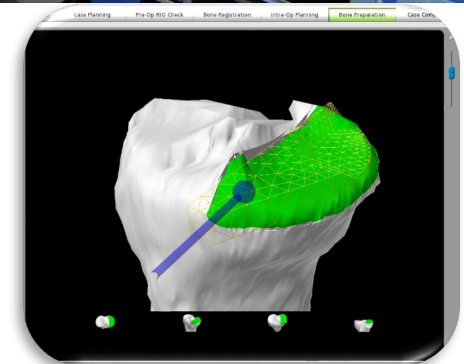
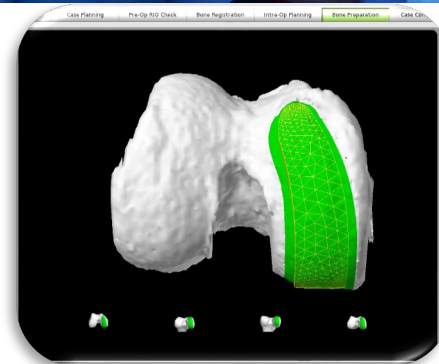
Bone Preparation

- Done through a minimal incision to allow for less tissue damage.

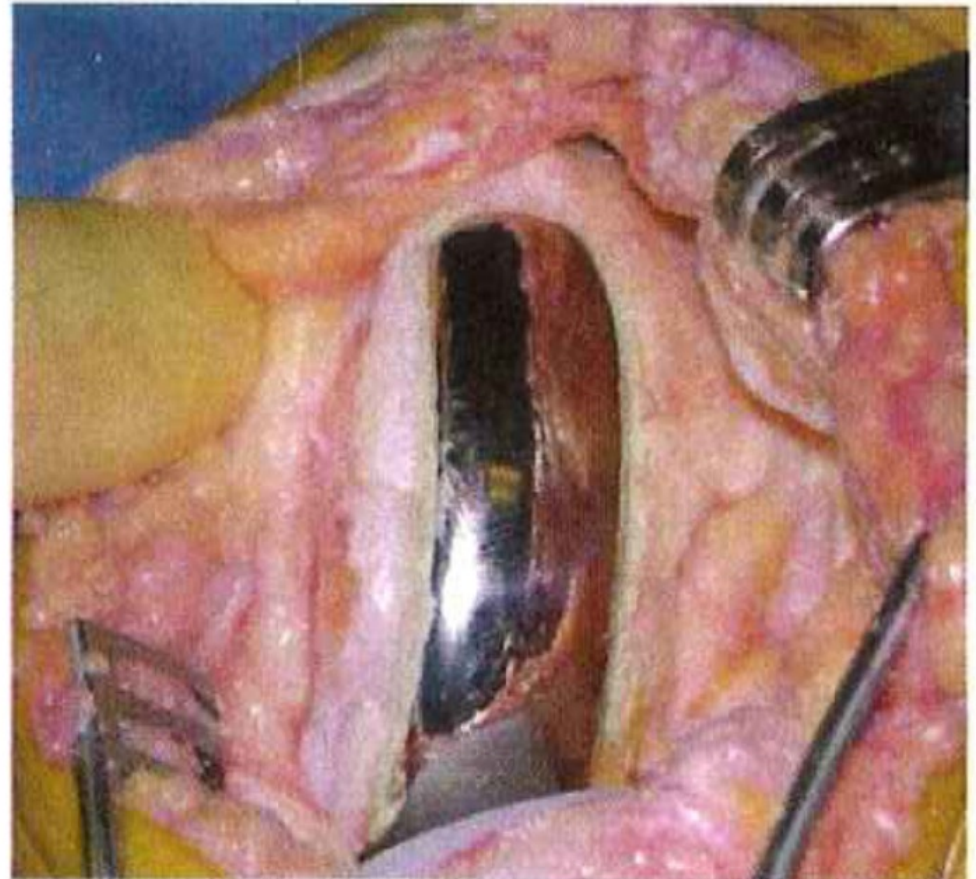
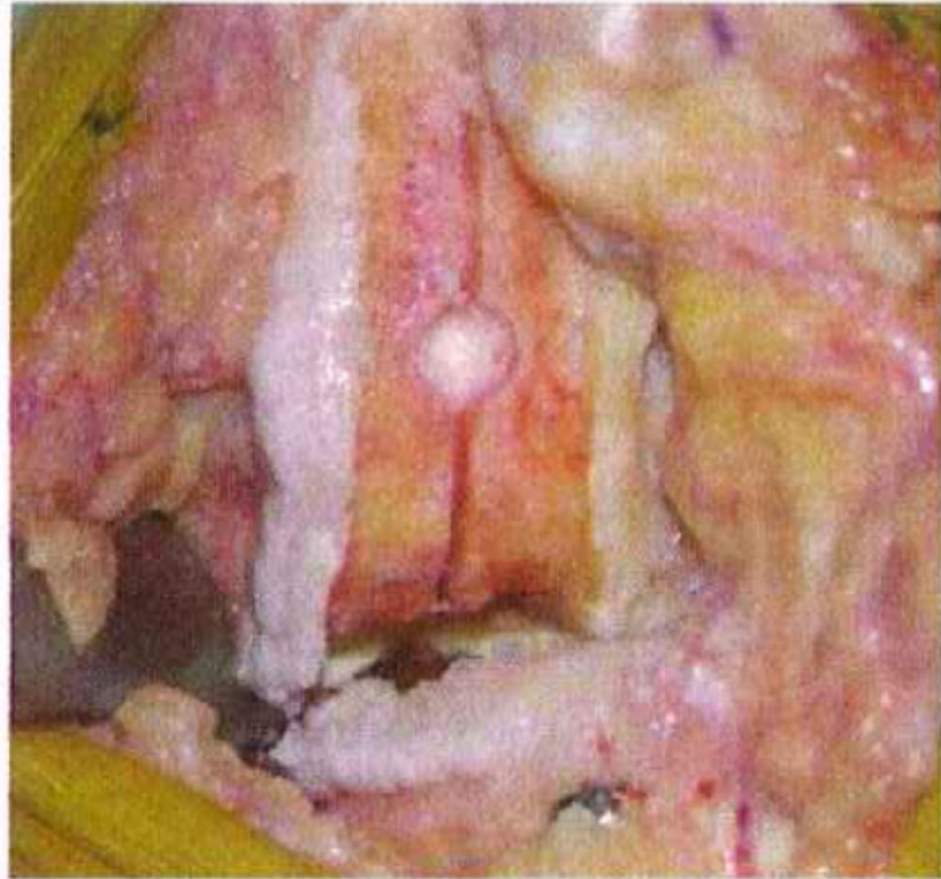


Surgical Technique (cont.)

- After finalizing operative plan a high speed burr is used to make the femoral and tibial cuts.
- The haptic feedback increases and will not allow you to go outside of the planned resection.



Surgical Technique (cont.)



Pre-op



Post-op



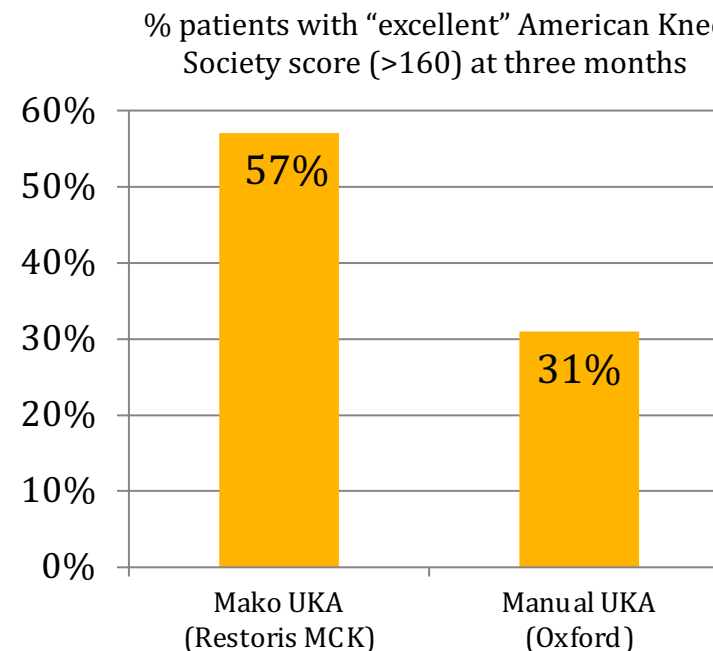
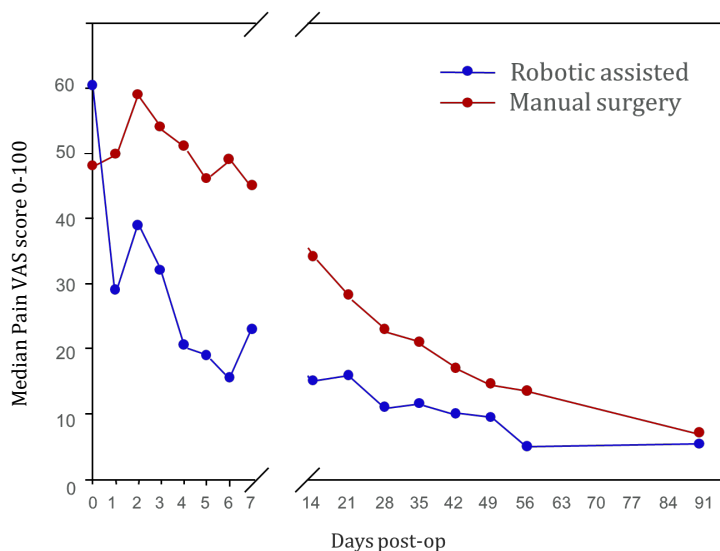
- Less invasive
- Accurate
- Reproducible
- Bone conserving



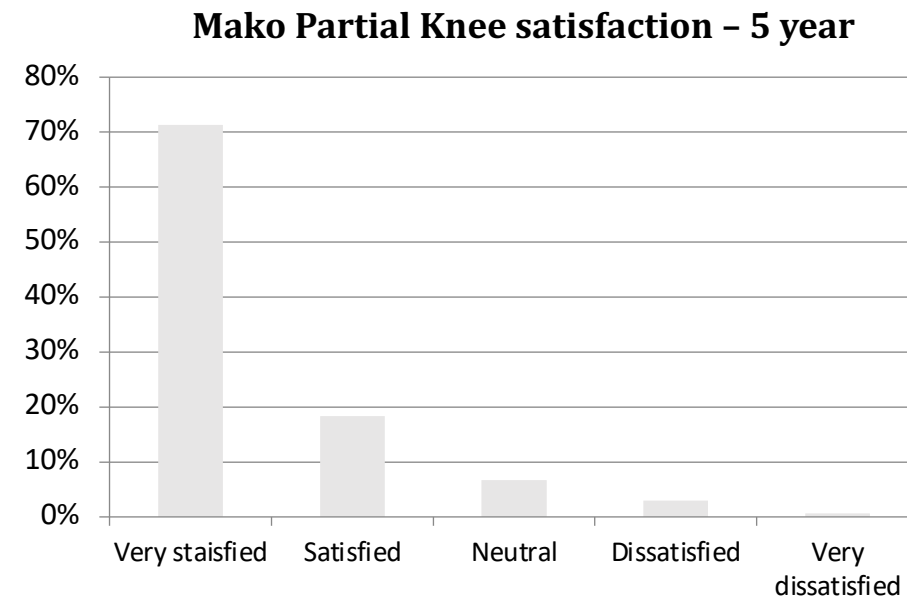
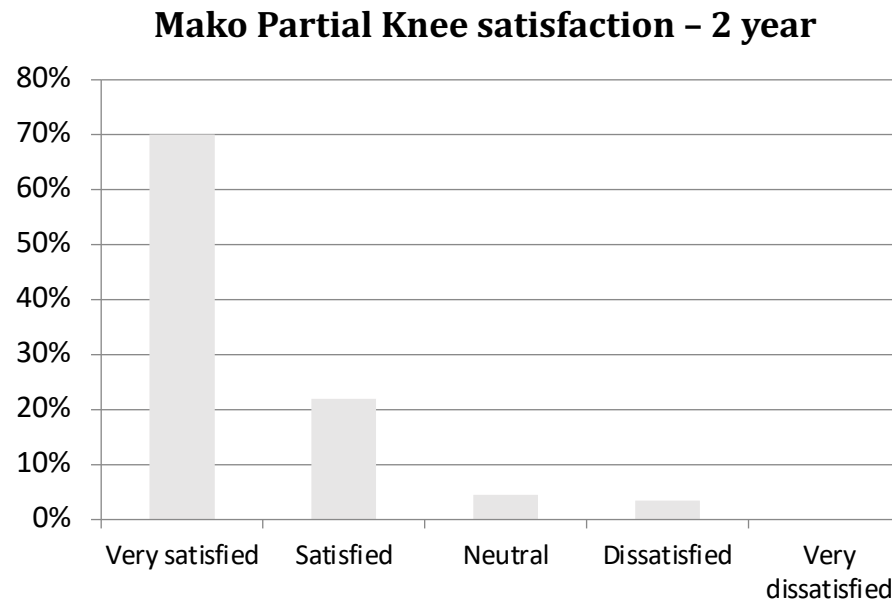
Patient satisfaction: Mako Partial Knee⁶

This prospective, single-center, level I, blinded, randomized controlled trial compared Mako Partial Knee and Biomet Oxford.

Early results showed higher functional outcomes scores and less early post-operative pain for Mako Partial Knee vs. manual procedures with Biomet Oxford.

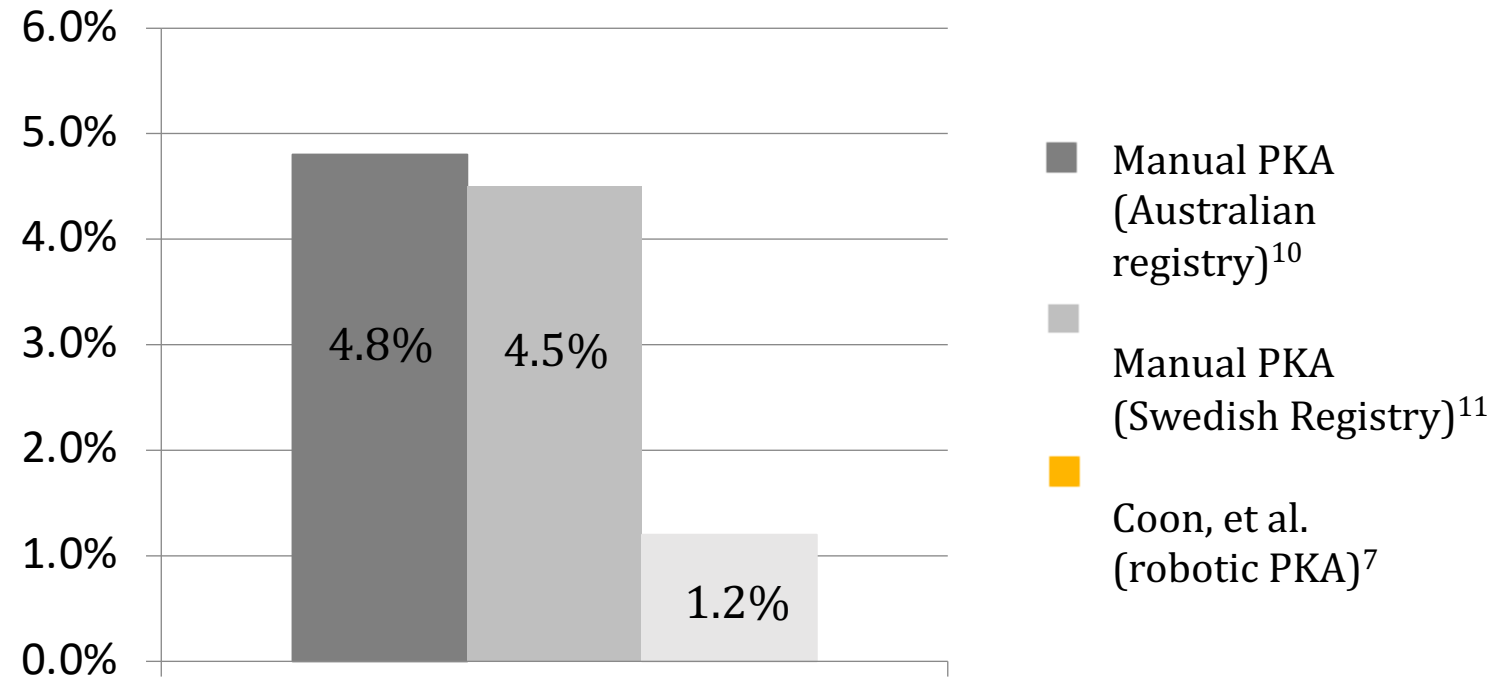


- Mako Partial Knee showed high patient satisfaction at two-year and five-year follow-up.



Survivorship: Mako Partial Knee

- Mako Partial Knee showed low revision rate at two-year follow-up.



- Average cost of a revision following a non-robotic primary knee replacement in the US: >\$39,000¹²
- Revision subsequent to a robotic arm-assisted primary knee arthroplasty surgery in the US: \$22,941¹²

Mako Total Knee

Total Knee Joint Replacement

- End surface of femur replaced with metal
- End surface of tibia replaced with metal
- Plastic liner is inserted between femur and tibia
- Patella is resurfaced with plastic



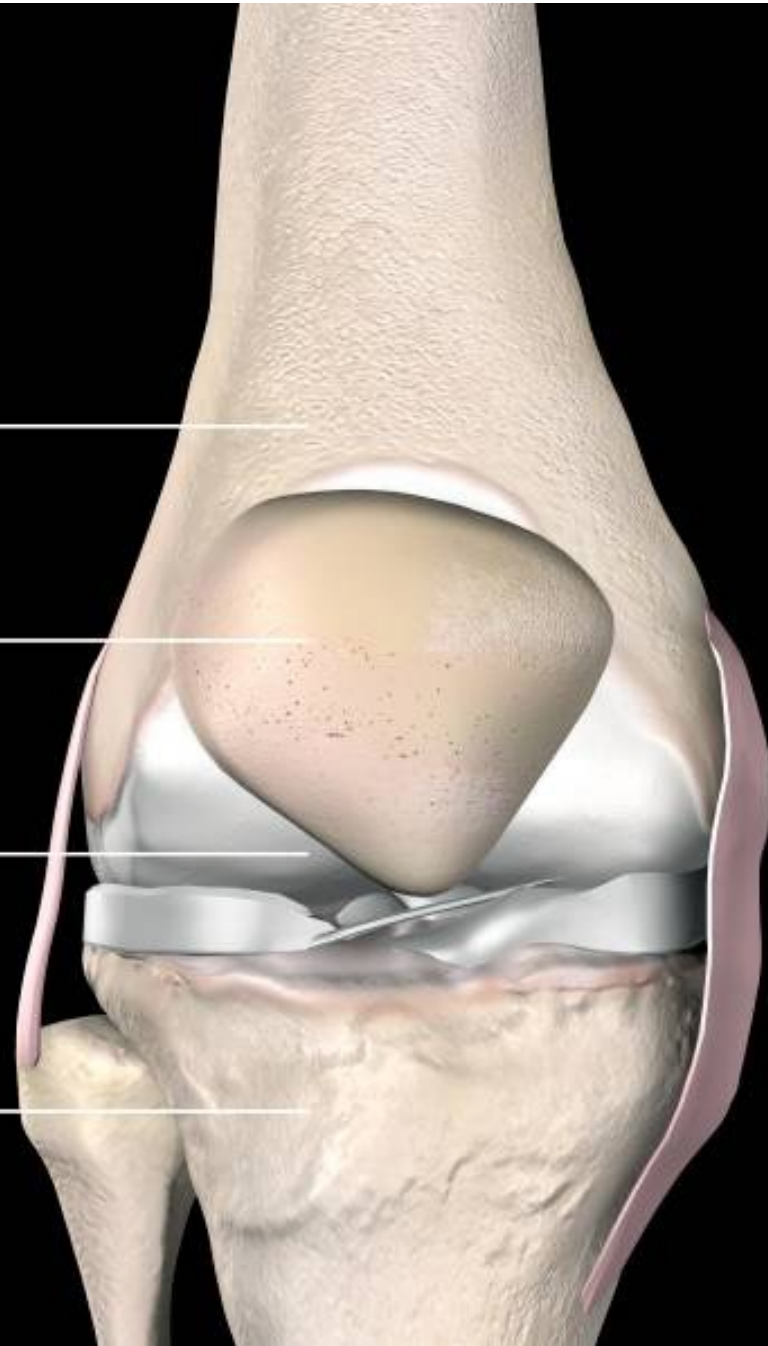
A Normal Knee

Femur (thigh bone)

Patella

Healthy Cartilage

Tibia (shin bone)

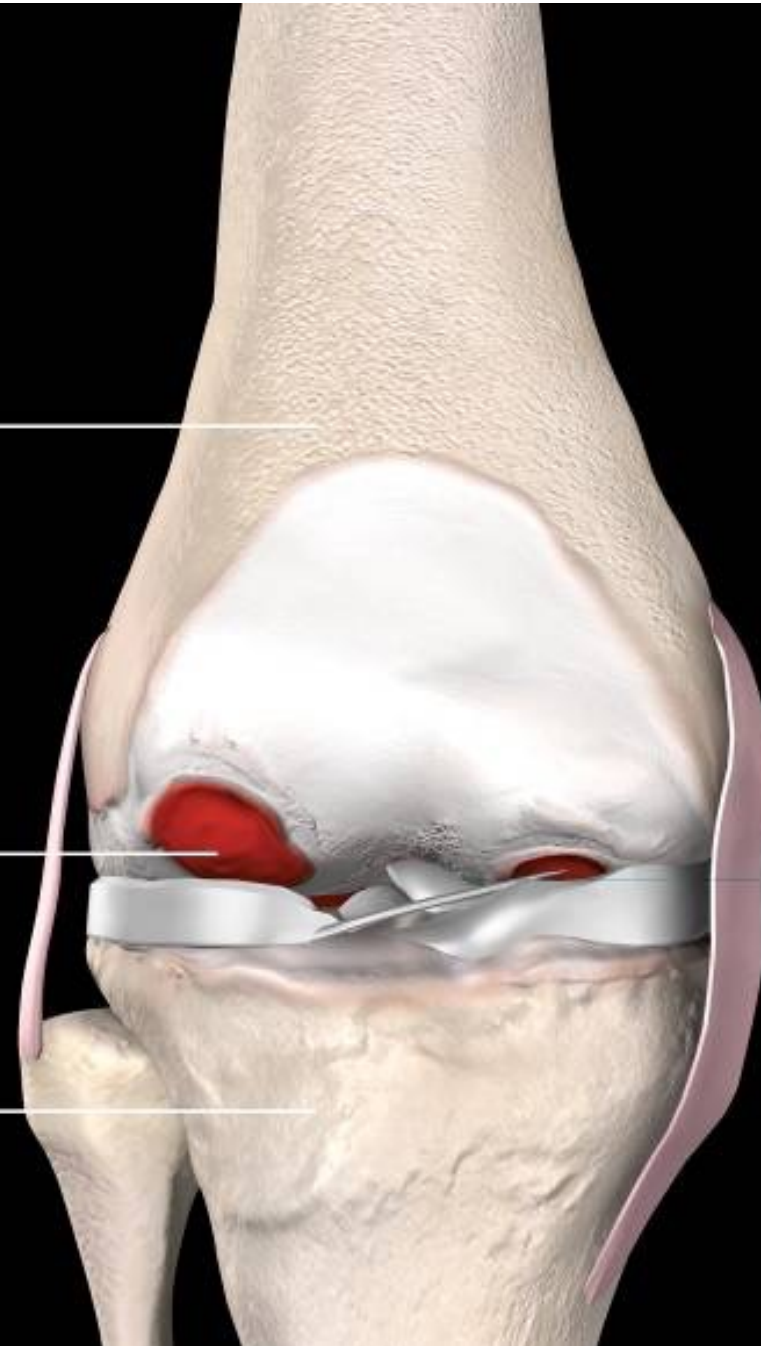


An Arthritic Knee

Femur (thigh bone)

Diseased Cartilage

Tibia (shin bone)

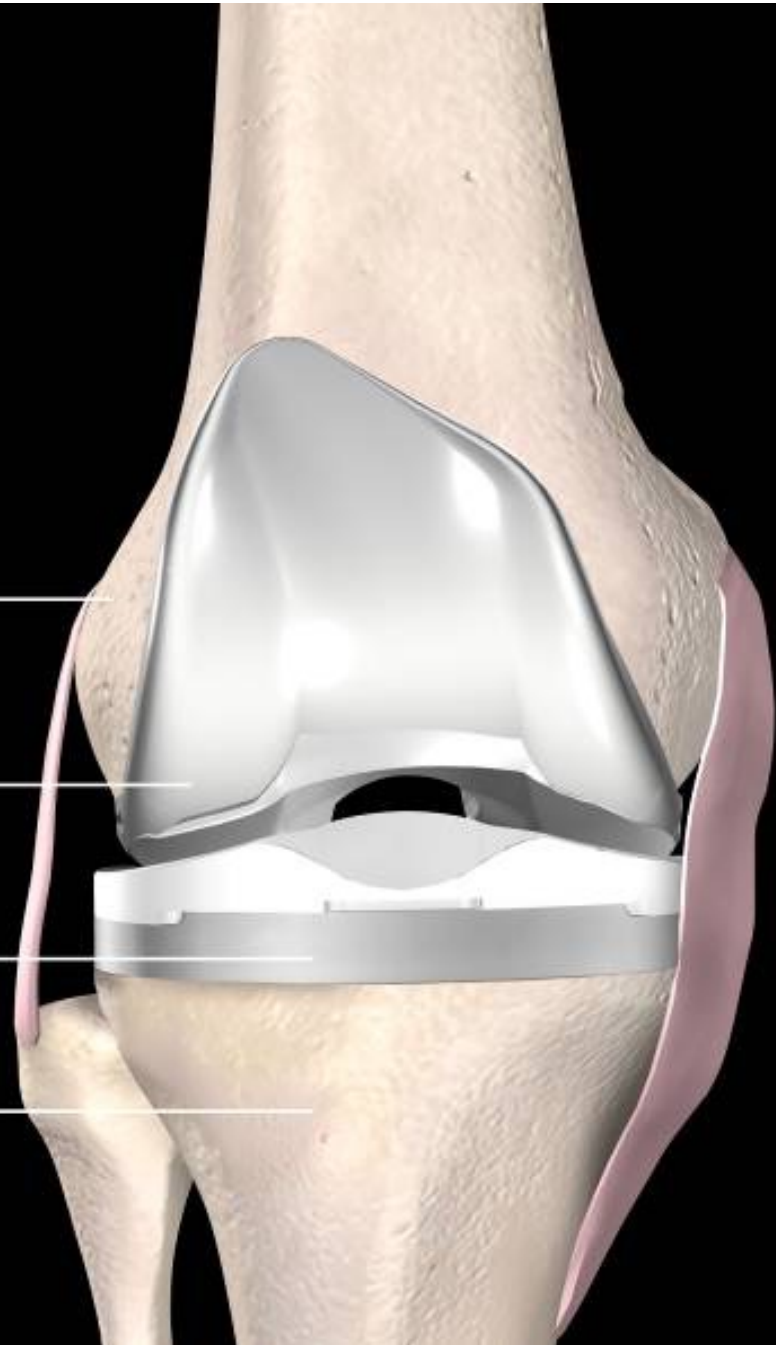


A Replaced Knee

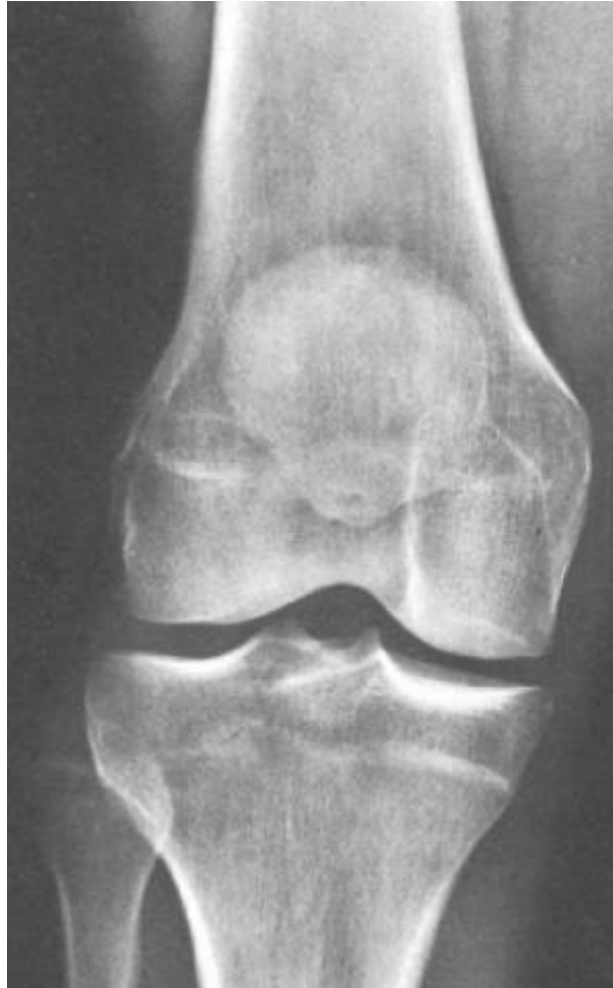
Femur (thigh bone)

Artificial Knee Implant

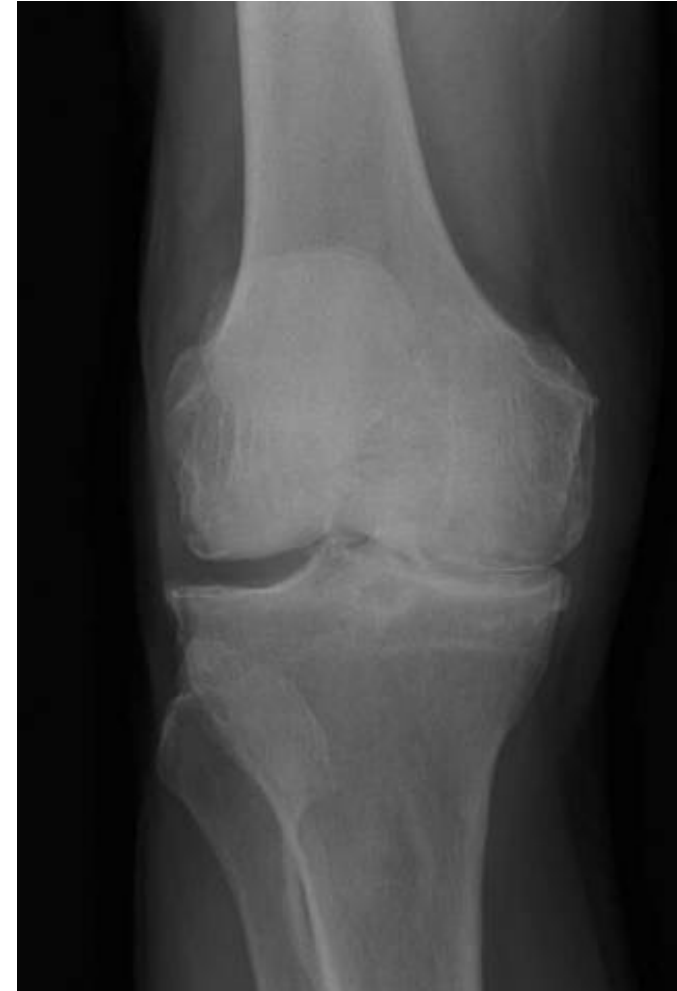
Tibia (shin bone)



Normal Knee X-ray



Arthritic Knee X-ray



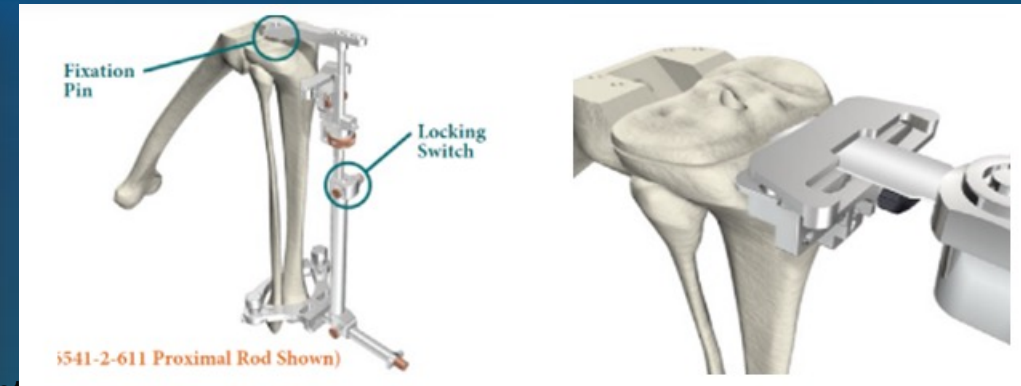
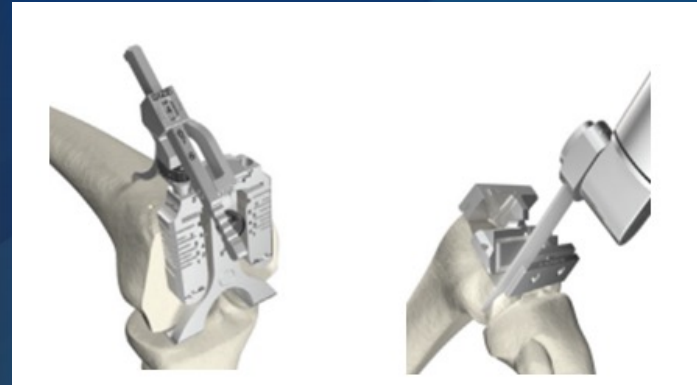
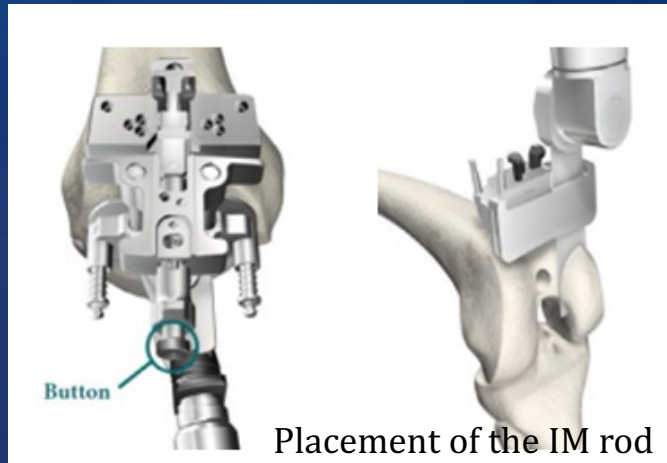
Anterior View



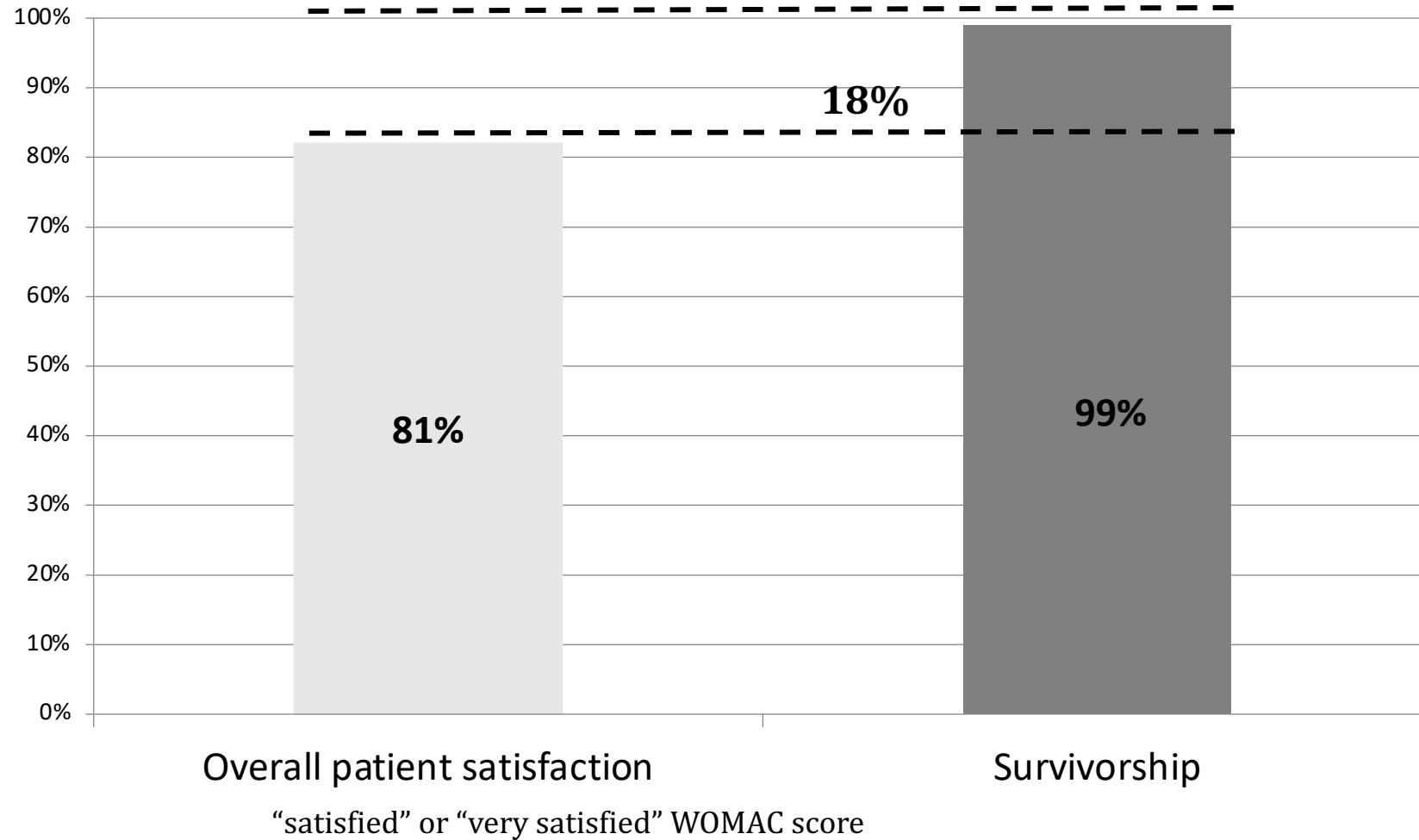
Lateral View



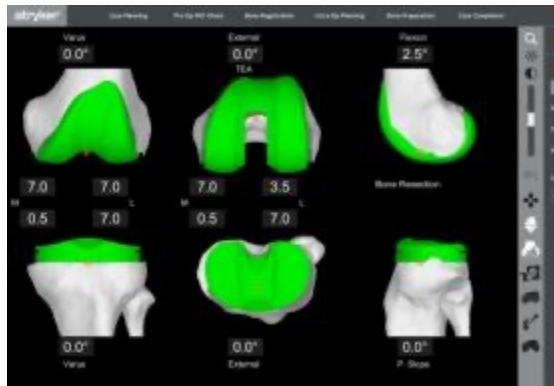
Variability of manual instrumentation



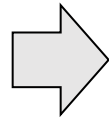
Primary TKA



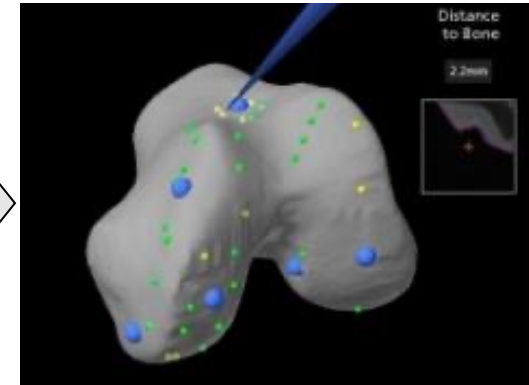
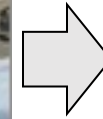
Mako Total Knee Workflow



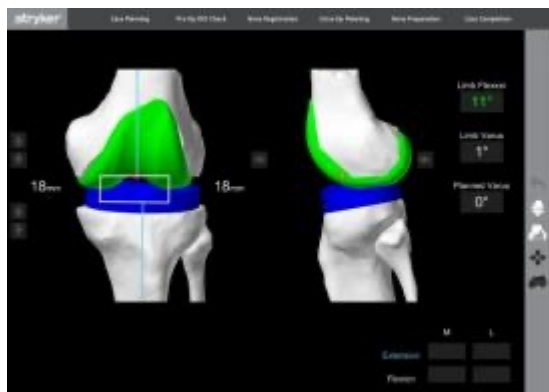
Pre-op planning



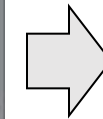
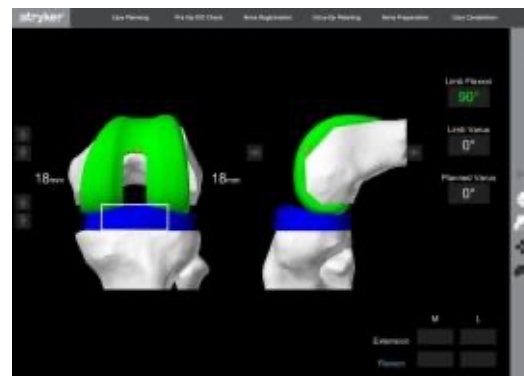
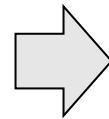
Array placement



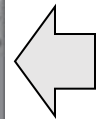
Bone registration



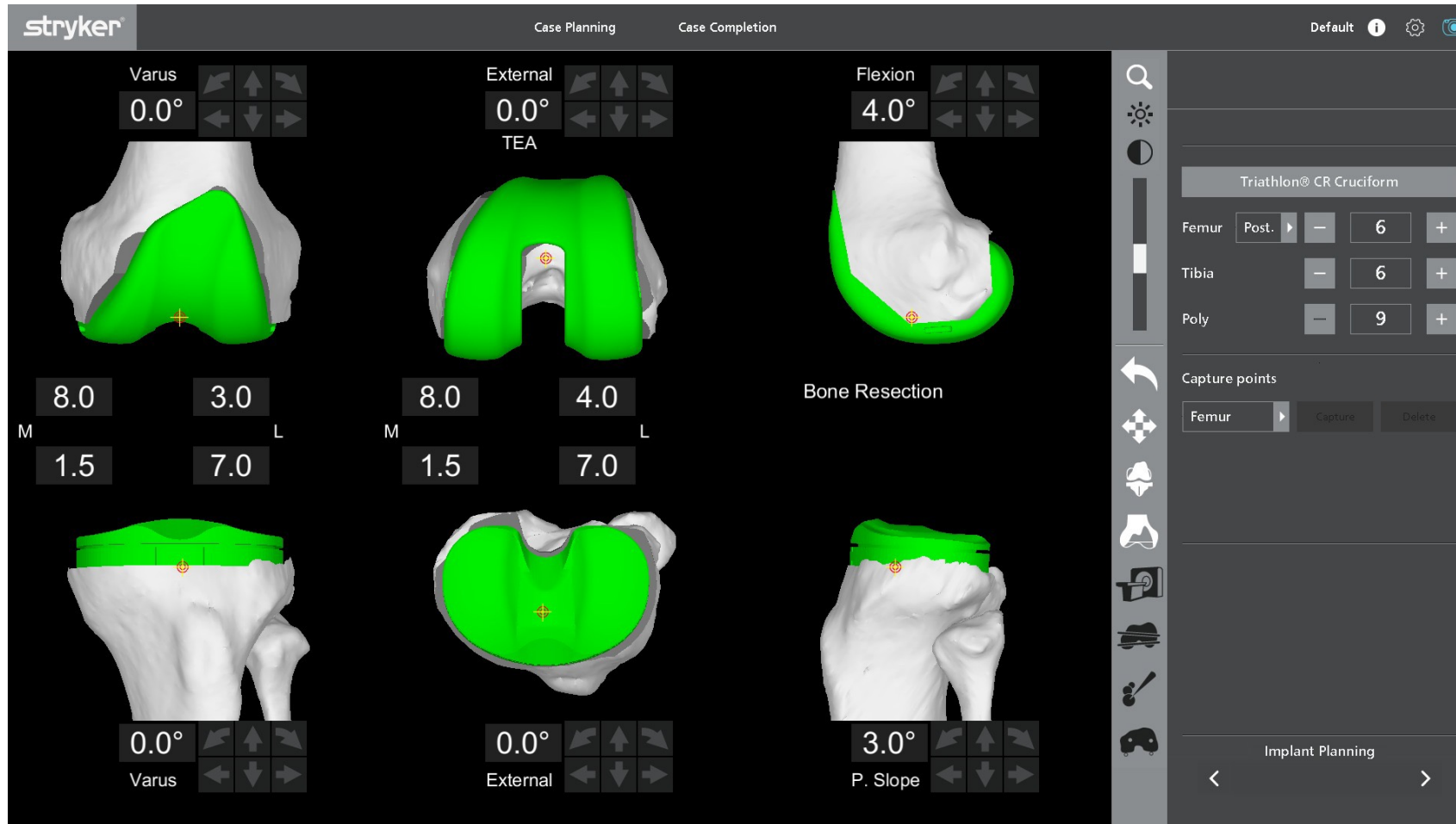
Ligament balancing assessment
Intra-op plan adjustments



Bone resection



Preop Planning



The screenshot displays the Stryker preop planning software interface, showing a 3D model of a knee joint with various parameters and controls.

Case Planning / Case Completion

Parameters:

- Varus: 0.0°
- External TEA: 0.0°
- Flexion: 4.0°
- Varus (bottom): 0.0°
- External (bottom): 0.0°
- P. Slope: 3.0°

Dimensions (M/L):

- Top Left: 8.0 (M), 3.0 (L)
- Top Middle: 8.0 (M), 4.0 (L)
- Bottom Left: 1.5 (M), 7.0 (L)
- Bottom Middle: 1.5 (M), 7.0 (L)

Implant Selection: Triathlon® CR Cruciform

Dimensions:

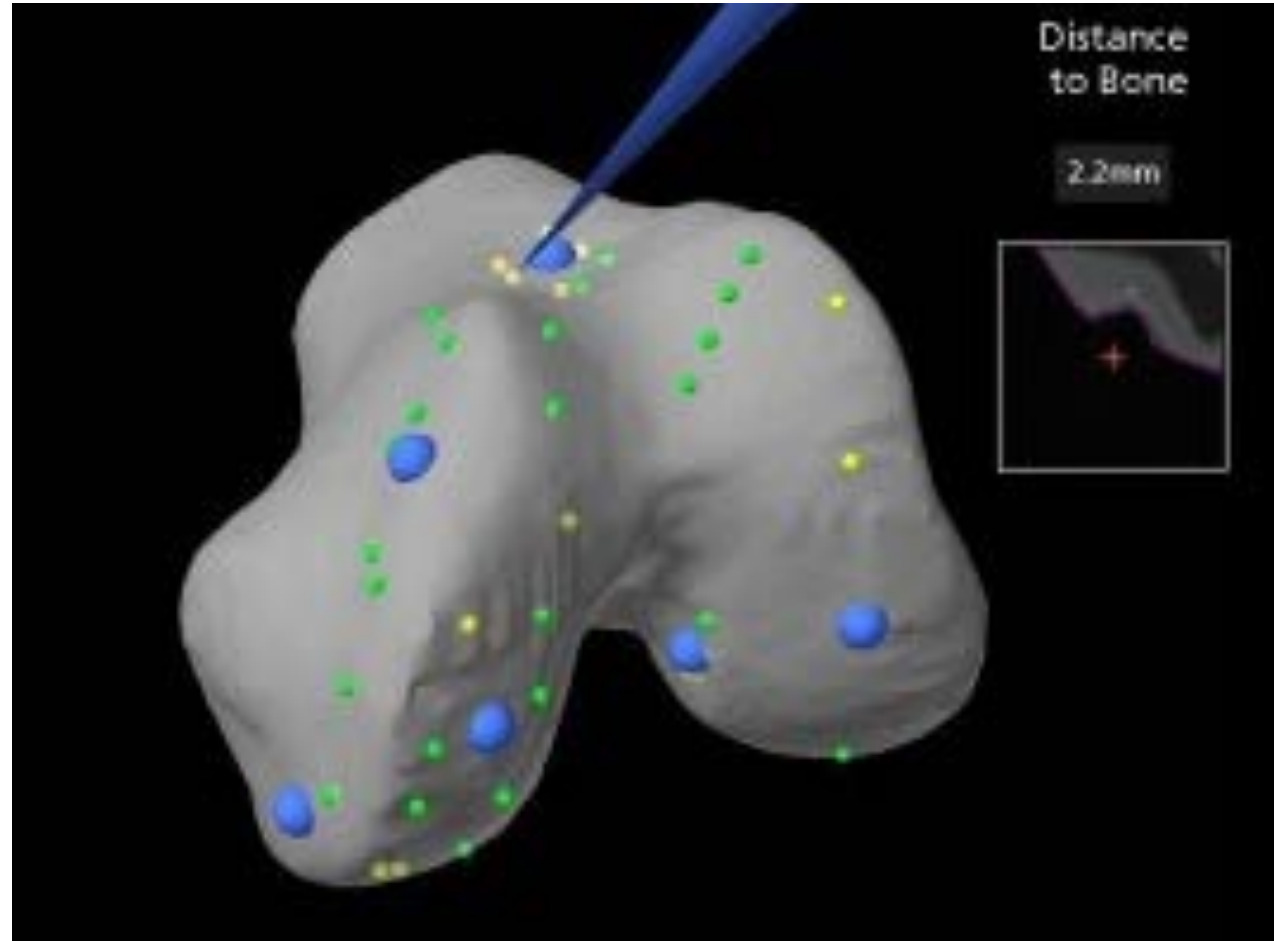
- Femur Post.: 6
- Tibia: 6
- Poly: 9

Controls: Bone Resection, Capture points (Femur), Implant Planning

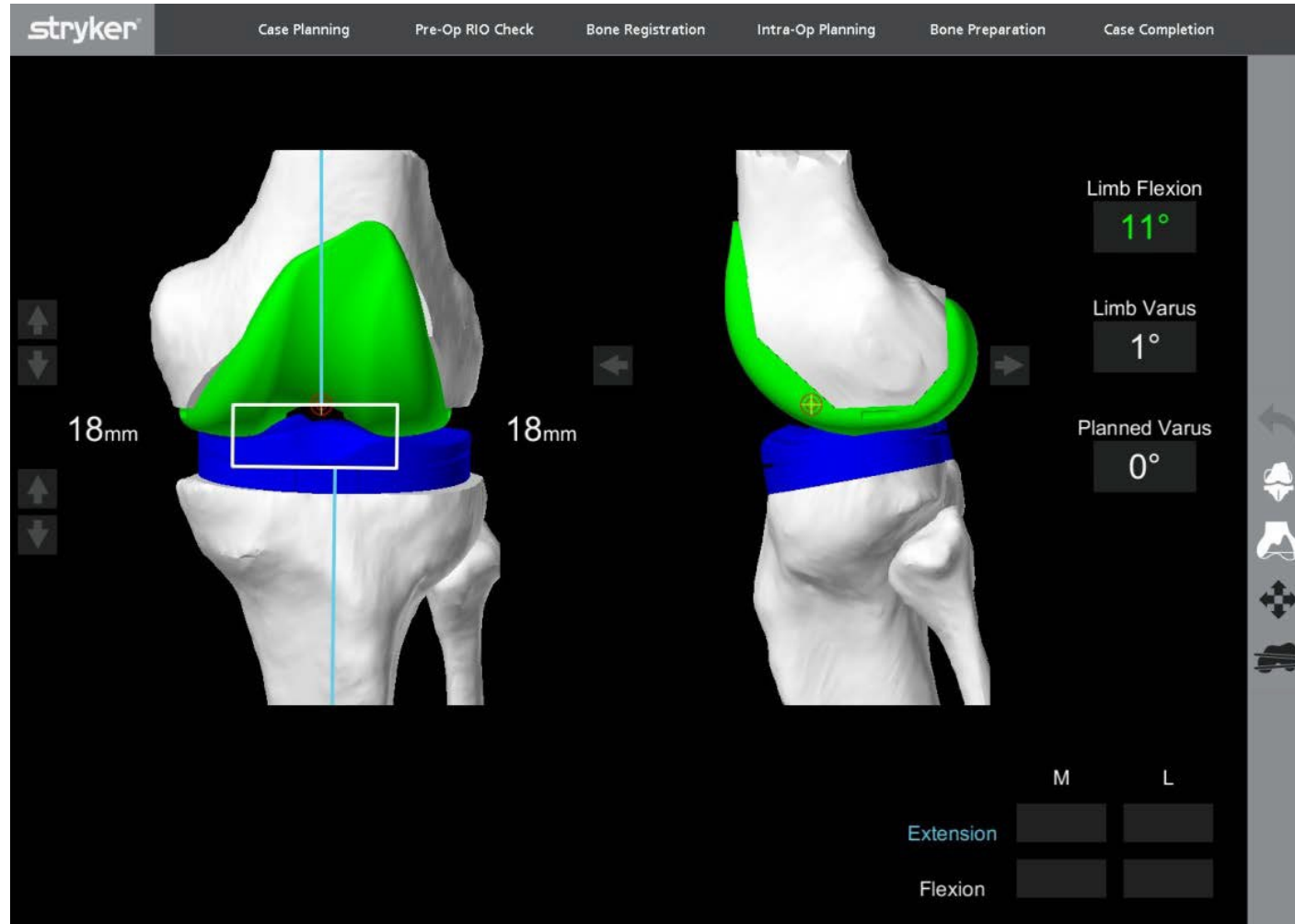
Array Placement



CT-guided Bone Registration



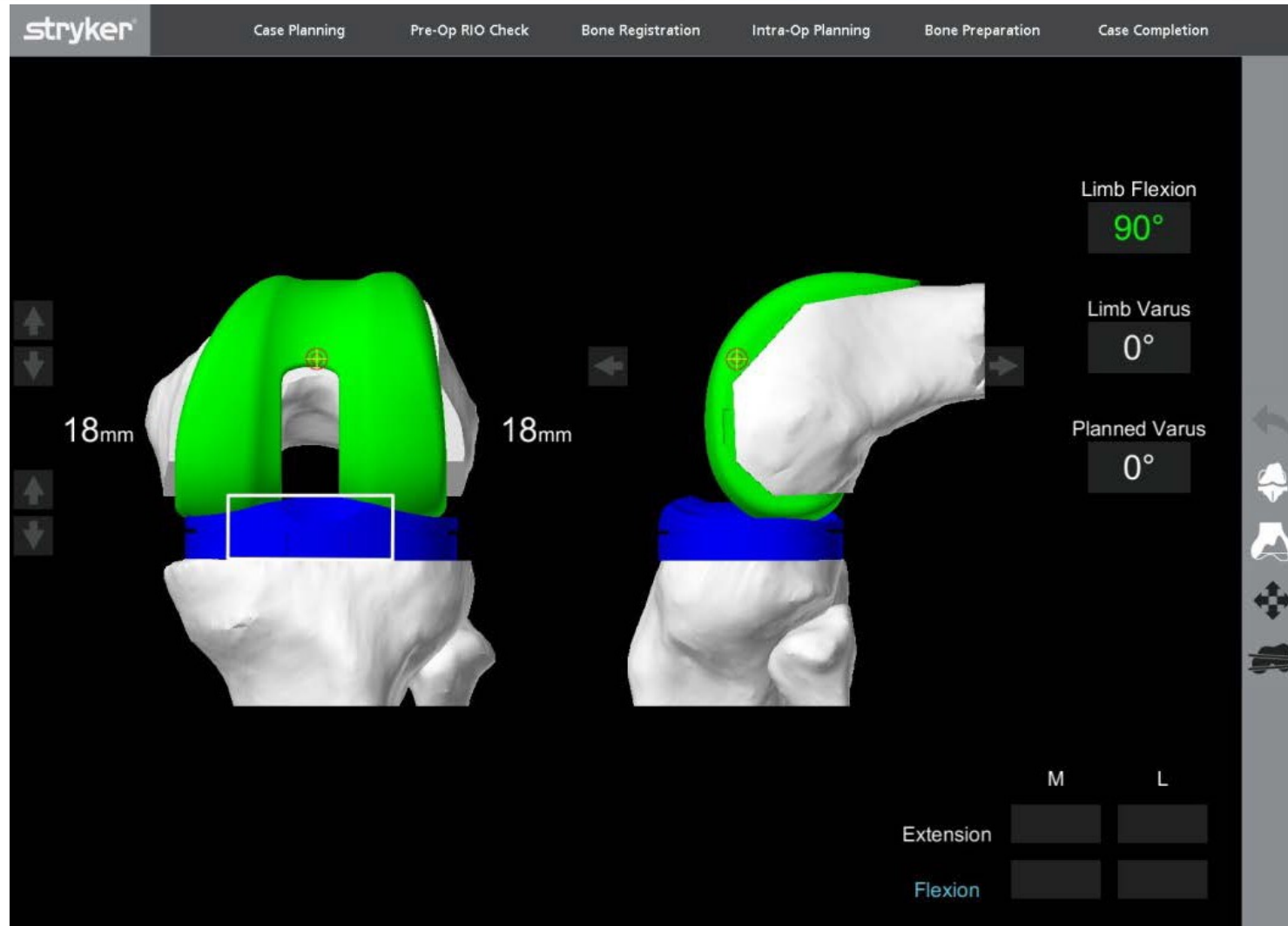
Dynamic Pre-resection Balancing



Joint Balancing

stryker

Case Planning Pre-Op RIO Check Bone Registration Intra-Op Planning Bone Preparation Case Completion



18mm 18mm

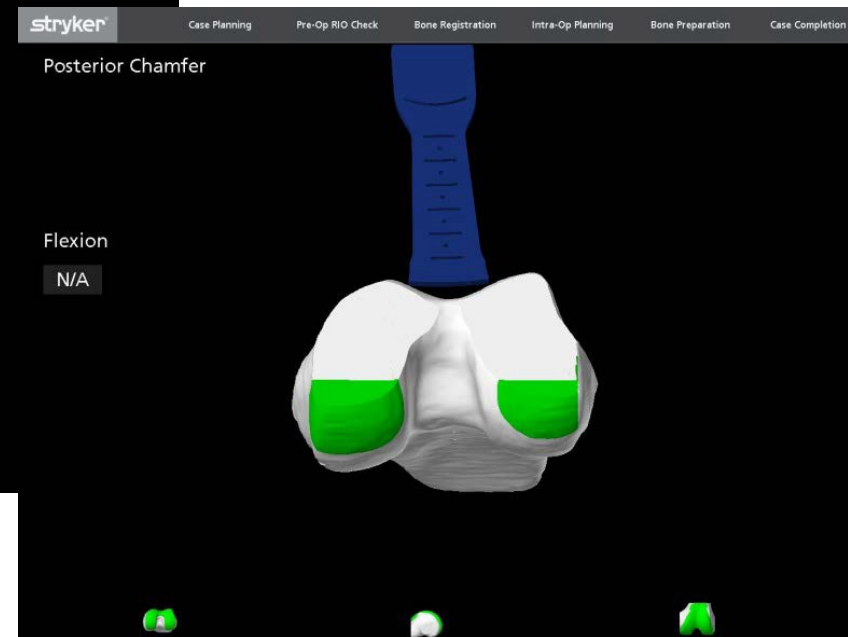
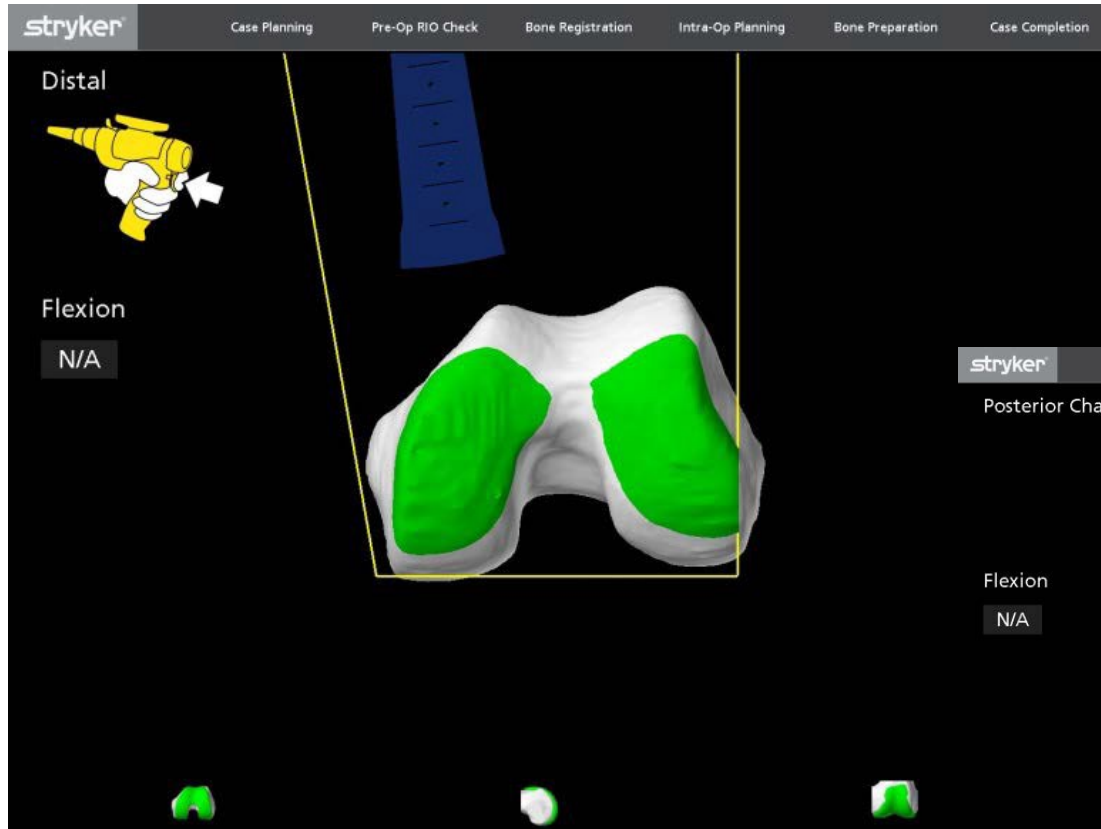
Limb Flexion
90°

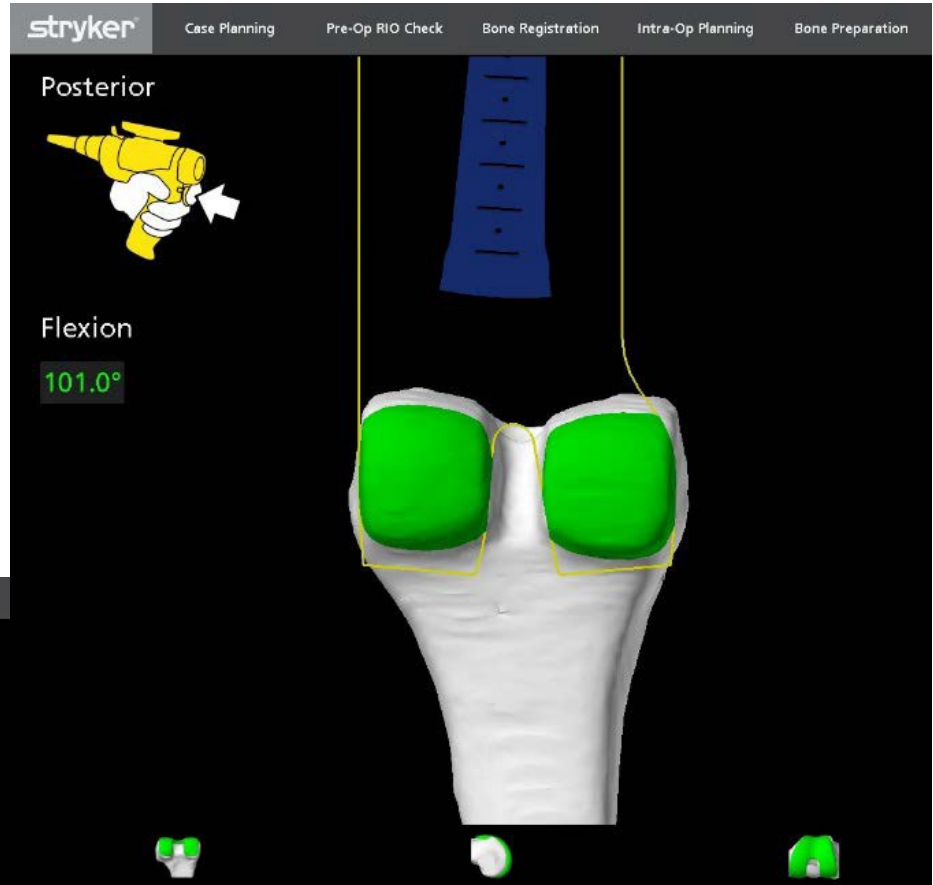
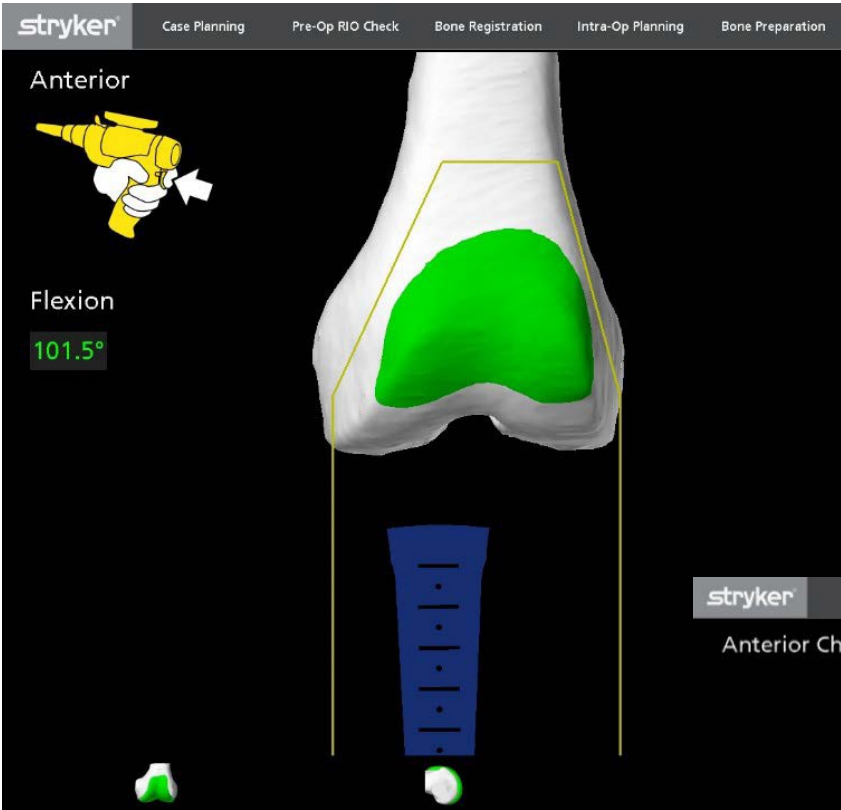
Limb Varus
0°

Planned Varus
0°

	M	L
Extension		
Flexion		


Distal Femur and Posterior Chamfer



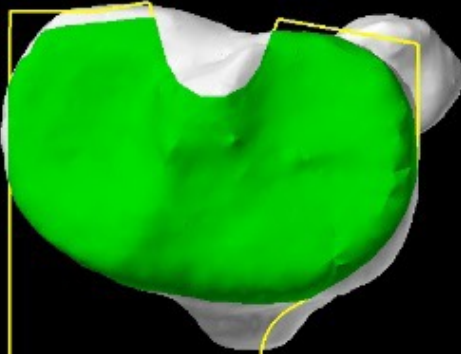


stryker® Case Planning Pre-Op RIO Check Bone Registration Intra-Op Planning Bone Preparation Case Completion stuff ⓘ ⚙️ 📷

Tibia



Flexion
101.0°





1: Tibia

Side	Left
Femur	3
Tibia	3 x 9mm
Tool	Straight Saw, Standard
Mode	Approach

Hold the trigger to start alignment.

Bone Preparation

Knee

 Free Access | 

Robotic-arm assisted total knee arthroplasty is associated with improved early functional recovery and reduced time to hospital discharge compared with conventional jig-based total knee arthroplasty

a prospective cohort study

B. Kayani, S. Konan, J. Tahmassebi, J. R. T. Pietrzak, F. S. Haddad

Published Online: 28 Jun 2018 | <https://doi.org/10.1302/0301-620X.100B7.BJJ-2017-1449.R1>

Table II Study outcomes for patients undergoing conventional jig-based total knee arthroplasty (TKA) and robotic-arm assisted TKA

Outcome	Conventional (n = 40)	Robotic (n = 40)	p-value
Mean operating time (mins)	61.2 (54.6 to 83.1)	70.4 (59.2 to 91.7)	0.34*
Mean fall in Hb (g/L)	26.1 (5.1 to 49.6)	18.7 (8.0 to 37.2)	< 0.001*
Mean postoperative Hb (g/L)	106.7 (77.3 to 138.4)	114.7 (86.4 to 139.1)	0.01*
Mean pain score (NRS) – Day 0	5.4 (3.0 to 7.0)	3.1 (2.0 to 5.0)	< 0.001*
Mean pain score (NRS) – Day 1	6.3 (4.0 to 8.0)	3.6 (2.0 to 6.0)	< 0.001*

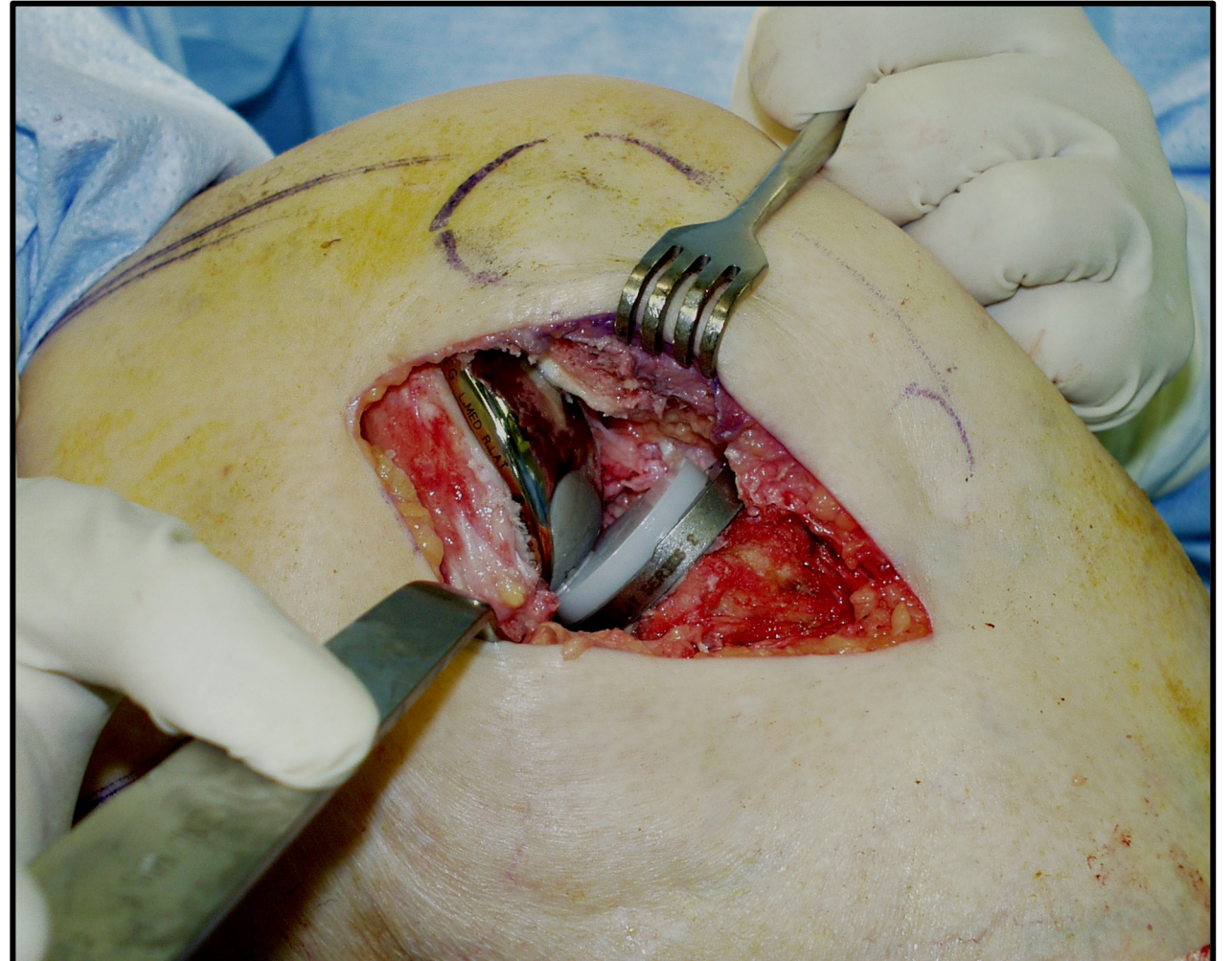
Minimally Invasive TKA

- Provide early and exceptional analgesia
- Low trauma surgery
- Early discharge and rapid rehab

- Pre-emptive analgesia
 - Celebrex
 - Spinal Anesthetic
- Pre-emptive anti nausea
 - Pepcid

Operative Management

- SPINAL anesthetic
- IV sedation
- Capsular injection



Post-Operative Management

- Early ROM with PT
- Ambulation same day

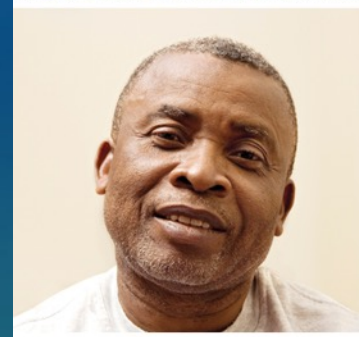


Post-Operative Management

- Gait training POD1
- Stairs and PT instruction
- Possible outpatient



Update on Hip Arthroplasty



The Very Important Bearing Surface Hip Arthroplasty

- The bearing affects
 - Performance
 - Flexibility
 - Durability
 - Longevity
- Options for bearings in hip replacements
 - Ceramic-on-ceramic
 - Metal-on-plastic
 - Metal-on-metal
 - Ceramic-on-plastic

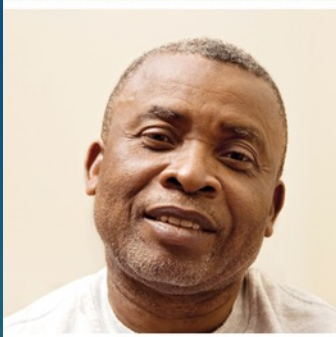
The bearing surface:
The two parts that glide together throughout motion

Femoral head and acetabular insert in hips





MIS Hip Replacement Direct Anterior Approach



What is the 'Direct Anterior Approach'?

- The direct anterior approach is a minimally invasive hip replacement technique that allows the surgeon good access to the hip without detaching any muscles or tendons.

Traditional Hip Replacement

- 8-12 inch incision
- Surgical approach - side (lateral) or back (posterior)
- Disturbance of the joint and connecting tissues

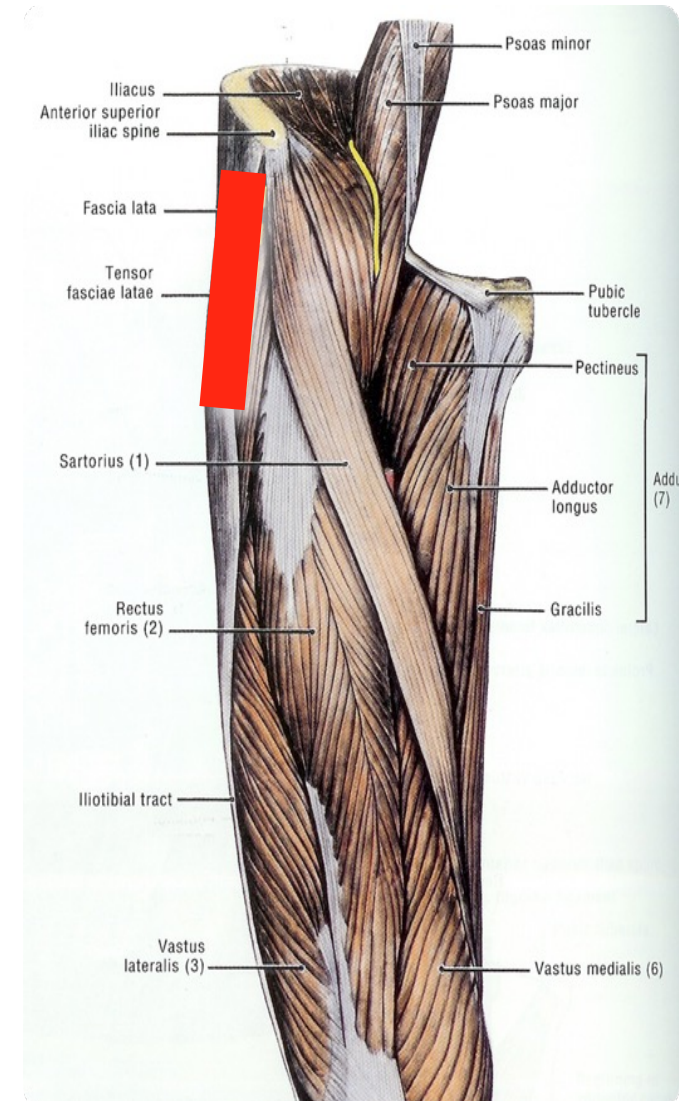
MIS with Direct Anterior Approach

- 4-5 inch incision
- Surgical approach – front (anterior)
- Muscles or tendons not detached

Why I Do The Direct Anterior Approach?

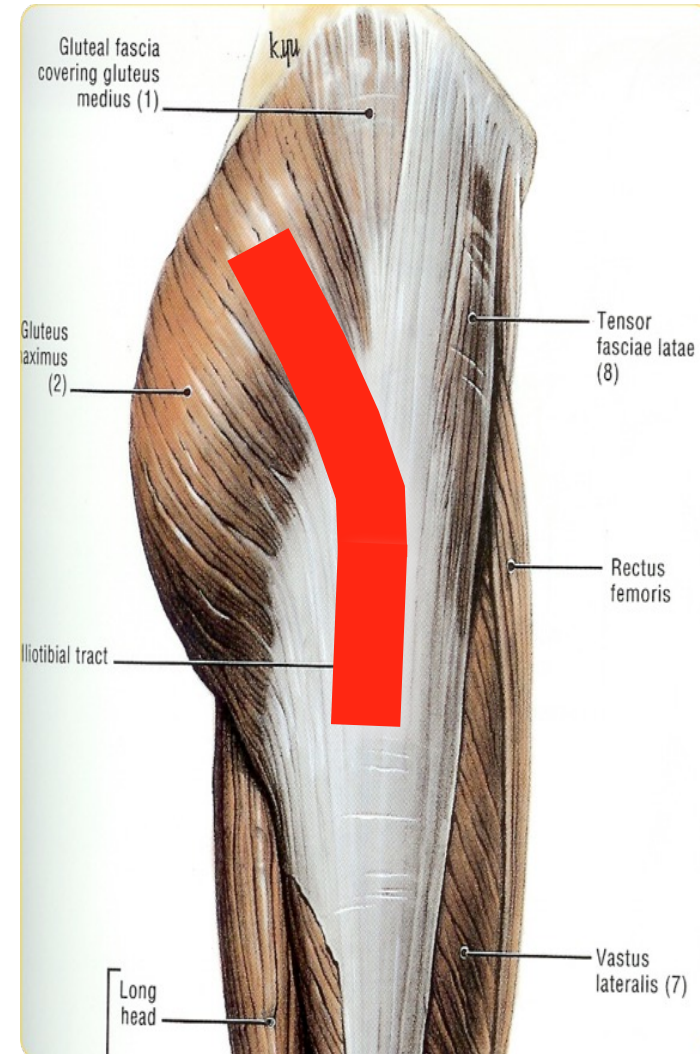
Why Direct Anterior?

- Hip closer to the front of the body
- Surgical anatomy
- Doesn't detach any major muscles
- Minimal risk to nerves
- Truly MIS



Why Direct Anterior?

- Less pain
- Quicker restoration of function
- Shorter hospital stay
- Probably more economical



Why?

- Ideal soft tissue interval
- Ease of patient position
- Simple socket instrumentation



Why not?

- Unfamiliar territory
- Femoral exposure is difficult
- Specialized equipment



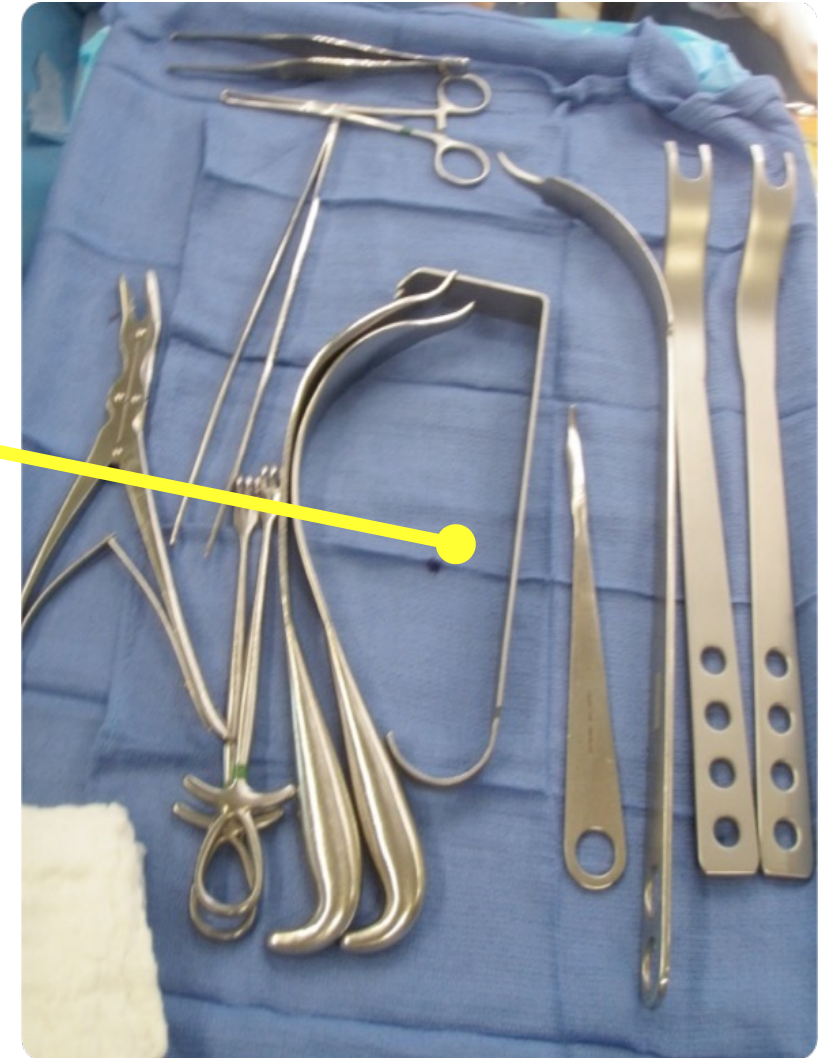
How it's done

Special Instruments



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Retractors



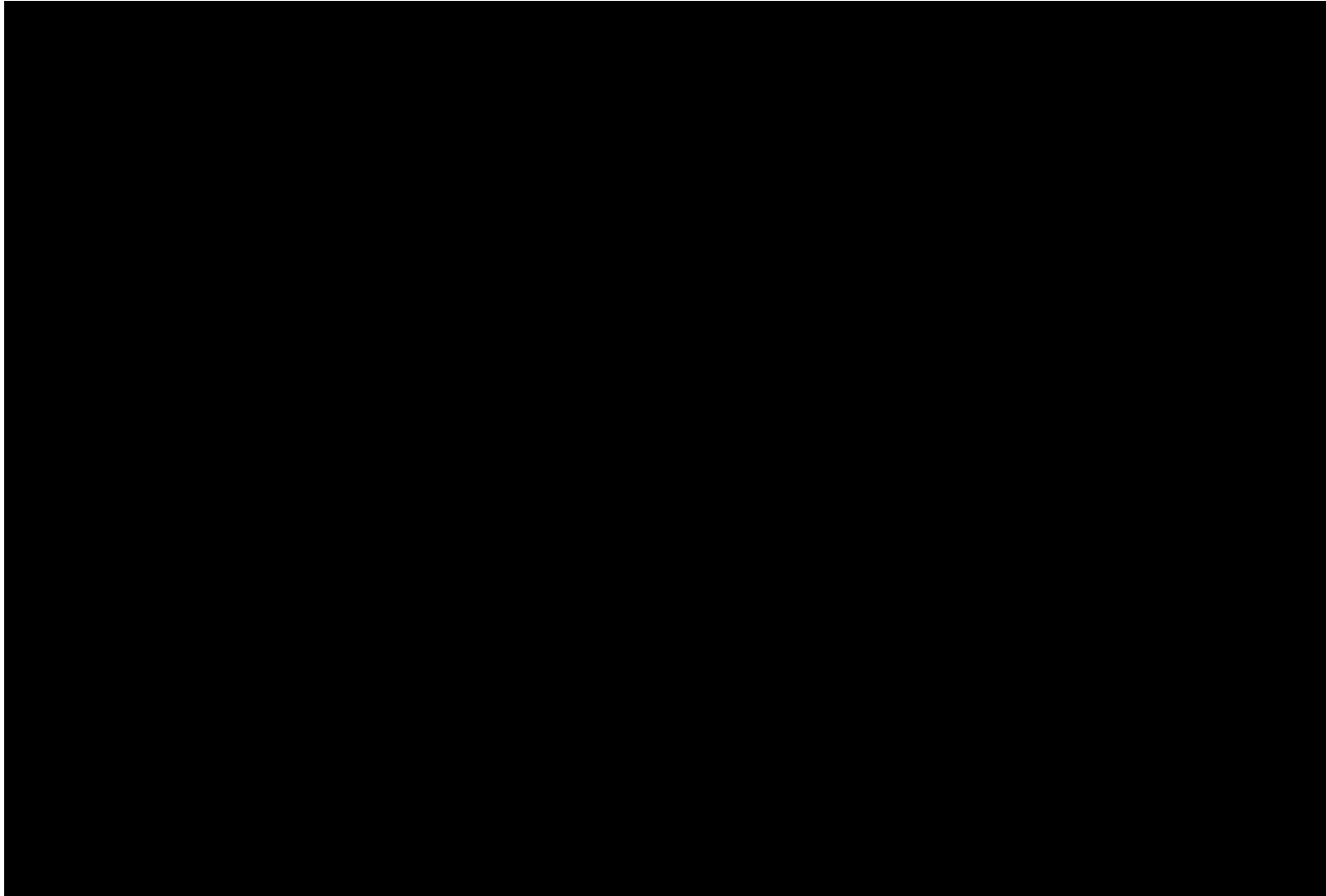
Special Equipment

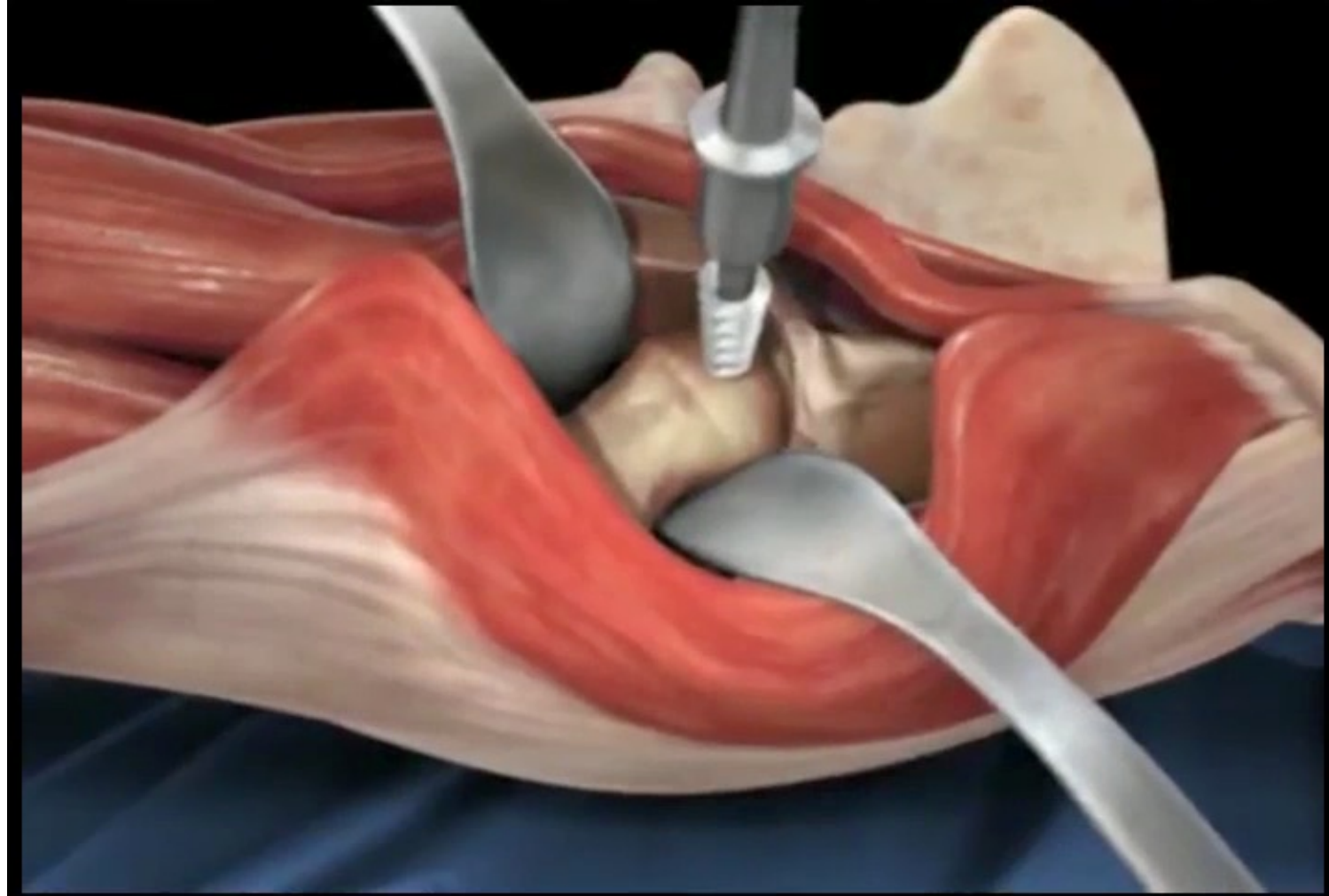
Lighting

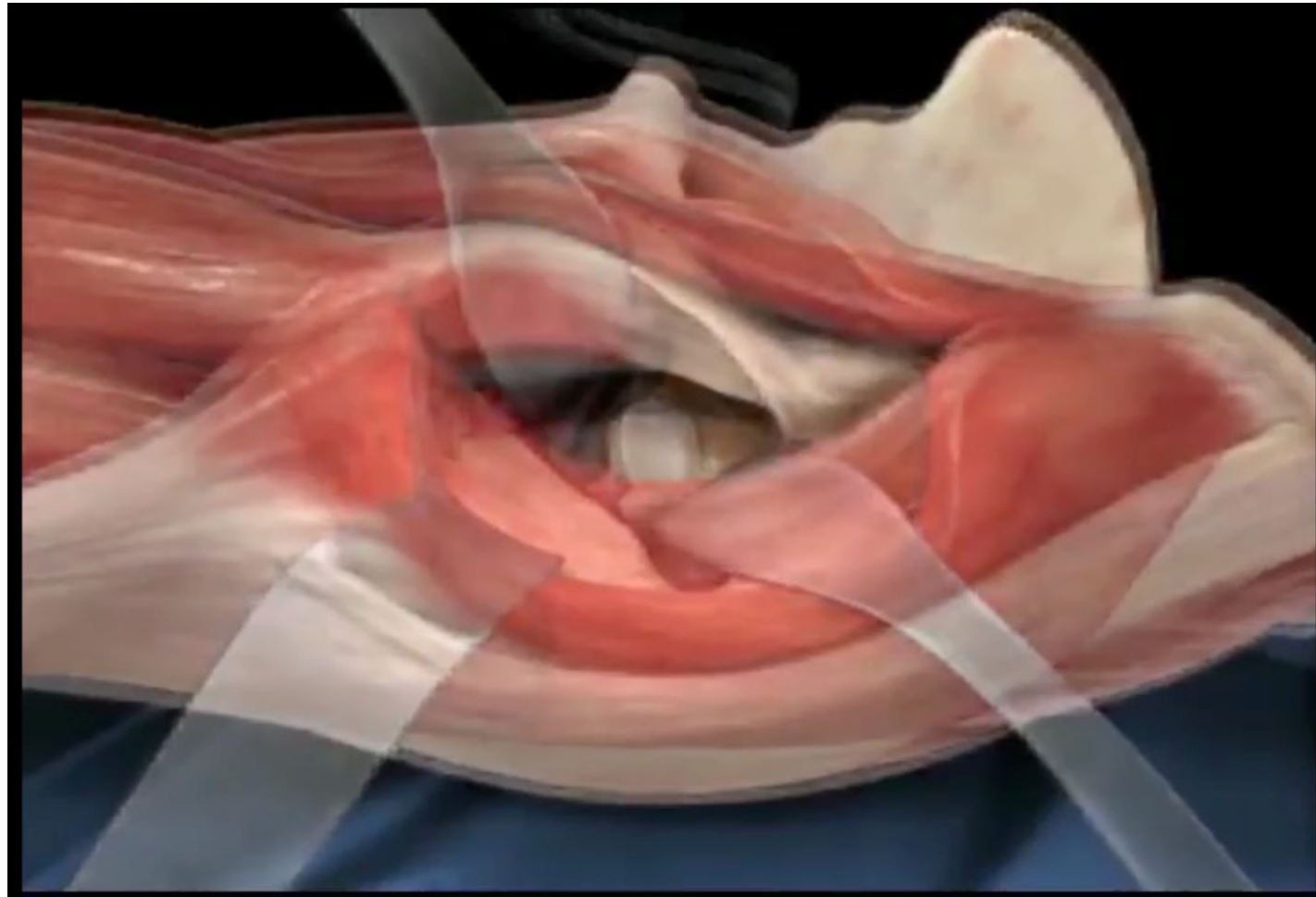


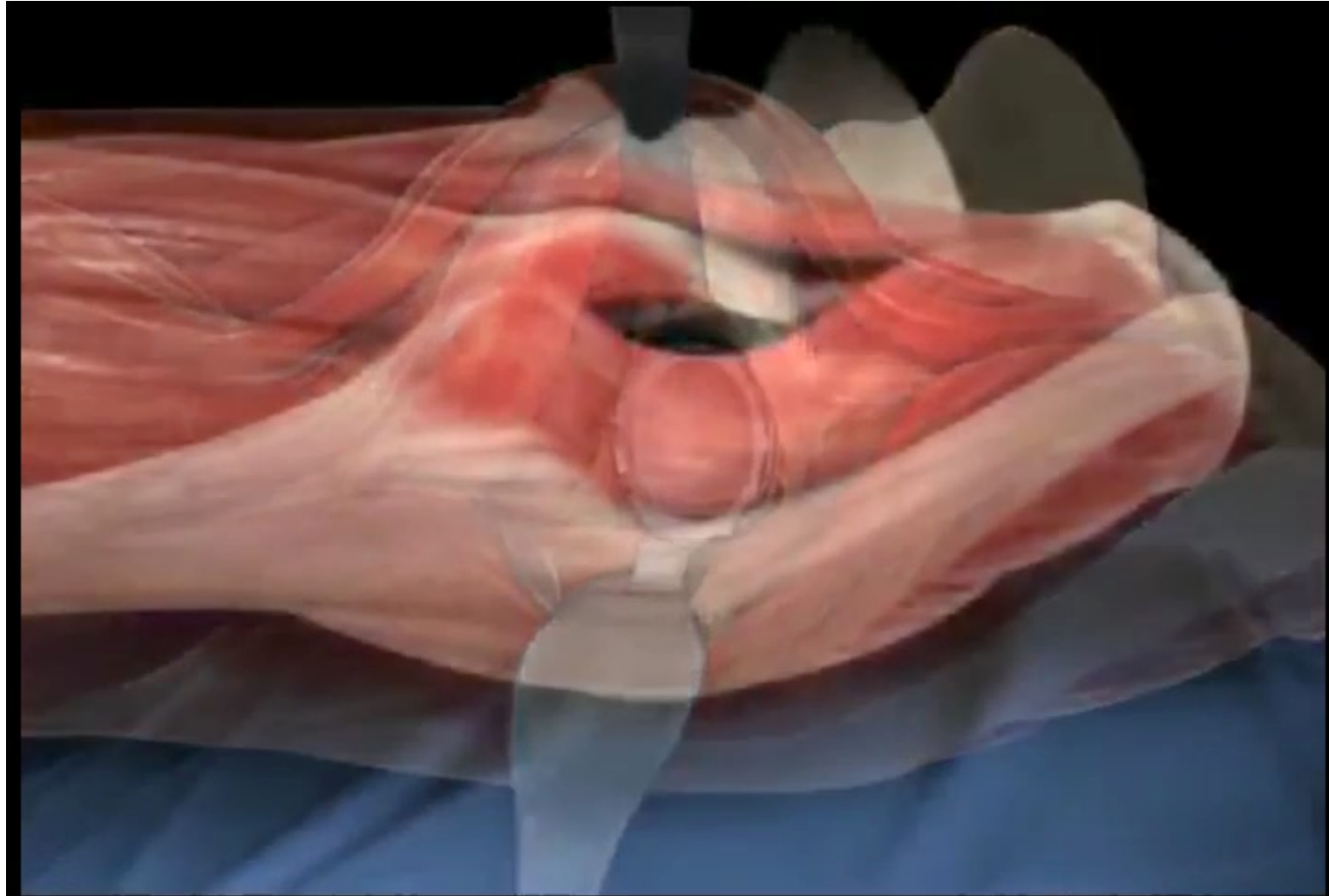
Arch table

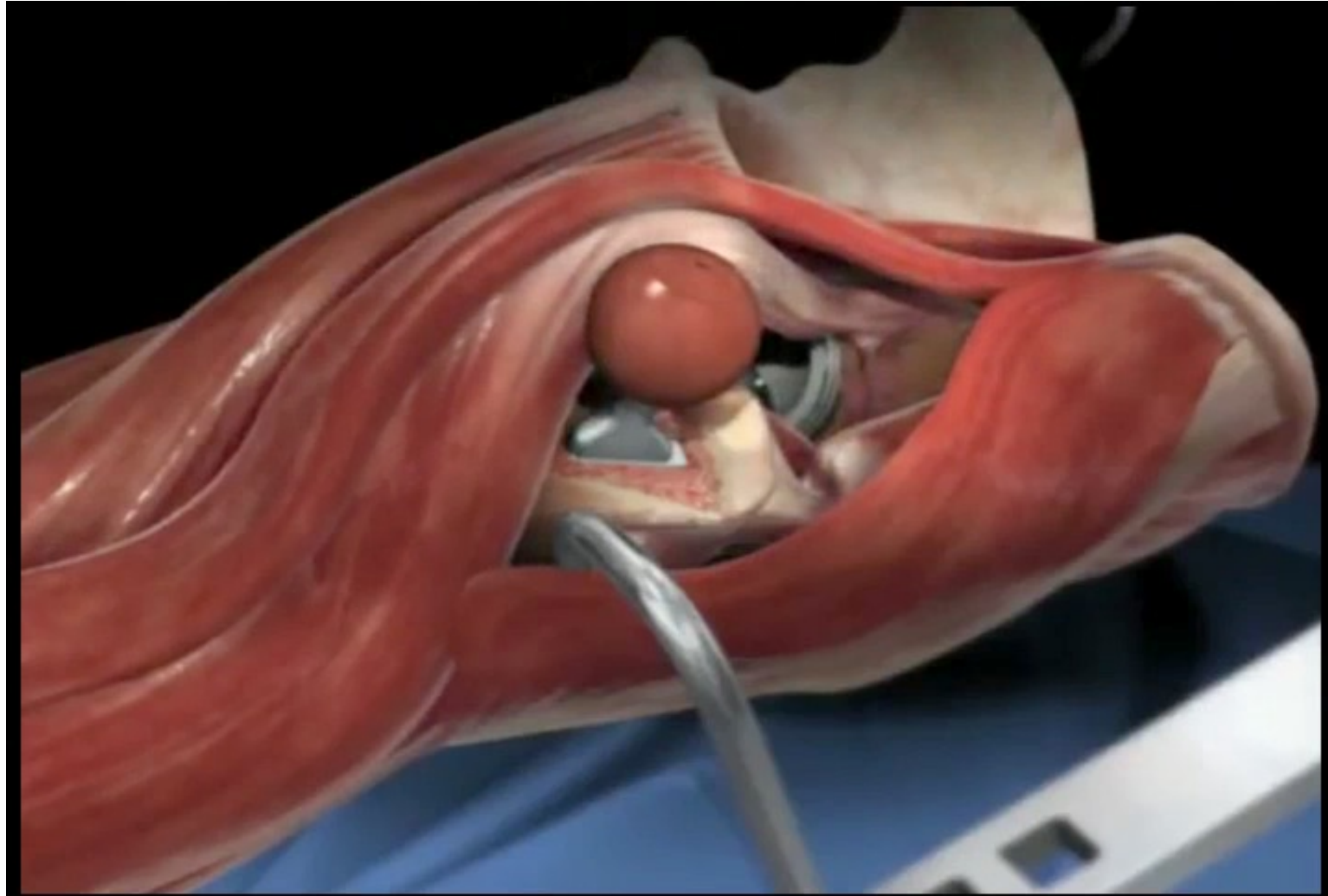












Typical Precautions: Traditional vs. Direct Anterior

Traditional Hip Replacement

- Do not cross legs
- Do not bend hip more than a right angle
- Do not turn feet excessively inward or outward
- Use a pillow between your legs when sleeping

Direct Anterior Approach

- Under doctor's supervision, may be immediately allowed to move their hips
- May potentially avoid restrictions associated with traditional hip replacement¹

1. <http://www.anteriorhip.org/anterior-hip-replacement.html> accessed Nov 2010.

Potential Benefits of MIS with Direct Anterior Approach

- Decreased hospital stay and quicker rehabilitation.²
- Smaller incision and reduced muscle disruption may allow patients a shorter recovery time and less scarring.¹
- Potential for less blood loss, less time in surgery, and reduced post-operative pain.^{1,3,4}
- Risk of dislocation reduced.²
- May allow for a more natural return to function and activity.^{1, 3}

1. Wenz, J, Gurkan, I., Jibodh, S., "Mini-Incision Total Hip Arthroplasty: A Comparative Assessment of Peri-operative Outcomes," Orthopedics Magazine, 2002.

2. www.anteriorhip.org/anterior-hip-replacement.html accessed Nov 2010.

3. Keggi, Kristaps, I., "Total Hip Arthroplasty Through a Minimally Invasive Anterior Surgical Approach," JBJS, Vol. 85-A. 2003.

4. Baerga-Varela, L., Malanga, G.A., "Rehabilitation after Minimally Invasive Surgery." Hozack, W., Krismer, M., Nogler, M., Bonutti, P., Rachbauer, F., Schaffer, J., Donnelly, W., ed. Minimally Invasive Total Joint Arthroplasty. New York, NY: Springer-Verlag; 2004: 2-5.

Advantages of Direct Anterior

- MIS approach is better for patients
- No Hip Precautions
- Improved control over component position



The Use of Technology in Hip Replacement

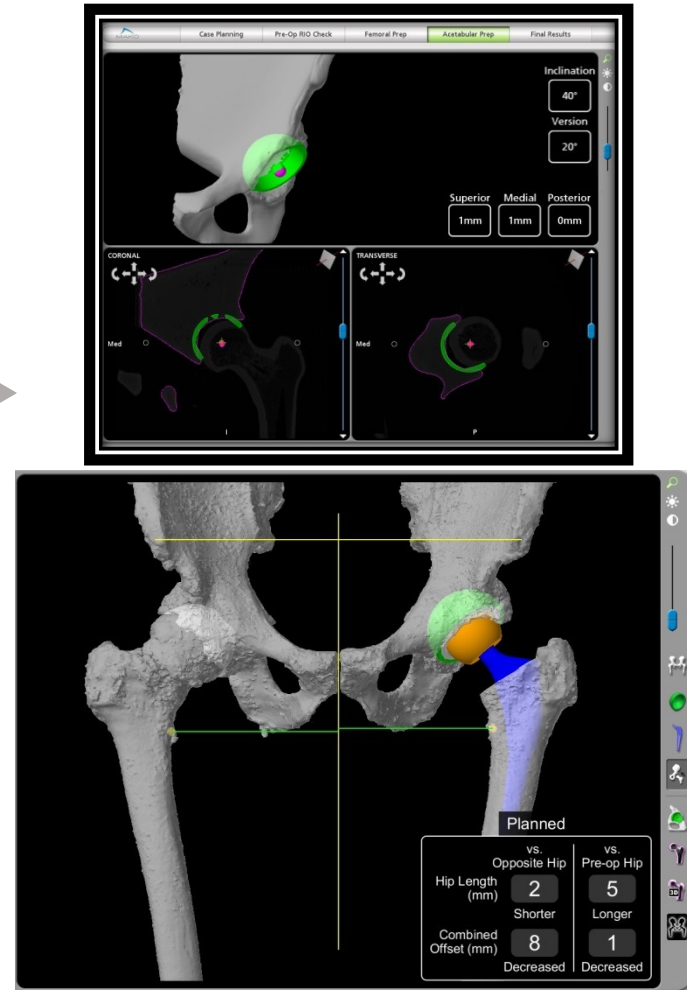
Why Navigation?

- Increased level of precision
- Confidence in component position
- Recovery room film is too late for changes
- Optimize surgical results

mTHA- Plain x-ray



rTHA- 3D CT

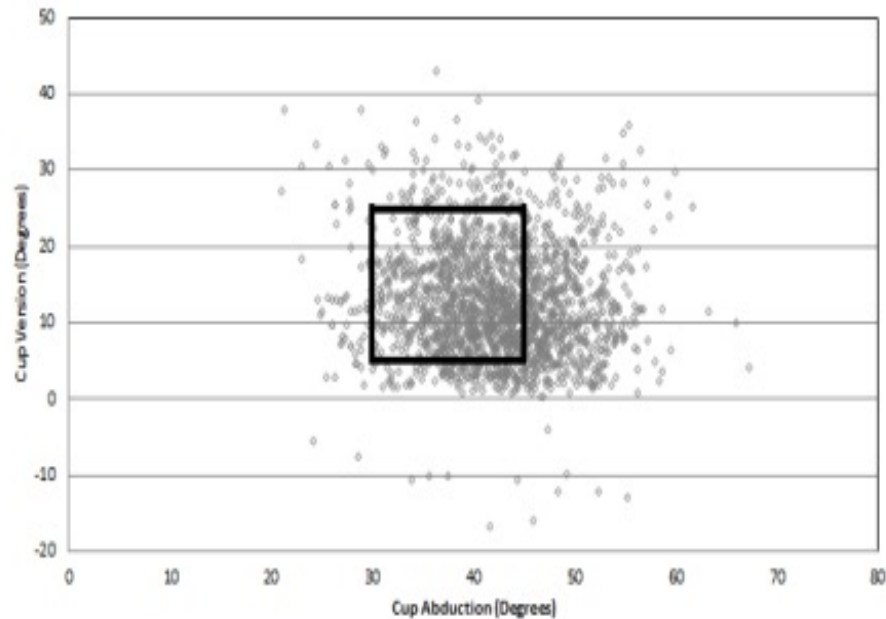


rTHA vs. mTHA: Multicenter study Boulder Community Health

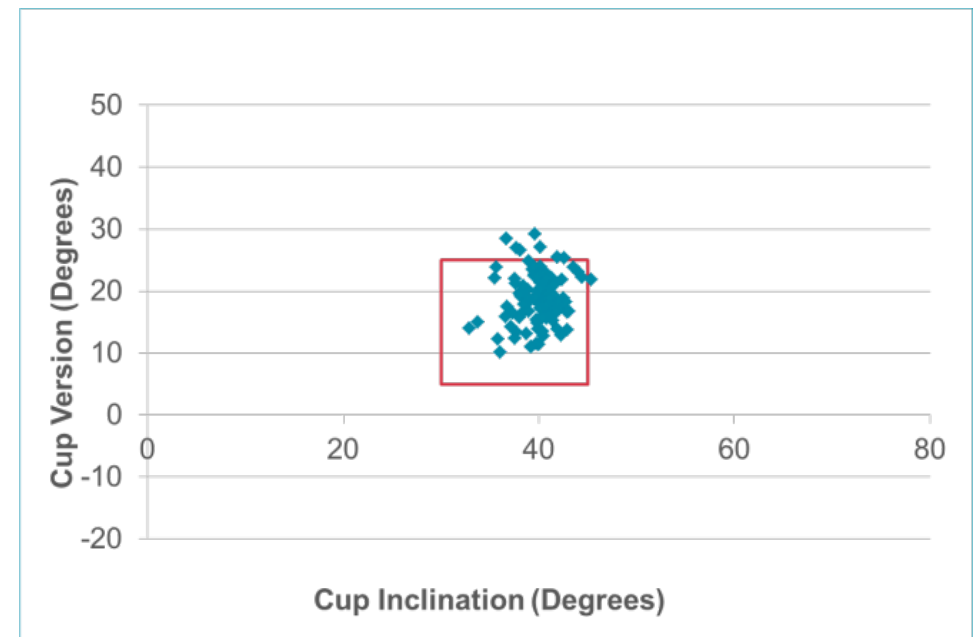
MGH, University of Wisconsin, HSS (Malchau, Padgett, Douchis, Illgen, Marchand)

Manual THA : N= 1883
47% inside target zone

All Patients(n=1883)



Robotic THA: N=119
96% inside target Zone
95% within 4 degrees of plan

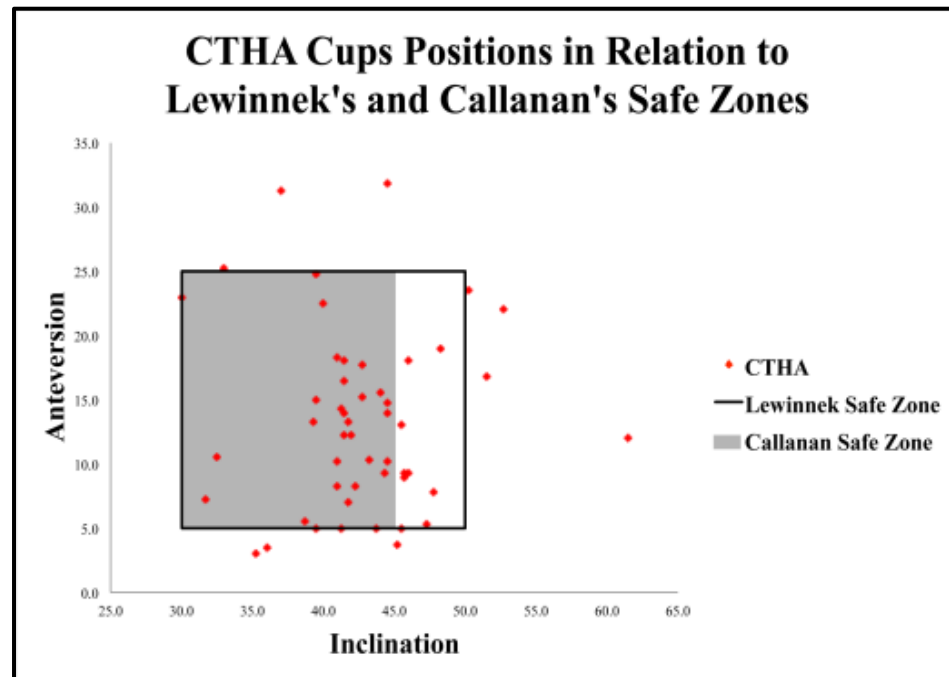


1. The John Chamley Award: Risk factors for cup malpositioning: Quality improvement through a joint registry at a tertiary hospital.
Clin Orthop Relat Res. 2011 Feb;469(2):319-29.

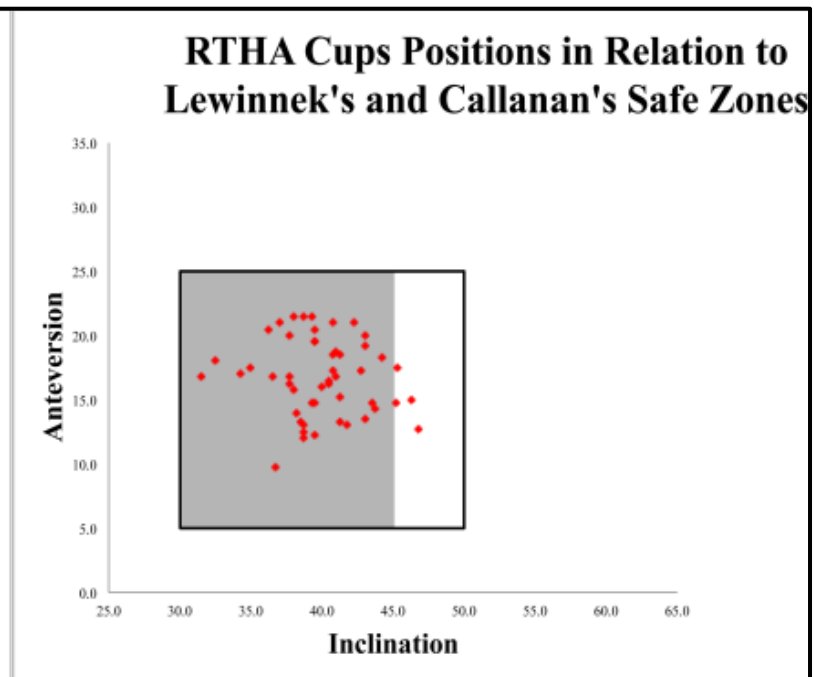
A Matched-Pair Study- Dr. Domb – [Hinsdale, IL CORR 2013](#)

- rTHA (N=50) vs. mTHA (N=50), X-ray analysis (HAS)
- **rTHA vs. mTHA- 100% vs. 80%** in Lewinnek “Safe Zone”

Conventional THA



Robotic assisted THA



Surgical goals of hip replacement

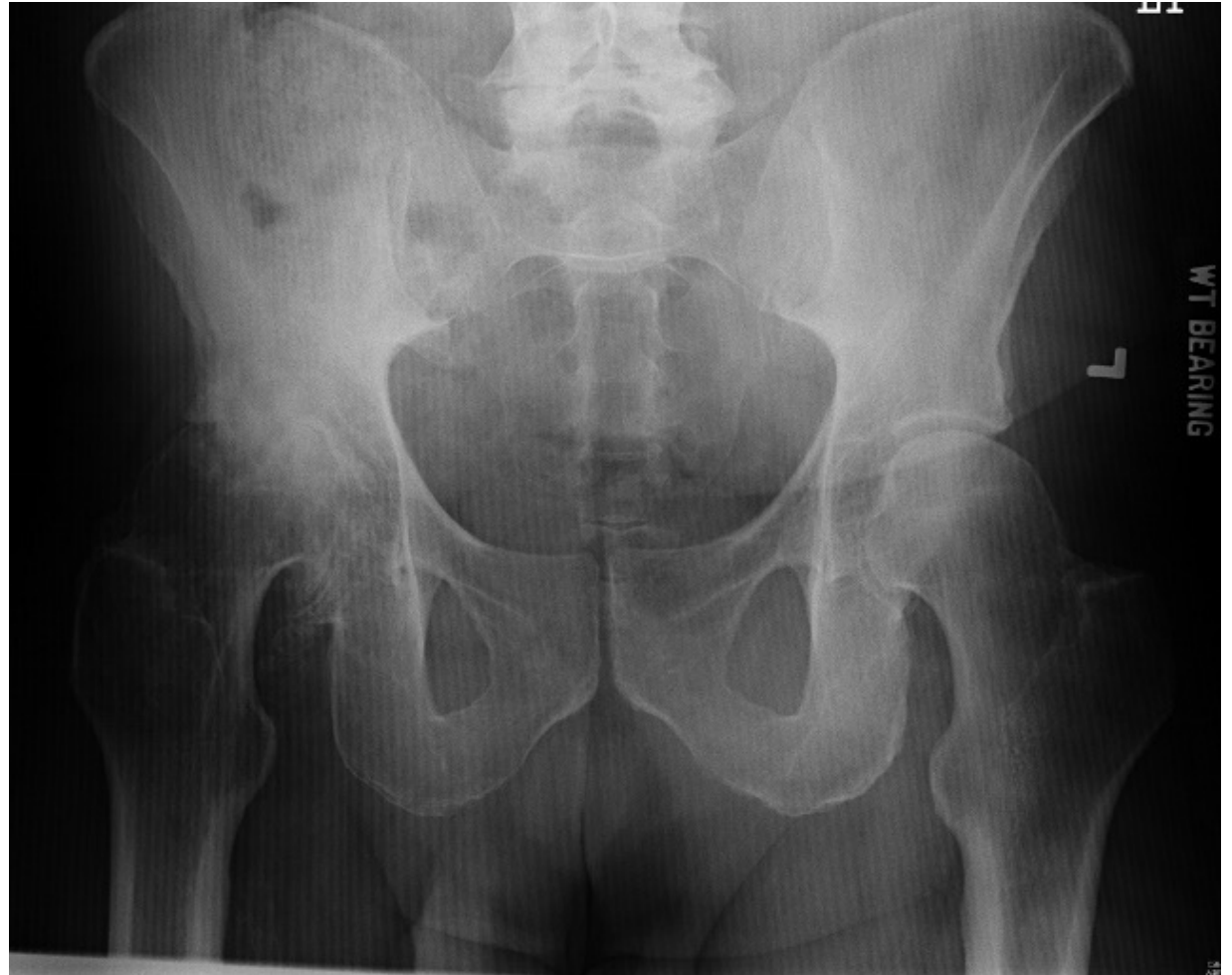
- Pain relief
 - Restoration of function/lifestyle
 - Optimize patient outcomes
 - Economics

- Provide early and exceptional analgesia
- Low trauma surgery
- Early discharge and rapid rehab

Prevent the Bad Effects

- Pre-emptive analgesia
 - Celebrex
 - Spinal anesthesia
- Pre-emptive anti nausea
 - Pepcid

- IV sedation
- Capsular injection



Post-Operative Management

- Gait training POD1
- Stairs and PT instruction
- Ideally same day ambulation



10,000 Miles in 18 mos after THA



- rTHA more accurate than mTHA- multiple studies
- Improved accuracy with rTHA correlated with improved clinical outcomes at 1 year
 - Lower dislocation rate
 - Less LLD
 - Less blood loss
 - Excellent PROM
 - Better HHS and UCLA activity scores than mTHA
- Robotic-assisted THA:
 - Longer OR time than mTHA, no infections
 - Cost benefit analysis requires further study



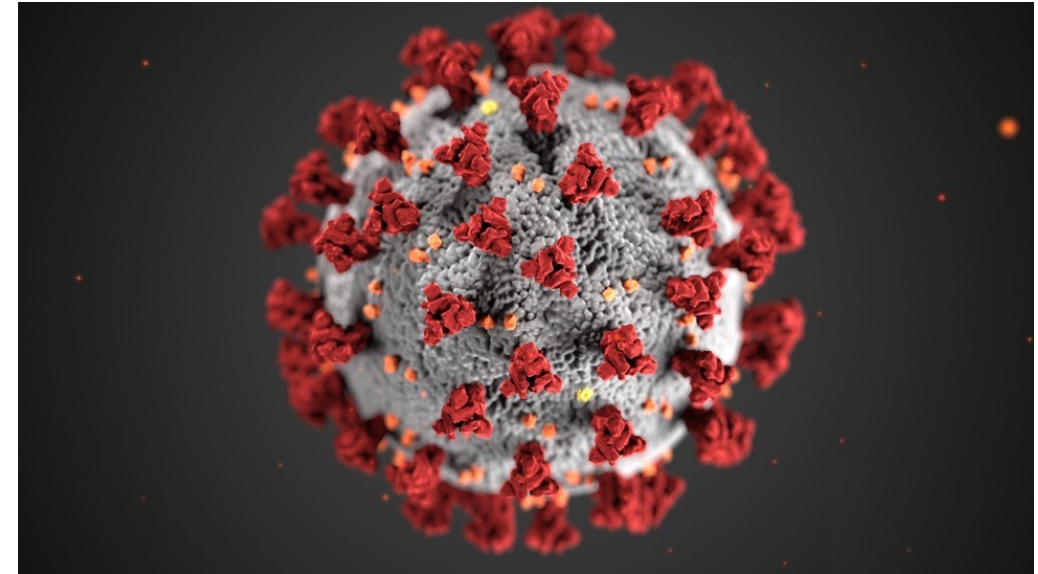
Including but not limited to:

- Bleeding
- Infection
- Damage to nerves and vessels
- Blood clots (DVT)
- Blood clots in lungs (PE)

And rare things like:

- Stroke
- Heart attack
- Death

- Elective surgery has been going since April 2020. There are no current plans to stop but that may change.
- Every patient gets COVID test and all staff follow proper PPE protocol.



Questions?



Relieving Painful Hip or Knee Arthritis

C. Brian Blackwood, MD
BoulderCentre for Orthopedics
Co-Medical Director Joint Program
www.boulderhipandknee.com
720-807-5065

