Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Evidence Based Intervention

Primary Hip Replacement

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Policy: Primary Hip Replacement

The most common indication for elective primary total hip replacement (THR) is degenerative arthritis (osteoarthritis) of the joint, other indications include rheumatoid arthritis, injury, bone tumour and necrosis of the hip bone.

Recommendations

The aims of THR are the relief of pain and improvement in function, and this operation can be very successful for the appropriate patients. More than 90% of people who undergo these operations will never need revision surgery.
A small number of patients who have elective THR experience complications which can be devastating, and for this reason patients should not be considered for joint replacement until their condition has become chronic and conservative methods have failed.
Cemented hip replacements are recommended for patients over the age of 65. This will be at the discretion of the surgeon.

Guidance to Primary Care on the treatment of hip pain due to osteoarthritis

The Musculoskeletal Services Framework from the Department of Health (DH), and guidance from NICE, The Centre for Change and Innovation in Scotland, and the GP Training Network suggest that;

- Management of common musculo-skeletal problems, including hip pain, in primary care is ideal.
- Primary Care practitioners need to have direct access to therapy, walking aids, dietetic and health promotion services
- Management within primary care should aim to maximise the benefits and minimise the complications of surgery when this becomes necessary. Offer accurate verbal and written information to all people with osteoarthritis to enhance understanding of the condition and its management.

Ensure that self-management programmes for people with osteoarthritis, either individually or in groups, emphasise the recommended core treatments.

The initial non-surgical management of hip pain due to osteoarthritis should be provided by a package of care which may include weight reduction, adequate doses of non-steroidal anti-inflammatory drugs (NSAIDs) and analgesics, changing activity, introducing walking aids, other forms of physical therapies. Intra-articular steroid injection should be considered as an adjunct for moderate to severe pain.
Do not offer acupuncture for the management of osteoarthritis.

Referral should be considered when other pre-existing medical conditions have been optimised, and there has been evidence of weight reduction to an appropriate weight. Patients who are overweight (BMI 25 – 29.9) or obese (BMI ≥30) should be encouraged and supported to reduce their BMI below 25[6]. Equally, patients who smoke should be encouraged to stop smoking at least 8 weeks before surgery to reduce the risk of anaesthestic or operative complications.

There are few absolute contraindications for THR other than active local or systemic infection and other medical conditions that substantially increase the risk of serious peri-operative complications or death. Advanced age and obesity are not a contraindication to surgery; however, there may be an increased risk of delayed wound healing and peri-operative infection in obese patients. Severe peripheral vascular disease and some neurological impairments are both relative contraindications to THR.

Referral criteria for immediate or urgent referral to orthopaedics services should be based on NICE referral guidance[1,9]

NICE recommendations state that the threshold for immediate referral to orthopaedic services is when there is evidence of infection in the joint.

Symptoms that are suggestive of a rapid deterioration in the joint or persistent symptoms which are causing severe disability necessitate urgent referral to orthopaedic services.

Referral thresholds involve a shared decision making between patients and clinicians, and a holistic assessment of the patient.

Referral for joint replacement surgery should be considered for people with osteoarthritis who experience joint symptoms (pain, stiffness, and reduced function) that have a substantial impact on their quality of life and are refractory to non-surgical treatment. Referral should be made before there is
prolonged and established functional limitation and severe pain.

Patient-specific factors (including age, gender, smoking, obesity and
comorbidities) should not be barriers to referral for joint replacement surgery, however these may need to be taken into account in preparation for surgery.

A joint X-ray MUST have been performed and show evidence of joint damage prior to referral.

Referral criteria for routine referral to orthopaedic services

Candidates for elective THR should have;

- Moderate- persistent pain not adequately relieved by an extended course of non-surgical management (see below)
- **AND** Clinically significant functional limitation resulting in diminished quality of life
- **AND** Radiographic evidence of joint damage

Guidance for secondary care on thresholds for hip replacement surgery

Evidence suggests that the following patients would benefit from hip joint replacement surgery [7-10]

1. Where the patient complains of
    a. severe joint pain *(please refer to the appendix for a detailed definition)*
    b. **AND** has severe functional limitation *(please refer to the appendix for a detailed definition)* irrespective of whether conservative management has been trialed.
    c. **OR** has minor to moderate functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

2. Where the patient complains of
    a. Mild to moderate joint pain *(please refer to the appendix for a detailed definition)*
    b. **AND** has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.
    c. **AND** is assessed to be at low surgical risk *(please refer to the appendix for a detailed definition)*

Evidence suggests that the following patients would be INAPPROPRIATE candidates for hip joint replacement surgery [7,8]

1. Where the patient complains of
    a. Mild joint pain
    b. AND has minor or moderate functional limitation

2. Where the patient complains of
    a. Moderate to severe joint pain
    b. **AND** has minor functional limitation
    c. **AND** has **not** previously had an adequate trial of conservative management as described above

Patients whom are assessed by the above criteria to be inappropriate for hip replacement surgery should not be listed for surgery.

Patients who partially fulfill the criteria for appropriate hip joint replacement surgery *may* benefit from the operation and a decision will need to be taken on an individual basis.

For all patients who fulfill all the criteria for surgery as indicated above, or only partially fulfill the appropriate criteria for surgery, clinicians are required to document in the medical record that they have fully informed the patient of the risks and benefits of the procedure, and have offered a patient information leaflet prior to listing the patient for surgery.

The Medicines and Healthcare products Regulatory Agency (MHRA) monitors the safety of devices used in clinical practice. In June 2010, the MHRA issued an alert on all MoM hip replacement prostheses (both THR and resurfacing arthroplasty) after reports of soft tissue reactions that may be associated with pain. In June 2012, the MHRA released an updated alert noting that MoM prostheses (THR and resurfacing arthroplasty) may wear at an accelerated rate. The MHRA stated that people with MoM prostheses may develop soft tissue damage caused by wear debris from these prostheses. It advised annual monitoring of the hip using imaging and measurement of metal levels in the blood to determine whether a revision is needed in people with MoM hip replacement prostheses who have symptoms, or who have a certain type of MoM hip replacement, including stemmed MoM THRs with a larger femoral head (36 mm diameter or more) or the recalled DePuy ASR hip replacements (THR and resurfacing arthroplasty).

Annual monitoring is to be undertaken by the patient's GP.

Relevant OPCS(s):

W37 – Total prosthetic replacement of hip joint using cement
W38 – Total replacement of hip joint not using cement
W39 – Other total replacement of hip joint

Human Rights and Equalities Legislation has been considered in the formation of this policy statement.

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the ICB policy.

References

1. National Institute of Clinical Excellence. Primary Care referral guidelines for Common Conditions. NICE 2003;London.
2. NHS Scotland. Centre for Change and Innovation. Musculo-skeletal patient pathways 2004. See also the National Guideline Clearing House (www.guideline.gov).
3. GP-training.net. Orthopaedic Referral Guidelines
4. British Orthopaedic Association. Total Hip Replacement; A Guide to Best Practice. 1999
5. The Musculoskeletal Services Framework – A joint responsibility: doing it differently. Department of Health, 2006
6. Optimizing Outcomes in Hip Surgery by Javad Parvizi, presentation to the American Association of Orthopaedic Surgeons Annual meeting, March 22nd 2006. (www6.aaos.org/news/pemr/anmt/Bios_Wed_9am.cfm)
7. Evaluation of explicit criteria for total hip joint replacement by Quintana, JM et al, Journal of Clinical Epidemiology, 2000;53:1200-1208
8. Health-related Quality of Life and Appropriateness of hip or knee Joint Replacement by Quintana J et al. Archives of Internal Medicine. 2006; 166:p220-226
9. National Institute of Clinical Excelence. Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip. (CG177). NICE 2014; London. Available from: https://www.nice.org.uk/guidance/cg177/chapter/1-Recommendations#referral-for-consideration-of-joint-surgery-2
10. Royal College of Surgeons (2017) *Commissioning Guide: Pain Arising from the Hip in Adults*. London: Royal College of Surgeons. Available from: https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/boa--pain-arising-from-the-hip-guide-2017.pdf
11. https://www.boa.ac.uk/wp-content/uploads/2015/03/GIRFT-National-Report-MarN.pdf

Appendix

Variable	Definition
Pain level[1]	
- Mild	Pain interferes minimally on an intermittent basis with usual daily activities Not related to rest or sleep Pain controlled by one or more of the following; NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol
- Moderate	Pain occurs daily with movement and interferes with usual daily activities. Vigorous activities cannot be performed Not related to rest or sleep Pain controlled by one or more of the following; NSAIDs with no or tolerable side effects, aspirin at regular doses, paracetamol
- Severe	Pain is constant and interferes with most activities of daily living Pain at rest or interferes with sleep Pain not controlled, even by narcotic analgesics
Previous non-surgical treatments	
-Correctly Done	NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatment if overweight, physical therapies done
-Incorrectly Done	NSAIDs, paracetamol, aspirin or narcotic analgesics at inadequate doses or less than 6 months with no pain relief; or no weight control treatment if overweight, or no physical therapies done
Functional Limitations[2]	
- Minor	Functional capacity adequate to conduct normal activities and self care Walking capacity of more than one hour No aids needed
- Moderate	Functional capacity adequate to perform only a few or none of the normal activities and self care Walking capacity of about one half hour Aids such as a cane are needed
- Severe	Largely or wholly incapacitated Walking capacity of less than half hour or unable to walk or bedridden Aids such as a cane, a walker or a wheelchair are required

Surgical risk divided into; Low (ASA 1 to 3); High (ASA 4)[3]

[1] Lequesne M. Indices of severity and disease activity for osteoarthritis. Seminars in Arthritis Research, 1991;20:48-54

[2] Hochberg et al. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. Arthritis Rheum, 1992;35:498-502

[3] Schneider AJL. Assessment of risk factors and surgical outcome. Surgical Clinics of North America, 1983; 63:1113-26

Change History:

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