

## Single Stage Revision Joint Replacement for Infection

Infection adds a large number of difficulties to fixing a joint replacement that has gone wrong. Some patients are not suitable for single stage surgery, and are better treated with two operations six weeks or more apart.

### What does it mean?

An infected hip replacement can be like having an infected splinter. It is almost impossible to eradicate the infection without removing the foreign material. A traditional viewpoint is that the foreign material is removed at one operation, and some weeks/months later, a second operation undertaken to reimplant a new hip replacement (a so called two stage operation).

A single stage operation does it all in one go. The theory is that a new implant and antibiotic bone cement will restore function faster, although six months of antibiotics by mouth are usually necessary as well.



Figure 1. A hip immediately after a single stage revision. The polyethylene cup can't be seen except for a wire marker, and the white bone cement between the cup and the pelvis. The stem is also cemented in place with an antibiotic loaded cement. Large drain tubes in and around the joint are just visible.

### Single Stage Surgery is Controversial

Most orthopaedic surgeons in Australia usually recommend two stage surgery. Two stage surgery involves a period of time between removing the old implant, and inserting the new one. This may be more advisable if the bacteria causing the infection has not been identified, and will be advised if an uncemented implant is required to reconstruct the leg after removing the existing implant.

The long term results of single stage revision surgery is in the realm of 90% success. This is a similar success rate to two stage uncemented revision at two years.

### Who should have one stage?

Single stage revision allows a fast recovery, and shorter hospitalisation. It is not suitable where structural bone deficiencies are present, or where an extended osteotomy is necessary. Some uncemented hip replacements may not be able to be easily removed and may require two stages. Patients who are profoundly unwell with sepsis may be safer treated as two stages.

### How is infection proven?

Infection may be suspected because of particular loosening pattern on XR, because the history included fevers or rigors, wound discharge either intermittently or continuously, or blood tests suggest a problem. Infection may be hard to categorically prove or disprove. Placing a needle into the joint (under XR or CT control for the hip) and removing some fluid, can allow our microbiologist to identify an organism & which antibiotics will be most effective. The diagnosis can be confirmed at operation, but clearly it is better to plan for infected cases.



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## Advantages of single stage

Single stage surgery means full weight bearing is permissible from the first operation. Transfusion requirements are lower, and theoretically this should avoid the immune compromise of transfusion. Time in hospital is reduced, and the time to being functional again is reduced from typically 3-6 months to 4-6 weeks.

A recent article from the American Journal of Bone and Joint Surgery indicates the one stage revision improves quality of life, and has a lower death rate.(1)

## Why is two stage surgery more common?

Most surgeons only use un-cemented components, especially on the pelvic side of the hip replacement. A certain amount of “dead space” exists between the implant and the bone, giving the bacteria a place to hide & multiply in this environment.

The cement option overcomes this dead space by being pressurised into all the little porosities of the bone.

There are cases that are not suitable for one stage surgery, and two stage will be recommended under those circumstances. Of those where a one stage operation has been recommended, there is a theoretical risk that intra-operatively it will be decided to do a two stage procedure with or without a spacer block.

## Is a sinus a contra-indication?

In Rout & Wroblewski's study of 57 cases using a single stage technique without antibiotics in the cement or long term antibiotics afterwards, they noted a 86% success rate(2). Presumably with antibiotics the success would be higher. The sinus means that the pus escapes from the body, rather than continuing to

expand an abscess within the body. This makes removing the implant more difficult. In my experience to date, the presence of a sinus has not affected the result.

## Is a gram negative infection a contraindication?

In Raut and Wroblewski's study from 1996, fifteen cases had been undertaken. The two failures had no antibiotics in the cement, which is clearly part of the modern treatment plan.(3) In my experience, many gram negative infections can be treated in this one stage manner.

## Trochanteric Osteotomy

A key part of the plan is removing all existing foreign material. Bone cement can be very difficult to remove, and a better view of it can be obtained by detaching muscles with a sizable fragment of bone. It is an old fashioned, but proven way of doing the surgery. It does add a risk that the wires can break, and the fragment of bone not heal. The wires can be tender to lay on. If an osteotomy is necessary, you will require crutches for three months.

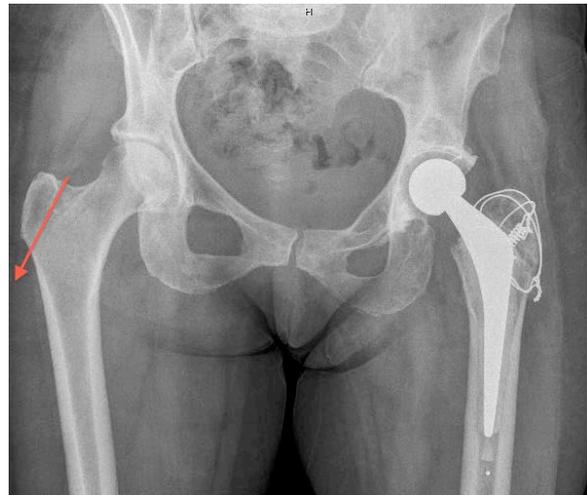


Figure 2. The red line on the left of this image indicates the fragment of bone that would be cut off to allow access to the femoral canal, if that was the side having surgery. The wires (right) are used to reattach the cut fragment of bone at the conclusion.



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## Alternatives to revision surgery

Infection of a hip replacement may be ignored, treated by antibiotics alone, or the surgery could be to remove all the implants with no intention to replace the hip replacement.

## Girdlestone Procedure

Some patients are so ill or the infection so difficult to eradicate, that the prosthesis is removed, with no immediate (or sometimes any) intention of ever reconstructing the joint replacement. Surprisingly, people manage quite well without a hip joint (a so-called Girdlestone procedure). It is hard to imagine resuming a physical job without a hip joint though. In the knee joint, a fusion or stiffening of the joint may be undertaken.

## Washout & antibiotics

Washing the joint out and using a six month period of antibiotics may be considered under certain circumstances. If a joint replacement has been in place for a long time, but suddenly (acutely) becomes infected, it may also be rescued with this plan. If a joint becomes infected immediately after the joint replacement surgery, it is said to be a good plan, but actually does not address any dead space behind the implant. The success rate is in the realm of 50% to 85%.

## Antibiotics alone

Sometimes long term suppressive antibiotics are used, particularly if the risk of surgery seems excessive. It is plausible that no treatment could be undertaken if the patient can tolerate the symptoms, and the situation not predicted to significantly worsen.

## No treatment

It is rare to ignore an infection. However, if the treatment options seem worse than the existing symptoms, it is reasonable. A low grade infection might

have no pain, no discharge, and no disability. A frail nursing home patient may be better to not treat, even though the infection may contribute to their eventual demise.

## Successes to date with one stage

Staphylococcal infections have been cleared. The antibiotic in the cement is effective, but the oral rifampicin & fusidic acid for six months has increased success from 85% using flucloxacillin to close to 100%

Gram negative infections have been cleared. One case, where the surgery was undertaken six weeks after the initial operation, the stem was well fixed, and a sinus existed. The cup was removed, a new cup cemented in place with appropriate antibiotics, and no recurrence has occurred.

Multiple organisms represent a problem in antibiotic choice both for the cement and intravenously. I can only recall one definite case – he had 5 organisms, we used intravenous antibiotics and kept him in hospital for six weeks. At two years, there has been no recurrence of infection.

## Failures to date

### References

1. Wolf CF, Gu NY, Doctor JN, Manner PA, Leopold SS. Comparison of one and two stage revision of total hip arthroplasty complications by infection. *JBJS (Am)*. 2011;93-A(7):631-9.
2. Raut V, Siney P, Wroblewski B. One-stage revision of infected total hip replacements with discharging sinuses. *J Bone Joint Surg Br*. 1994;76(5):721-4.
3. Raut V, Orth M, Orth M, Siney P, Wroblewski B. One stage revision arthroplasty of the hip for deep gram negative infection. *Int Orthop*. 1996;20(1):12-4.

## Complications following revision surgery for infection



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A hip replacement is a major surgical procedure, revision for infection bigger. It carries substantial risks. This list cannot be complete, but does deal with more common problems. Accepting and minimizing these risks is a responsibility of both the patient and the surgeon. If the patient doesn't accept that a joint replacement occasionally goes wrong, then they should not submit themselves to surgery.

### **Urinary catheterisation**

Urinary catheterisation is routine for major revision operations. It prevents a complication called urinary retention, which is painful and treated by catheterisation. It provides information to the nurses & doctors on your fluid balance. It is usually removed the following morning. Rarely, we can have problems putting the catheter in & may need a urologist (another surgeon) to help. We don't routinely do this for primary hip or knee replacement but some surgeons do.

### **Thrombosis & pulmonary embolism**

Clots can occur within the veins of the leg and pelvis before, during or after surgery. They carry a risk of dislodging and moving up to the lung. It can be fatal. A 'post phlebotic syndrome' where the leg remains swollen can occur, and may develop ulcers.

In first time joint replacements – aspirin, stockings and early mobility is enough to avoid clots. In revision surgery we use Clexane injections, it carries a risk of increased bleeding, swelling and transfusion requirement.

### **Infection**

To minimize the risk of infection, we prepare the operation site with antiseptics, use antiseptic impregnated drapes, use intravenous antibiotics at the time of and after surgery. At St

John's we have a laminar flow operation theatres and 'space-suits'.

Removing an infected joint replacement and inserting a "clean one" alone is not enough. The surgery is quite particular & time consuming, antibiotics administered through the cement, intravenously, and by mouth. Despite this, the infection may not be cured and may recur.

### **Late infection**

You are at particular risk for the first two years following surgery. Any dental extractions, urethral catheterisations, or colonoscopy are usually "covered" with antibiotics. Any cuts to your skin should be taken seriously.

### **Dislocation**

The risk of dislocation is about 2% for traditional hip replacements, and probably for this sort of revision. Most will be a single dislocation, the others will go on to recurrent dislocations. The most common position patients dislocate their hip is bending right over. Alternately when sitting, leaning forward, and leaning towards the side of the hip replacement. Less common is with walking and turning abruptly away from the side of the hip replacement. We avoid these for 3 months after surgery.

Dislocations are very distressing. Often an ambulance needs to be called to take you to hospital. A dislocation will upset your confidence.



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## **Leg length discrepancy**

The intention after hip replacement surgery is for the leg to match the other one, but stability of the hip joint is more important. If the leg length is right, but the hip keeps popping out requiring an ambulance trip to the hospital, little has been achieved! The leg may seem long for 6-12 weeks after the surgery because the muscles over the side of the hip (glutei) may be tight. As the muscles stretch, the leg returns to a more normal position. Leg length discrepancy is rare with current templating techniques.

## **Fracture**

A fracture of the femoral shaft can occur at the time of surgery, or after injury. It occurs 1:300 primary hip replacements, and probably 1:20 revision operations. The intraoperative cases I have seen have required a cable around the femur and restricted weight bearing. Late post operative cases may require extensive surgery and slow recovery.

## **Trochanteric osteotomy**

This may be required to remove the existing implant safely. This is an old fashioned approach to the hip joint, the author of this (DJM) has used this approach for perhaps 3-400 cases. The complications specific to this are local tenderness contributed to by the wires, It can disappoint us by failing to unite, and some wires are used to reattach the bone at the completion of the operation which will cause limp, and can increase the risk of the hip dislocating.

## **Death and severe complications**

Death occurs in 1% of patients within 90 days of the surgery. In those under 70, the rate is 0.2%, 70-80 1%, and over 80 2.5%. The deaths occur from heart attacks, strokes, and blood clots. A physician assessment prior to surgery is usual for over 70s. Revision surgery is riskier than primary surgery.

## **Bowel obstruction**

Narcotics such as morphine can slow the gut action. On occasions the gut gets worse, becomes distended and may require surgical treatment! This is usually a "pseudo-obstruction" and occurs in 0.5% of cases. Constipation is a very common complication.

## **Neurovascular injury**

Passing around the hip are nerves and arteries. These supply the leg. Rarely they can be injured, although the cause of nerve injury is only found 50% of the time. Injury to nerves or arteries, permanent loss of function or viability of the limb is possible. The sciatic nerve is close to the hip joint and prone to injury.

## **Stiffness**

Hip replacement does not guarantee a normal range of movement of the hip. This is typically most obvious when trying to put on a shoe or sock. The minimally invasive surgery and the modular Birmingham minimises this risk.

## **Scar pain and numbness**

The hip replacement involves cutting a number of layers to do the surgery. It is common for an area below the scar to be numb. The area may become smaller with time (years) but it is usually permanent. More often an area of tenderness over the point of the hip (trochanter) may settle with an injection. These problems have been rare since I changed to minimally invasive surgery. Thigh pain can occur in about 1% of uncemented hip replacements.

## **Heterotopic ossification**

New bone can form around the hip joint after surgery. It may not cause a problem but can cause pain or stiffness. We usually give tablets (eg Celebrex) for three weeks to minimize the risk.



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## **Loosening**

For a variety of reasons, the fixation between the hip replacement and the bone may fail, this loosening may cause pain and require re-operation. Infection is a cause of loosening, but others exist.

## **Wear**

All hip replacements can wear out. The plastic component is most at risk, but should be able to be replaced fairly easily.

## **Stroke**

A stroke occurs in 0.2% of patients, causing possibly permanent weakness, and one in four die as a result.

## **Other**

It is not possible to provide a full list of complications. Extremely rare occurrences eventually happen to somebody. If you have a specific question, ask your surgeon, and he will answer it as well as possible.



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