

# Hip and Knee Reconstruction: An Evolving Patient Population

Michael A. Kelly, MD

**T**he October issue of *The American Journal of Orthopedics* features articles focused on hip and knee adult reconstruction surgical procedures. Today's aging population is more active than ever. The original goals of pain relief with both hip and knee arthroplasty are no longer satisfactory in this population. These patients want to continue participating in more aggressive athletic and exercise programs that may prove detrimental to their implants.

In addition, we are seeing an ever-growing number of younger patients (ie, 40-60 years) who suffer from end-stage arthritis of either the hip or knee. The published long-term clinical success of both total knee arthroplasty (TKA) and total hip arthroplasty (THA) has led patients, and their orthopedic surgeons, to entertain the idea of joint arthroplasty at younger ages. This group of patients presents new issues of a quicker postoperative recovery and return to work to limit financial implications, as well as demanding expectations on their clinical results, and activities following these procedures.

Two surgical procedures addressing this patient population are discussed in the issue. Over the past decade, hip resurfacing has emerged as one option for the younger, more active patient with arthritis of the hip. This procedure, along with metal-on-metal hip arthroplasty has featured its own controversial issues these past few years. Drs. Edwin and Sherwin Su ("5 Points on Hip Resurfacing," on page 446) review 5 critical points of hip resurfacing based on their considerable clinical experience with this procedure. The concept of compartmental knee arthroplasty preserving both anterior and posterior cruciate ligaments has also gained popularity. This includes recent designs of patellofemoral arthroplasty for isolated



patellofemoral arthritis. There is a great deal of literature regarding thromboembolic disease following TKA, but very little dealing with patellofemoral arthroplasty. Dr. Kamath and colleagues ("Incidence of Symptomatic Thromboembolic Disease After Patellofemoral Knee Arthroplasty," on page 456) present a clinical series on this subject representing a valuable addition to surgeons using these techniques.

During the past decade, there has been a great deal of interest on minimally invasive surgical techniques in both THA and TKA. Decreased patient morbidity, shorter hospital stays, and quicker return to activity and possibly to work, have been attributed to these techniques.

However, possible compromise of correct surgical technique potentially impacting clinical success has been suggested as a negative feature of this surgery. Dr. DiCesare and colleagues present the first part of a careful review of minimally invasive surgery TKA surgical technique in this issue ("Review of Minimally Invasive Surgical Technique in Total Hip Arthroplasty," E-published online). Two final original papers involving revision total hip replacement with a specific femoral component and an evaluation of blood loss in both TKA and THA as it relates to body mass index. In addition, as the number of morbidly obese patients seeking both THA and TKA continue to increase, this is an important contribution to the clinical expectations in this cohort of patients. Revision surgeries are ever increasing in number and significance to the overall financial implications of joint arthroplasty in the US.

We hope you enjoy this issue of *The American Journal of Orthopedics*.

## AUTHOR'S DISCLOSURE

The author reports no actual or potential conflicts of interest in relation to this article.

Dr. Kelly is Associate Editor for Adult Knee Reconstruction in this journal; and Chairman, Department of Orthopedic Surgery; Chairman, Department of Physical Medicine and Rehabilitation, Hackensack University Medical Center, Hackensack, New Jersey.

Address correspondence to: Michael A. Kelly, MD, 360 Essex Street, Suite 303, Hackensack, NJ 07601 (fax, 551-996-8873; e-mail; michaelkelly@Hackensackumc.org).

*Am J Orthop.* 2012;41(10):444. Copyright Quadrant HealthCom Inc. 2012. All rights reserved.