

Hip & Pelvis

X-ref For other Round-ups in this issue that cross-reference with Hip & Pelvis see: *Children's orthopaedics roundup 3*; *Research round-ups 1 & 4, & 7*; *Trauma round-up 1*.

Outcomes for cemented versus uncemented hip hemiarthroplasty

Uncemented hip hemiarthroplasty avoids cement implantation syndrome and is considered a safer option for the treatment of intracapsular hip fractures by some surgeons. However, conditions such as osteoporosis and the consequent wider femoral canal make uncemented femoral stems less reliable in the treatment of hip fracture patients compared to a population undergoing total hip arthroplasty. Despite avoiding cement implantation syndrome, uncemented stems in this cohort are prone to periprosthetic fracture or subsidence. What is not clear is where the risks and benefits of these approaches lie. In order to make a recommendation, authors from **Oxford (UK)** designed a multicentre, randomized controlled trial (RCT) comparing cemented and uncemented hemiarthroplasty in patients aged 60 years or older presenting with an intracapsular hip fracture needing arthroplasty.¹ They designed outcomes to look at quality of life at least four months after the primary procedure, and in addition report adverse events and healthcare costs. The authors randomized 1,225 patients to receive either a cemented or uncemented stem hip hemiarthroplasty and followed them up at one month, four months, and 12 months post-surgery. Nearly 72% of patients were available for follow-up at four months, with small but significantly improved quality of life score (EuroQol five-dimension index utility score 0.371) in patients receiving a cemented implant (compared to 0.315 in the uncemented group; adjusted difference 0.055; 95% confidence



interval (CI) 0.009 to 0.101). They also noted a reduced all-cause 12-month mortality in the cemented group (23.9% vs 27.8%; odds ratio (OR) for death 0.80; 95% CI 0.62 to 1.05) and a reduced periprosthetic fracture rate in the cemented group (0.5% vs 2.1%; OR (uncemented vs cemented) 4.37; 95% CI 1.19 to 24.00). The differences in mortality here demonstrate that although cemented implants carry a slight increase in early mortality associated with the cement burden, overall this is outweighed by better long-term survivals. This large, appropriately powered RCT suggests that improved outcomes are found in the medium term with a cemented stem for hip hemiarthroplasty in the treatment of intracapsular hip fractures.

Shared decision-making is associated with better outcomes in patients with knee but not hip osteoarthritis

X-ref

Setting patient expectations has long been thought to be very important for allowing patients to achieve a realistic outcome in all

branches of surgery. This is underlined in the change in the law in the UK (the Montgomery ruling), where patients legally need to have advice on all treatment options (including no treatment) to be said to have given informed consent for any one particular treatment. In orthopaedic practice, it is certainly the case that patients buying in via a 'shared decision-making approach' prior to hip and knee arthroplasty will improve outcomes thereafter. Part of this process is the gaining of informed consent for the surgical procedure. The ideal informed consent includes the patient having information about the intended benefits of any procedure, the alternatives to it, and the risks and expected outcomes afterwards. Ideally the patient will have this in both written and verbal formats, with enough time to process the information to make a high-quality, informed, patient-centred decision. While this aspect of obtaining informed consent is critical from a legal and regulatory point of view, it is not clear whether it leads to better patient outcomes because of more realistic expectation-setting. In this interesting paper from **Boston (Massachusetts, USA)** the authors set out to explore this by designing a multisite, randomized controlled trial looking at two different decision aids for patients considering hip and knee arthroplasty, and calculating whether or not the patients made a high-quality, informed, patient-centred decision with the information they received.² They included 854 patients in their series, 68% of whom demonstrated that they had made such a decision. In the high-quality, informed, patient-centred decision group, for both hip and knee arthroplasty, a greater quality of life score was achieved at six months (mean difference in EuroQol five-dimension index 0.04; 95% confidence interval (CI) 0.02 to 0.07; $p < 0.001$). However, while the well-informed knee