

Dr. Zelicof Interview, NY

Question #1: How did you get started with hip resurfacing and tell us about your background experience as an orthopedic surgeon. Where did you train for hip resurfacing and who trained you?

Answer: I have been practicing orthopaedic surgery in Westchester County, New York since 1990. Prior to beginning my practice, I attended college and medical school at the University of Pennsylvania and performed an orthopedic residency at the Hospital for Special Surgery in New York. After my residency, I sought advanced training in the field of joint reconstruction and replacement at the Brigham and Women's Hospital & Harvard Medical School. This specialized fellowship allowed me to obtain a comprehensive view of joint preservation, restoration techniques and arthritis management.

I have had the opportunity to treat many patients with arthritis over the years. Most of my patients presented because of pain and loss of function. I have been very impressed by the initial improvement in their pain through surgical intervention. However, many patients have continued to feel somewhat limited by their functional restrictions associated with conventional joint replacement. This has led me to look for better options in performing joint replacement surgery. We have subsequently introduced more muscle sparing and minimally invasive techniques into our practice. We use computer navigation systems to optimize implant position and have worked very closely with our anesthesiologists to make our patients experience as painless as possible. When the opportunity to perform hip resurfacing came to the USA, I felt that this procedure was a natural option for our "younger" active patients. The ability to provide an implant which is more bone conserving, and more closely reproduces the patient's own hip anatomy, was very exciting. Subsequently, I had the opportunity to travel to Birmingham, England, where I trained with Mr. Derrick McMinn, who developed the Birmingham Hip Resurfacing system.

My experience with hip resurfacing over the past several years has been very positive. I have performed over 100 resurfacing procedures and I have been extremely impressed by the successful outcomes in our patients both regarding pain relief and the return to high levels of function including running, basketball, and competitive sports.

Photo: Dr. Zelicof

Question #2: What surgical approach do you use and why?

Answer: I have been using the posterior approach to the hip in most of my hip resurfacing procedures. I have had a long experience with posterior approach to the hip. I find it to be very extensile, allowing me to adapt to the patient's anatomy very successfully. I also feel that it provides a great degree of versatility in terms of giving the patient a very successful and reproducible outcome.

Question #3: How long is the typical hip resurfacing surgery take?

Answer: Most procedures take on the average of about two hours. There is a great deal of preparation involved in the surgery, which includes the positioning of our patients and the anesthesia protocol.

Question #4: Barring any complications, how many days in the hospital will the patient normally stay?

Answer: My patients typically spend about three days in the hospital after which they either return home with home physical therapy and visiting nurse services or they go to an acute care rehabilitation center. However, everyone's needs and situations at home are different, so follow-up care is greatly determined on an individual basis.

Question #5: What is your typical recovery time after resurfacing? What is your typical rehab protocol regarding 90 degrees restriction, walker, crutches, cane, amount of time, blood thinners, TED stockings, ice, and PT?

Answer: My typical post-operative rehabilitation protocol begins pre-operatively with what we refer to as "Prehab". We have our patients meet with a physical therapist prior to their surgery to review exercises and any needs they may have regarding their upcoming surgery. We recommend that patients see their dentist and medical doctors to make sure that they are healthy and infection free. When needed, we have them meet with an anesthesiologist for a consultation before their surgery. If patients choose, they may pre-donate their own blood prior to surgery.

After the surgery, I place patients in an abduction pillow for initial transfers until the patient is awake and recovered from anesthesia. Once the patient is aware and alert, the abduction pillow is removed. At this point, I am less restrictive in terms of the 90-degree rule, allowing patients to bend and trying to have them gain their functionality and minimizing their restrictions when possible.

Regarding the use of a walker, crutches or a cane, I protect my patients with crutches for six weeks in the postoperative period. At this point, they may progress to their activities as tolerated, usually with a cane for the first week or so. After six to eight weeks, patients may return to many of their activities including cycling, golf, yoga, hiking, etc. I recommend avoiding high impact sports such as running for six months after surgery. However, it is important to keep in mind that every patient is different and people's recuperation and return to function will vary.

Every patient is placed on DVT prophylaxis. The treatment used depends on the patient's individual risk factors. We commonly used multi-modality therapy including low molecular weight heparin, Coumadin or aspirin, and thromboembolic stockings or compression boots.

We routinely use a cryotherapy unit after surgery or we apply ice to the site of the surgery, as I do believe that ice can minimize swelling and improve pain. All patients will see a physical therapist while in the hospital. We try to have patients out of bed and walking either the day of surgery or the next morning. Once they are discharged, they will continue to work with a physical therapist, following a structured rehabilitation protocol. Most importantly, we try to get our patients to transition from being patients back to being people as soon as possible!

Question #6: How long before a typical patient is allowed to drive and return to work?

Answer: I usually allow my patient to drive approximately at about 4-5 weeks if it is the right leg and approximately 1-2 weeks if it is the left leg and if they do not have a car that requires a clutch. Regarding return to work, if the patient has a fairly sedentary job they can return to work as soon as they can safely commute. If the patient is required to either drive a car or operate heavy machinery or stand for long periods of time, we individualize it to the patient's needs with a particular focus on making sure that they are off all narcotics before returning back to work. We want our patients active, but we also want our patients safe!

Question #7: How long do you feel it takes for the bone to be fully healed or grown into the prosthesis? What is the

recommended time to tell your patient before they can start to run again or do impact sports? Are there any sports you do not want your patient to participate in after surgery and out of the patient's you have resurfaced what sports have they returned to?

Answer: I do believe that it can take up to six months for the bone to be fully healed and to grow into the prosthesis. I generally try to have the patient avoid running and performing high impact sports for six months. Any activity needs to be individualized to the particular patient. This often depends on their bony architecture, muscle conditioning and overall health. Regarding the sports that I do not want my patient to participate in after surgery, again I tend to individualize it to the specific patient and their particular level of expertise. If the patient has not performed very extreme sports prior to resurfacing, I probably would not recommend that they begin afterwards because of the risk of potential injury. Patients have returned to many activities including full court basketball, running, jogging, martial arts, yoga, cycling as well as motorcycle riding and motocross racing.

Question #8: What is your take on cementless femoral devices for resurfacing?

Answer: The successful long term resurfacing experience we have seen has been with cemented femoral components. I feel that until the data catches up on cementless fixation for femoral devices, I am satisfied with our current fixation. Regarding the acetabular component, we have been very successful with cementless fixation.

Question #9: Which resurfacing device do you prefer to use and why?

Answer: I have had the greatest experience using the Birmingham hip resurfacing (BHR). The BHR has the longest positive track record. While there are other devices that are currently available, I have had less experience with these implants.

Question #10: Do you have a cut off age for resurfacing patients or do you go on a case by case basis?

Answer: I tend to treat every patient individually. Everyone is different! My decision is made depending on the anatomy and the quality of the patient's bone. I will also take individual patient concerns regarding function and activity into account. The majority of patients receiving hip resurfacings tend to be males and under sixty-five years of age. We do perform resurfacing procedures on women, although we evaluate their bone density prior to surgery with a bone densitometry (DEXA) scan. However, I believe that your physiologic age is more important than your chronologic age.

Question #11: Do you preserve the neck capsule?

Answer: I attempt to preserve the neck capsule whenever possible. It is our intention to disrupt the soft tissues as little as possible throughout the procedure.

Question #12: What type of anesthesia do you use, general, epidural or spinal?

Answer: I tend to use a regional anesthetic such as epidural or spinal. In most of the cases, we try to keep the patient very comfortable with light sedation throughout the procedure as well.

Question #13: Are there any cases you will not take in particular AVN, dysplasia or small cysts?

Answer: I tend to perform surgery on many complex cases. I will individualize the procedure to the specific patient. If I do a case with osteonecrosis or femoral cysts, I am very cautious and very cognizant of the defects and the underlying supporting structure of the femoral head .

Question #14: Do you do bilateral surgeries the same day? If not how far you recommend?

Answer: I will perform bilateral procedures on the same day. However, the patient needs to be healthy enough to tolerate the increased amount of surgery. Additionally, they have to be willing to deal with the increased rehabilitative challenges.

Question #15: If you cannot perform hip resurfacing, what total hip device do you prefer and why?

Answer: If I cannot perform a hip resurfacing, then I will most likely recommend a cementless stem with a metal-on-metal bearing utilizing an anatomic head size when possible. Alternatively we would look into either a ceramic on ceramic or a ceramic on highly cross-linked polyethylene depending on the patient's age, anatomy, and lifestyle. When feasible, I try to reproduce the patient's own anatomy as closely as possible.

Question #16: What do you consider an adequate number of surgeries for a doctor to be proficient doing hip resurfacing?

Answer: I believe that number varies from individual to individual depending on previous surgical experience. However, there has been data to support that one needs to have performed at least 25 to 30 resurfacing procedures to achieve a reasonable degree of proficiency. Additionally, it is important to continue to perform hip resurfacing procedures on a fairly regular basis.

Question #17: How many hip resurfacings have you done to-date?

Answer: I have currently performed over 100 hip resurfacing procedures.

Question #18: How successful have you been obtaining insurance approvals for resurfacing?

Answer: Currently, we do not have trouble obtaining insurance approvals for total hip resurfacing procedures.

Question #19: Do you test for metal allergies or bone cement allergies?

Answer: We ask our patients if they have any sensitivity to metal jewelry. If they report that there is sensitivity, then we will work them up further. If not, then we do not do routine skin testing or metal testing for metal allergies.

