Interview with Dr. Pritchett at the BHR Symposium April 2011

Hi Dr. Pritchett, can you please first start out by telling us how you got started with Hip Resurfacing and give us a little background on your experience as a surgeon. Where did you train for hip resurfacing? Who trained you? Did you continue your training after starting resurfacing?

I originally trained with Charles O. Townley MD in 1984 (as a resident). He was one of the pioneers of hip resurfacing. I used his TARA device in many forms until the Conserve Prosthesis became available. Harlan Amstutz and Derek McMinn are both friends and I began using the Conserve and BHR when they became available.

2.) Do you do the neck capsule preservation technique in your surgeries? YES

3.) Do you re-attach the gluteus tendon? Do not routinely release this.

4.) Which approach do you prefer to use anterolateral or posterior?

Originally I only performed Anterior and Anterolateral approaches as advocated by Heinz Wagner and Charles Townley. Both Amstutz and McMinn used the posterior approach. I use the superior approach. All three approaches are quite satisfactory. I will follow a patient preference unless there are unique circumstances. I find the superior approach the least traumatic.

5.) What size do your incisions normally range in inches? They vary by size of patient, approach and specific issues with the hip. I do not favor minimal incision surgery for resurfacing but will do this for total hip replacement.

6.) What is your opinion on the Direct Anterior approach for hip resurfacing, not the antero-lateral approach where the incision is on the side but the Direct Anterior approach? For some patients I do favor the direct anterior approach. For most the superior approach is the best.

7.) How long do you feel it takes for the bone to be fully healed, actually grow into the prosthesis? 3 months

8.) Barring any complications, how many days in the hospital will a patient normally stay? We perform our resurfacing procedures as outpatients.

9.) What is your typical rehab protocol? 90 degree restriction? Walker" Crutches Cane? amount of time? Blood thinners? TED stockings? Ice? PT

We move patient along full weight bearing as fast as possible. Patients come off external support as they are able (days to up to 2 weeks). Usually just aspirin, usually don't use TEDs. Yes for PT and ICE. 90 degree limit is for 6 weeks only.

10.) How long before a typical patient is allowed to drive a car, return to work? 2 weeks

11.) What is the recommended time you tell your patients before they can start to run again/do impact sports? Are there any sports you don't want your patients to participate in after surgery? Out of the patients you have resurfaced what are some of the sports they have returned to? Sports start at 3 months (gently). No permanent restrictions including professional sports. We have had professional basketball and hockey players return to their sport.

12.) What is your take on cementless (femoral) devices for resurfacing? We used a cementless femur for many years and it worked well either with or without porous coating. We primarily use cementless femurs.

13.) Do you have a cut off age for resurfacing patients or do you go on a case by case basis? Case by Case

14.) What type of anesthesia do you use general or epidural or? Spinal

15.) Are there any cases that you will not take in particular, AVN, dysplasia, small cysts? Maybe touch on some of the very difficult cases you have been able to resurface. I'm very interested in dysplasia. All other indications also acceptable. With bone building drugs available we do not have to turn down many cases.

16.) Do you do bilateral surgeries same day, if not how far apart do you recommend? Not any longer. We have done about 200 bilateral cases and there did not seem to be any advantage to match with the increased risk. 6 weeks between procedures.

17.) What device do you prefer to use for hip resurfacing and why? At this time I use mostly a polyethylene socket and cementless femur. We will use some large BHR devices. I thought both the Durom and ASR were poor designs and did no cases with these devices.

18.) If you can't perform a hip resurfacing – what THR device do you prefer and why? Usually use a dual mobility total hip as this is the closest hip to a resurfacing from a function and stability standpoint.

19.) What do you consider an adequate number of surgeries for a doctor to be proficient at hip resurfacing? Minimum 300. It is important to perform these procedures every week.