



# THE BRITISH HIP SOCIETY

NEWSLETTER - June 2018

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[www.britishhipsociety.com](http://www.britishhipsociety.com)

Dear BHS Member,

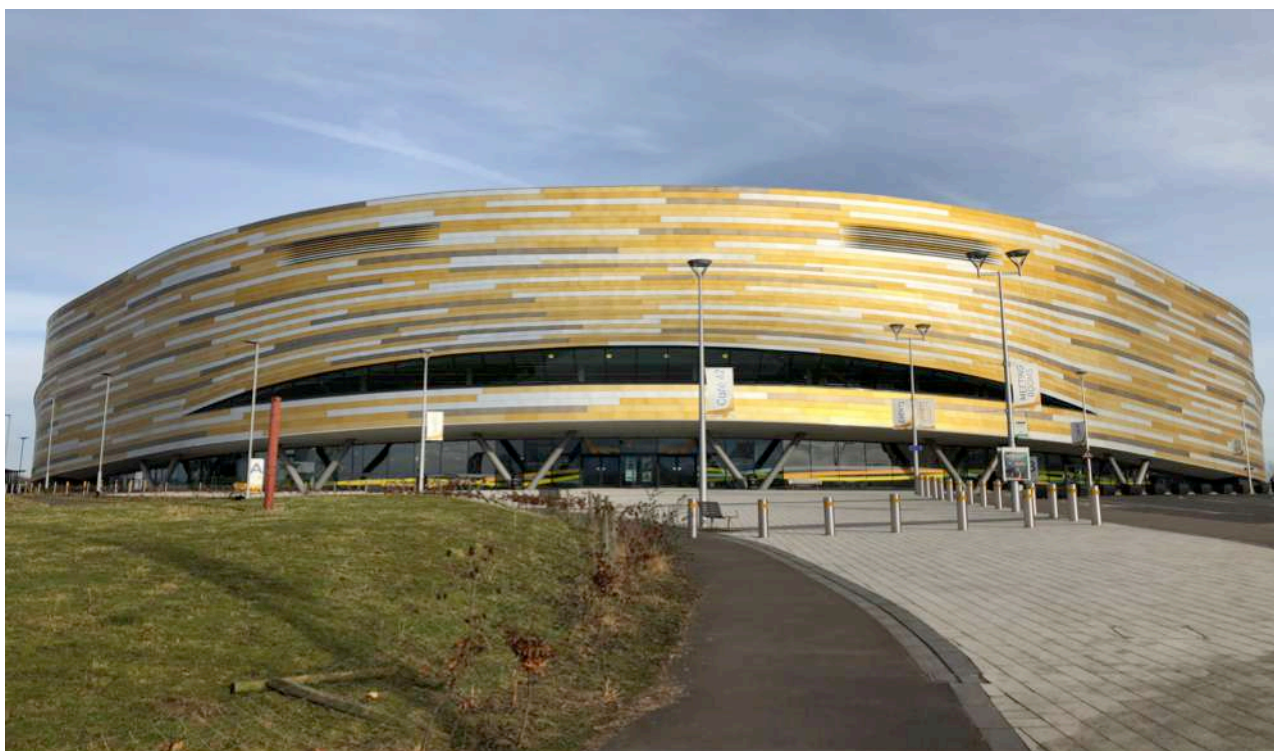
Welcome to the Summer 2018 British Hip Society Newsletter. We hope that you find the contents of this both useful and enjoyable.

The contents focus on the annual meeting in Derby, which we hope was well received. Andrew Manktelow took over from Peter Howard as President and shares some thoughts with us below about the future direction of the BHS.

We were delighted to welcome Professor Khaled J Saleh from Harvard University School of Public Health who contributed greatly to the quality of the meeting, and on whom the BHS were proud to confer Honorary Membership.

The surroundings of the Derby Velodrome were unique and remained a talking point long after the scientific sessions were over!

Andy Hamer Hon Sec BHS



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The British Hip Society Annual Scientific Meeting  
Derby March 2018



Professor Khaled Saleh and Peter Howard

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# The President Writes

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Having previously served as the Editorial Secretary before becoming Vice-President, it was a huge privilege and honour to become the President of the British Hip Society at the Scientific Meeting in Derby in March.

Let me start by congratulating Peter Howard on all his hard work in the role as President. As I am rapidly finding out, the role creates a constant flow of work with regular meetings and e-mail requests for response, often sent requiring an immediate reply. Considering and formulating a response on behalf of the BHS, contributing to the arguments that surround the provision of orthopaedic and hip surgery within the UK takes time. It is obvious that the UK health economy is in turbulent times. The BHS, alongside the BOA, will continue to support hip surgery, in all its variety, and will work to publicise to those with influence, the excellent clinical outcomes we achieve and the cost-effective nature of our surgery.

Last year was a challenge for the BHS. The criminal fraud to which we fell victim, resulted in the loss of our financial reserve. The executive worked hard to find ways to keep the society solvent. Significant contributions were gratefully received from BHS members. Subsequently, a number of potential options were discussed and the Extra General Meeting at the British Orthopaedic Association in Liverpool, provided an opportunity to seek the views and indeed the support of fellow BHS members in our strategy.

As a consequence of that meeting, we invited industry colleagues to be involved in the first part of the Annual Scientific Meeting this year in Derby. We tasked industry with delivering a number of short seminars aimed specifically at new technologies that could influence colleagues' practice, rather than simply marketing components and products. The feedback from that component of the BHS meeting has been good and, following the AGM, a decision has been taken to continue to develop our

relationship with industry within a small part of the BHS meeting. The executive will work hard to ensure that industry involvement does not change the character of what has become one of the highlights of the year for hip surgeons in the UK.



There are a number of challenges as I approach the year. We have already contributed to developing 'Elective Care Standards' with the British Orthopaedic Association. On behalf of the BHS, I have been involved, alongside the BOA, in meetings with central commissioning colleagues and NHS England to discuss the indications for, and the provision of hip surgery in the NHS. Similarly, the BHS alongside other Specialist Societies, has been involved with the BOA in discussions regarding how best to approach NHS 'winter pressures'. We will look to identify how and why some units were more able to continue their important work while others were not. The BHS will work alongside the BOA, to ensure that appropriate patients are not denied our skills. Up and down the Country commissioners are looking to reduce costs in secondary care. Similarly, the ongoing GIRFT initiative will continue to challenge us to be cost effective and evidence based in our practice. As a Society and as an orthopaedic group, it is essential that we work to demonstrate sound clinical outcomes against a background of responsible use of cost-effective implants. As is detailed elsewhere in this Newsletter, some of the contentious areas surrounding possible 'rationing' in the NHS was discussed in the 'Hot Topics' session.

With regard to the British Hip Society itself, as President supported by a hard-working and excellent Executive, I intend to do all possible to maintain the reputation of the British Hip Society. We are keen to enhance the annual meeting, improving the experience for BHS members while maintaining the quality of the scientific and clinical content. Plans are already well under way to ensure that the meeting, to be held in Nottingham from February 27<sup>th</sup> to March 1<sup>st</sup>, 2019, will be every bit as powerful as recent meetings in London and Derby.

### **BHS Developments**

Prior to becoming BHS President, I spent time in discussion with BHS colleagues, established and new. Grateful for their suggestions and guidance, we are looking to develop the BHS and its Executive in specific areas. We will look at ways to support research in hip surgery, helping units and surgeons to communicate opportunities

and developments. We will look to develop and enhance present educational activities. Building on the success of recent annual meetings we will look into the option to introduce a second, slightly smaller, perhaps less formal, meeting within the year, at which BHS colleagues can gather to discuss cases, clinical challenges and political concerns. We hope that this meeting will provide a valuable forum for BHS members. We will look to develop the social side of any meeting, perhaps with scope to involve wives, husbands and partners in the gathering. Further details in this regard will follow in the future.

## **Communication**

Our secretary, Andy Hamer introduced a regular news update, which has proved popular. In addition to this and indeed to publications such as this 'Newsletter', we intend to use survey platforms to gauge BHS members thoughts on a number of options and issues that will then inform and guide Executive decisions as we plan and develop activities, between annual meetings. We will be in contact in the near future with the first of these surveys to look at the prospect of developing the winter meeting, mentioned above.

## **Founder's Prize**

The Executive are planning to introduce a Founders Prize to be awarded, when felt appropriate, to recognise an individual who it is felt has made a specific and major contribution to British Hip Surgery. We will look to BHS members to determine how that prize is administered in due course.

## **American Association of Hip and Knee Surgeons**



One of the very exciting areas for the British Hip Society this year, as I mentioned in Derby, is that we are the guest society at the American Hip and Knee Society meeting to be held in Dallas, from 1<sup>st</sup> to 4<sup>th</sup> November, 2018.

The five best papers presented to the British Hip Society have already been submitted for inclusion into the AAHKS meeting. We hope that as many BHS members as possible will consider travelling to attend AAHKS. BHS status as guest society will be recognised in a presentation and a number of BHS members will be involved in discussion panels. AAHKS has become the premium meeting for arthroplasty surgeons in the United States. Having spoken at AAHKS a couple of years back, I am aware of just how large and powerful the meeting has become. We are working as an Executive to try and make attending AAHKS as attractive as is possible. As part of that process and if there is sufficient interest, we could arrange some short visits to 'key' units in the US as part of that AAHKS trip. We will also be

inviting applications for a young surgeon's travelling fellowship, funded by AAHKS, as part of that arrangement. Further details on all of this will follow in the near future.

## BHS Website



Grateful to Richard Field as our webmaster for a number of years, that responsibility has now passed to Nic Wardle. Nic is working hard to update and upgrade the BHS website. We are really keen for this to represent a clinically-useful resource for BHS members. We plan to have a number of the talks given at the annual meeting available for review on the BHS website. We hope the BHS members will approve of the work that is being done and will spend time to visit the website. We most certainly welcome comments and suggestions as to how the web site can be developed as a useful resource.

As such, therefore, there are a number of changes and developments that are ongoing within the British Hip Society itself but also how the Society interfaces with other professional organisations such as the College of Surgeons, the Department of Health and the British Orthopaedic Association. It is essential that we, as hip surgeons, have a voice to support our clinical activities and to ensure that our patients are provided with ready access to our excellent arthroplasty and non-arthroplasty clinical activities.

As I have already mentioned, while I have already been busy with BHS work, it is a huge privilege to be President of the British Hip Society, following a prestigious list of wonderful and esteemed past colleagues. I will do everything I can to support and enhance the activities of the BHS. I hope that colleagues and members are excited by, and will contribute to, the developments detailed. I would hope that colleagues will feel free to be in touch directly with me, or indeed any of the other Executive members, should they have any suggestions or concerns with the BHS or indeed with their own clinical environment, if they felt that the BHS could be of any assistance

**Andrew Manktelow**

# British Hip Society Meeting 2018

## The prize winners

The standard of scientific presentations remained extremely high and the following were awarded prizes for their contributions:



**McKee Prize (Best Podium):** G Grammatopoulos

*“The acetabular and spino-pelvic morphologies are different in subjects with symptomatic cam morphology”*

**BJJ Prize for Translational Research:** A Raza

*“Diagnosing peri-prosthetic joint infection: An independent single-centre assessment of the alpha-defensin laboratory test”*

**Best Poster:** S Jain

*“The financial impact of treating periprosthetic fractures at a specialist tertiary referral centre”*

**Presidents Medical Student Prize:** G Pickering

*“KIF26B is necessary for osteogenic transdifferentiation and mineralisation in an in vitro model of pathological ossification”*



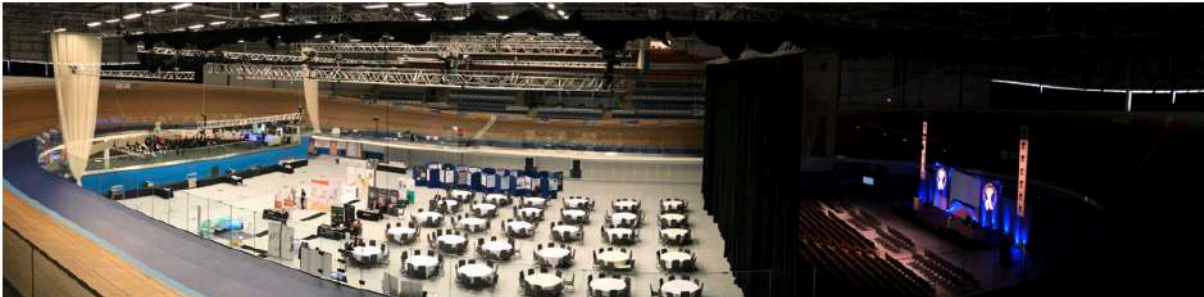
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# British Hip Society Annual Scientific Meeting

Derby 2018

The highlights

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## Hot Topics Session

Johan Witt gave an extremely well-balanced view of the indications for the anterior approach. Seeking inspiration from the bard Shakespeare himself he delivered the available information on learning curves and results. As is often in orthopaedics it indicated the requirement for appropriate randomized controlled trials although it appeared that in the correctly trained hands, it potentially delivered excellent results.

Mike Reid gave an outstanding lecture on both the up-to-date evidence from the literature and results from his hospital trust, for optimising preoperative blood management and reported his unit's dramatic reduction in use of any blood transfusion. This particular introduction had made significant savings for the trust and reduced length of stay. An excellent review of tranexamic acid followed and also of the new NICE guidelines for DVT prophylaxis for hip arthroplasty.

Dominic Meek gave a summary of the progress from enhanced recovery towards outpatient day surgery. Although evidenced that a stay less than 3 days was desirable the potential for same day discharge appeared ambitious for all. Co-morbidities precluded this for all patients. The development of a suitable stratification

risk assessment tools such as Outpatient Arthroplasty Risk Assessment (OARA) Score is necessary.

John Skinner delivered an excellent review of rationing in the NHS. He noted that rationing has always been present with free spectacles amongst the first things to be cut from the NHS scheme in 1950s. John reported on the innocuous use of postoperative outcome measures and other barriers to try and block appropriate care being apportioned to the patient. His data on BMI demonstrated how potentially 50% of the population would be denied a life improving arthroplasty by setting a bar of BMI 30 despite excellent outcomes being reported. He outlined his view that the BHS and BOA should view this as unethical as delays in surgery compromised functional results. This debate will continue.

**Dominic Meek**

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## **Complex Primary Hip Arthroplasty**

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As the first Topic in Focus for the Derby Meeting, we chose to review some of the more complex diagnoses for which primary hip arthroplasty is performed. This involved a series of presentations describing the clinical indications for surgery, alongside the technical aspects of approach and exposure with practical 'tips and tricks' regarding any specific techniques involved.

The session started with our presidential guest speaker, Prof Saleh, discussing the technical challenge associated with hip arthroplasty in obesity. Clearly while high BMI is an increasing challenge within the United Kingdom, in the United States this is a more common and often an extreme concern. Khaled was keen to show that in order to get the optimum results in these complex circumstances, a multi-disciplinary team approach is required. Extremely careful, thorough consent should be taken, explaining the various increased risks. With regard to the technical aspects of surgery, Khaled demonstrated the attention to detail required in positioning, soft tissue exposure and component implantation with particular and specific reference to accurate orientation. This is likely to be an increasing challenge in the United Kingdom, though Khaled's presentation provoked discussion regarding BMI restrictions being introduced by commissioners and how that may yet influence our practice.

In the second talk, Marcus Bankes, from Guys and St Thomas's Hospital, gave an excellent discussion of his own extensive clinical experience with the management of hip pathology associated with sickle cell disease. With patients now co-managed

regionally, with haematology colleagues, Marcus expressed concerns that some surgeons were reluctant to consider hip arthroplasty surgery, reassuring the audience that THR in sickle cell disease is no longer dangerous and unpredictable. Commenting that with appropriate pre and peri-operative multi-disciplinary management, it is very rewarding surgery. With regard to the technical aspects, Marcus explained that pre-operative exchange transfusion to reduce the percentage of sickle haemoglobin to below 30% prevents intra- and post-operative sickle crises. Marcus suggested that uncemented fixation of the acetabulum was mandatory, as the results of cemented fixation so poor. Concerns relating to femoral preparation, with hard brittle bone and the loss of the usual cortico-medullary architecture were discussed. With regard to bearing surface choice, Marcus uses ceramic on ceramic in view of the very young age of most sickle THR patients and their vastly improved life expectancy.

Andrew Manktelow, from Nottingham, then discussed the issues that surround total hip arthroplasty with femoral deformity, demonstrating some of the complex issues in femoral morphology, bone quality and retained metal-work concerns that can present in association with secondary degenerate wear. Pointing out that despite this complexity, the aims must be as per primary standard surgery, to achieve sound biomechanics, sound fixation and to ensure reliable and durable reconstitution of function. Cases were discussed in which the surgeon had to correct or accommodate for femoral deformity. Specific discussions surrounded the management of retained or previously implanted, and now incorporated, metalwork alongside concerns with regard to fixation in poor quality bone. Numerous examples were shown demonstrating all of the various options in reconstruction. With regard to removal of metalwork, Andrew identified the importance of communication and the requirement for specific instrumentation, particularly with some of the older screws and plates that had become truly interosseous. When possible, suggesting that metalwork should be removed at the same sitting however, in some circumstances, a staged approach was required. With regard to femoral mal-alignment, Andrew demonstrated cases that were managed using cemented fixation to accommodate poor bone quality and indeed for a degree of mal-alignment but, in certain circumstances, revision-type techniques with distal fixation and with proximal re-alignment osteotomy around a revision stem, is required. Against that background, Andrew presented a number of cases in which this degree of femoral deformity could actually be accommodated by using custom designs. In closing, Andrew suggested that more complex indications for hip surgery are likely to continue and that cases should be managed by colleagues with a specific and specialist interest in hip surgery, who have access to the required inventory and are aware of the various technique options in fixation, implant removal and corrective re-alignment.

Jim Holland, from Newcastle, subsequently gave a talk on the nuances that surround surgery for dysplasia. Again, Jim identified the spectrum of complexity on both femoral and acetabular side with this condition, going through the various classification systems and their relative merits and clinical relevance. Jim spent much of the talk discussing the practical issues of this surgery, identifying that the majority of cases can actually be dealt with using relatively 'standard' techniques on both femoral and acetabular side. In many cases, on the femoral side, the deformity is minimal, short of a degree of a rotational abnormality. However, in some cases retained metalwork or previous osteotomy can result in issues to be addressed simultaneously or in a staged procedure. Jim discussed the versatility of cemented fixation in these circumstances. With regard to the acetabulum, Jim described the various techniques for acetabular augmentation in Crowe 2 and 3 cases,

demonstrating the potential use of both trabecular metal augments above cemented sockets as well as femoral head autograft above cemented or indeed uncemented sockets to re-establish structural support in a deficient acetabulum. The technical issues and merits in bone availability and hip biomechanics surrounding the importance of looking working to re-establish the centre of articulation at the true anatomical hip centre was demonstrated. Practical issues surrounding exposure and retraction were identified to facilitate developing a socket from the vestigial acetabulum was described. The importance of having access to the required inventory and small component sizes was stressed. In more the dramatic Crow 4 cases, Jim demonstrated the various options and surgical techniques associated with sub-trochanteric shortening osteotomy. Demonstrating both cemented and uncemented fixation options.

Philip Mitchell from St George's London, gave an excellent presentation looking at the truly challenging complexity associated with the management of displaced acetabular fractures and the use of "primary hip surgery" in these circumstances. From his own and indeed colleagues' experiences in the major trauma and pelvic unit at St George's, Philip identified the challenges associated in this surgery. Detailing the complexity in diagnosis and characterisation of the injury using appropriate and specialist imaging, Philip made helpful suggestions with regard to how injury patterns can be identified. Again, the importance of a multi-disciplinary approach to this problem, with a combination of pelvic and acetabular fracture surgery was detailed. The use of enhanced bone fixation interfaces was described and the 'crossover' between this and indeed complex acetabular reconstruction and revision was made apparent. Philip finished the presentation with some truly remarkable and complex cases with excellent outcomes managed by him and indeed his colleagues at St George's.

In the final talk, Stephen Jones from Cardiff covered the topic of THA following failed fixation of proximal femoral fractures. At the outset Steve highlighted that the factors that contribute to successful fixation (fracture morphology, bone quality, fracture reduction, implant selection & position) also have a significant influence on conversion THA. In general this is a high-risk patient group with osteoporotic bone. Planning surgery is clearly vital and the challenge of metalwork removal that is often broken in these cases can be significant. Thereafter femoral implant selection is dependant upon the support of the metaphysis. For failed intra-capsular fractures, standard primary implants are usually adequate, but in failed sub-trochanteric fracture then distal fixation most commonly with a taper fluted stem is appropriate. Thereafter, bearing selection in this group of patients is important. These patients are often elderly with multiple co-morbidities; as such they present a high risk for dislocation. Steve then discussed the use of Dual mobility components in these frail patients to minimise the risk of dislocation.

**Andrew Manktelow**

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## Evidence for Non-Arthroplasty Hip Surgery

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The BHS Annual meeting in Derby was a historic one for many reasons. Foremost amongst them were that it hosted Industry sponsored educational sessions for the first time, and also scheduled the Hip Preservation “topic in focus” session in the main meeting on Thursday for the first time!

The focus of the session was on discussing Evidence for Non Arthroplasty Hip Surgery and was chaired by Mr. Marcus Bankes from London and myself. The first two talks were based on evidence for surgical intervention in patients with Femoroacetabular Impingement (FAI). Prof. Sion Glyn-Jones from Oxford presented the results of the **FAIT** trial, where he showed that patients with symptomatic FAI referred to secondary or tertiary care achieved superior

Outcomes with hip arthroscopy compared with non-operative measures. Prof. Damien Griffin from Warwick shared similar results from the **FASHION** trial. It was interesting to see that two large scale randomised controlled trials performed independently showed similar results. Mr. Johan Witt from UCL presented the evidence for periacetabular osteotomies (PAO) and how patients benefit from this procedure both in the shorter and longer term. Mr. Ajay Malviya from Northumbria presented that the evidence for periarticular hip surgery was weak and the best evidence in this arena stemmed from single centre cases series. Mr. Matt Wilson from Exeter summed up the available evidence succinctly and discussed the rationale behind the funding of these procedures. The last talk in this session was by Mr. Callum McBryde from Birmingham who presented the pathway for management of young adults with hip pain and stressed on the importance of a thorough work up including the diagnostic hip injection in the assessment of patients with hip pain.

Finally, Mr. Vikas Khanduja from Cambridge presented the 2<sup>nd</sup> Annual report of the Non Arthroplasty Hip Registry. The registry had recorded over 5500 procedures and the data was beginning to become more meaningful. The registry showed statistically significant improvement in iHot12 and EQ5D scores for patients having hip arthroscopy for FAI (both cam and pincer independently) and also for patients having a PAO.

The session was followed by a lively debate and the initial feedback received was very positive and encouraging.

I would also like to take this opportunity to request all members engaged in non-arthroplasty hip surgery to visit our new website [www.nahr.co.uk](http://www.nahr.co.uk) and if not already then to commence submitting your data to our National register.

**Vikas Khanduja**

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## Finesse in Hip Surgery

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The three speakers were asked to present their experience with what they felt could be done to optimise outcome in each of three areas.

**John Timperley** addressed cemented hip replacement. He stressed the importance of templating, and how he used this to accurately gauge femoral component placement. Acetabular preparation was to cancellous bone when possible, all cysts, smooth surfaces and the medial wall are grafted with cancellous bone, the latter sealing the obturator foramen at the transverse ligament. Prolonged cement pressurisation with an iliac bone suction cannula in place is followed by the late insertion of a flanged socket.

He opens the proximal femur with a high speed burr, then broaching to the templated depth. Careful cement technique was followed by the late insertion of a pre-warmed component, with cement pressurisation both before and after this. He concluded by discussing the future and how we might improve further with muscle sparing approaches, and improving implant placement with robotic assistance.

**David Beverland** addressed cementless hip replacement as a combination of tips and lessons learned. He emphasised his belief that the five most important aspects were component fixation, cup orientation, restoration of hip centre, and minimisation of wear and infection – and not the latest approach or shorter incision.

He addressed dislocation firstly by optimising version using the transverse acetabular ligament (and psoas groove) as an important guide, and subsequently inclination through patient positioning. He advocated a collared femoral component not for its ability to prevent subsidence, but to resist rotation.

**Khaled Saleh**, Presidential Guest Lecturer, gave his top tips in revision hip replacement, and broke this down into 8 “pearls”. Firstly diagnosis – why did it fail. Understanding this is often key to the right solution. Second pre-operative planning, including identifying the precise identity of implants to be retained, imaging considerations and making available all that could possibly be needed. Third

exposure, take into account previous scars and plan for maximal and extendable exposure, not minimal. Fourth, that the exposure and implant removal can be conjoint (eg ETO). Fifth pre- and intra-operative assessment of leg length, this includes preoperative counselling on what might and could happen. Restoring the correct hip centre and offset are key goals. Sixth pre- and intra-operative assessment of bony deficiency, this gives a clear indication of what reconstructive options there are. Seventh is to graft whenever practicable in order to enhance bone stock, impaction cancellous being the most versatile. Eighth structural grafting, need must be anticipated and planned for. If it is the best solution and is not available then refer to where it is.

The goals of revision arthroplasty were reiterated, relieving symptoms and restoring function, providing a weight bearing joint at the normal centre of rotation whilst correcting leg length and restoring bone stock in anticipation of future needs.

**Peter Howard**

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## **Hip Fracture Session**

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The final topic in focus for this year's meeting was dedicated to different aspects of hip fracture treatment. Matt Costa talked about choices for total hip replacement in fractured neck of femur and research in this area. Ajay Malviya shared the Northumbria experience on setting up and improving a hip fracture service and finally Rob Wakeman, the outgoing orthopaedic lead clinician for the National Hip Fracture Database, gave his summary of what has been achieved in hip fracture care and what has yet to be done.

### **THR for NOF: Who should get one, what should they get, are they getting it? Matt Costa**

Matt Costa explained that 1.4% of the Health & Social Care budget is put towards hip fracture treatment. Research and resources have highlighted the emphasis on getting patients to theatre expeditiously for treatment, be that for THR or hemiarthroplasty.

He demonstrated that there is an ongoing mismatch between the number of patients eligible for THR under NICE guidelines and the number that actually receive a one. Currently just 30% of eligible patients receive a THR for hip fracture. Older patients in particular are less likely to receive a THR and there is a large variation in practice around the country.

The debate was raised over who should do a THR for fracture; whether these cases should be done by specialist hip surgeons or all orthopaedic consultants performing trauma. This question has not yet been answered and remains a controversial subject and one for future study.

Matt presented an update on the WHITE study, the aims of which include studying what is important to hip fracture patients and their expectations for treatment. From this a list of PROM's for hip fracture has been created. The results have shown that HQoL scores correlated with hip scores and were sensitive to change. These outcome scores demonstrated a 20% loss of quality of life following a hip fracture.

### **Developing a hip fracture service that works for patients (and staff) Ajay Malviya**

Ajay Malviya presented the Northumbria experience of setting up and improving a hip fracture program, highlighting aspects of care that he felt had made the greatest difference to patient care. The service had started as a negative outlier on the NHFD, which had been the driver for change

Reducing the length of time taken between admission and surgery has been a major focus for the Northumbria service. A fast-track admission process through the Emergency Department has been developed, with X-rays performed within an hour of ED attendance. The use of trauma lists has been changed, with a fractured NOF patient booked as the golden patient on the start of each trauma list.

Pain control was highlighted as another important aspect of care that has been improved. A reduction in the need for opioid analgesia has been achieved by a combination of measures. A fascia iliaca block is administered preoperatively on admission to ED. Intraoperatively local anaesthetic infiltration is performed and patients are given IV paracetamol.

Ajay demonstrated that the safety of surgery for fracture neck of femur requires planned consultant involvement. He described the parameters for training that exist in Northumbria and the "20-minute rule." A non-consultant surgeon in training is allowed 20-min from incision to acceptable wire placement for extracapsular NOF patients being treated with a DHS or from incision to removal of the patient's femoral head in those having an arthroplasty for intracapsular NOF and if these times are breached the consultant intervenes.

Ajay presented data on the choice of design for hemiarthroplasty and questioned the validity of NICE's insistence that a "modern stem design" should be used. This was highlighted as a future area for research and clarification. The use of high dose dual antibiotic cement has significantly reduced the risk of infection for patients receiving a hemiarthroplasty.

Finally, the importance of fluid and nutritional support was emphasized as well as the need for additional HDU access for high risk cases. Ajay highlighted the importance of maintaining hydration with perioperative fluids and the use of vasopressors if a patient's blood pressure is low postoperatively. Involvement of dieticians in the care of these vulnerable patients has been associated with a 40% fall in their mortality.

### **The National Hip Fracture Database: What has been achieved and what is yet to be done? Rob Wakeman**



In his reflections on the achievements of the NHFD to date, Rob touched on many of the themes raised by the previous two speakers, and he highlighted some of the successes achieved since the inception of the database.

There has been an encouraging increase in the number of hospitals participating in the NHFD, which has increased from 11 in 2007 to 177 in 2017.

Progress has been made on the time taken from admission to surgery and the achievement of the 36-hour target, which has improved from 54.5% in 2007 to 71.5% in 2011.

There has been a reduction in 30-day mortality after hip fracture from 10.9% in 2007 to 7.1% in 2016 and an increase in the number of patients receiving bone-strengthening medication – from 66% in 2011 to 80% today.

Challenges remain around prioritizing the surgical treatment for these patients, their perioperative pain relief, improving the rates of THR for intracapsular neck fracture and ensuring that surgery is performed by correctly-trained surgeons, while at the same time providing a safe environment for the training of future generations of surgeons. These challenges and others will form the basis for future Topics in Focus on this subject at the British Hip Society meetings.

**Jonathan Howell**





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## ADDITIONAL SESSIONS

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In addition to the academic and clinical case presentation sessions at the BHS meeting, and in recognition of the sad passing during the last year of two of our founding members, it was important for BHS members to hear something of the activities of those founding colleagues.

We were extremely grateful to both Professor John Timperley and Professor John Skinner, who gave short presentations regarding the lives, activities, interests and contributions of Robin Ling and Mike Freeman.



Professor John Timperley



Professor John Skinner

It was made very obvious in these wonderful presentations, just how much of a contribution they had both made, how well both men were liked and, indeed, how inspirational they were in terms of hip surgery and hip practice in the United Kingdom.

The session was introduced by Keith Tucker who gave a first-hand account of the history of the British Hip Society and its early meetings. In addition, Keith recognised the part played by our third founding member, Hugh Phillips.

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## The Future

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Following the success of the Derby meeting, the Executive are already working extremely hard on preparation and planning for future BHS events. There will be more communication in the very near future in this regard relating to some of the matters raised in Andrew's comments above.

With regard to the British Hip Society Annual Scientific Meeting itself, this will take place in Nottingham on 27th February to 1<sup>st</sup> March, 2019.

The meeting will take place in the Royal Concert Hall in central Nottingham. Details with regard to registration submission and accommodation will be available in due course on the website.



It will be a great delight once again to welcome colleagues from the Arthroplasty Care Practitioners Association to our meeting in Nottingham.



Further details on the programme, speakers, clinical sessions and chosen topics in focus will follow in the near future.

We really hope that you find the newsletter a helpful resource. Please keep in touch with the BHS via the website. The executive will continue to welcome and encourage comment and suggestions regarding how best to develop our society.

We will be in touch in the near future with details surrounding developments and future events.

**Andrew Hamer**  
**Secretary British Hip Society**



BHS President, Andrew Manktelow with President Elect, Stephen Jones (left) and Vice President, Jonathan Howell (right)

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# Meet the Executive

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## **President**

Andrew Manktelow



Having been appointed in November 1999, at Nottingham University Hospitals NHS Trust, I have now been in post for nearly 20 years. I have been on the BHS exec for a few years now having been the Editorial Secretary previously. It was a great privilege to become President in March of this year.

## **Immediate Past President** Peter Howard



I was appointed Consultant to Derby hospitals in 1991, having trained in the Midlands. Closely involved with the BHS since 2001, Editorial Secretary from 2004-09. Involved in the NJR from its outset, and currently chair the Surgical Performance and Implant Performance Committees.

## **President Elect**

Stephen Jones



I was appointed as Consultant in Cardiff and Vale University Health Board in 2005. I have served on the BHS Executive committee since 2014 initially as Honorary Secretary. I was also appointed as the National Musculoskeletal Research Lead for Wales.

**Vice President**

Jonathan Howell



I was appointed a consultant at Exeter in 2004, having trained in the Southwest and in Vancouver. I was first elected to the BHS Executive as Member at Large in 2011 and I have been on the Executive since that time, for four years as Honorary Treasurer and for a year as Editorial Secretary. It is my great honour to have been elected Vice-President Elect in 2018

**Honorary Secretary**

Andy Hamer



I was appointed in Sheffield in 1998 and have a practice based in both hip and knee surgery. I was previously the TPD for our rotation and maintain an interest in both training and education. I am an FRCS Orth examiner and a member of the SAC. Having been on the BHS exec previously I returned to become Secretary in 2017.

**Treasurer**

Anil Gambhir



Appointed in 2003, I work at Wrightington Hospital, Wigan. I have a busy clinical practice providing a young adult hip, complex primary and revision hip arthroplasty service. I am the Divisional Medical Director at Wrightington. I was elected as Honorary Treasurer in March 2018.

**Editorial Secretary**

Dominic Meek



Appointed in 2003, I work at the Queen Elizabeth University Hospital, Glasgow as part of a group providing a regional complex young hip, revision and peri-prosthetic fracture and infection arthroplasty service. As an Honorary Professor at Glasgow University, I am a member of the BOA research committee and cofounder (2009) of the Glasgow Orthopaedic Research Society (GLORI).

**Non Arthroplasty Hip and Registry representative**

Vikas Khanduja



I am a Consultant at Addenbrooke's, Cambridge and have a special interest in treating young adults with hip and knee pathology. I am the Research Lead for Clinical Trials in Elective Orthopaedics in Cambridge and convene the Cambridge Basic Science and Hip Arthroscopy Course. I also sit on SICOT Executive Board and am the Associate Editor to the Bone and Joint Journal

**Member at Large**

Ben Bolland



I am a Consultant at Musgrove Park Hospital, Taunton. I have a special interest in Acetabular reconstructions. I am currently in my first role on the Executive Committee as the Member at Large. I am greatly enjoying taking a more active role in the society. I hope to act as a link for members to raise any issues to be discussed with the committee.

**Web master**

Nic Wardle



Following on from my Training around London and after getting involved with the BHS in the background for the original website upgrade, I was appointed to Colchester Hospital in 2012. I am passionate about improving the online presence of our Society and felt honoured to be invited on to the Exec this year.