

PROCEDURE COMPARISON

| | POSTERIOR | DIRECT ANTERIOR |
|-----------------------------|--|---|
| Type of patient | Virtually all patients | DAA may not be suitable for patients with hip deformities or flexion contractures. If you carry excess weight this may not be suitable but worth discussing with your orthopaedic surgeon. |
| Pre-operative planning | Posterior - standard hip X-rays. No intraoperative imaging routinely used to ensure optimum implant positioning during surgery | Standard hip X-rays and additional Hip CT utilised to make the patient specific cutting jig for latest laser technology for optimum implant positioning during surgery (small risk from necessary additional CT scan radiation) |
| Position during procedure | On your side | On your back |
| Location of incision | Behind the hip, along the outer buttock | Front of upper thigh |
| Length of incision | 4-6 inches (typically) | 4-6 inches (typically) |
| Reasons for larger incision | Excess weight, previous surgery, unusual anatomy. | Excess weight, previous surgery, unusual anatomy |
| Muscle preservation | Gluteus maximum is split, however it doesn't require repair, as the tendon isn't removed. 2 of 4 external rotators of the hip are detached from the femur, and reattached. | The muscles around the hip joint are preserved, as the surgeon will make an incision and work between the muscles, without having to cut them away from the bone. |
| Risks of nerve damage | No risk to lateral femoral cutaneous nerve, in thigh. Low risk to sciatic nerve – less than 1%. | Some risk to lateral femoral cutaneous nerve, in thigh and the majority recover with time. Very low, to no, risk to sciatic nerve. |
| Visibility for surgeon | Exposure means excellent visualisation for the surgeon. No intra-operative x-rays are used routinely. | Mildly impaired visualisation, as surgeon is required to work between muscles. Latest laser-technology is used for maximum accuracy of treatment. This may be augmented by an intra-operative X-ray” |
| Surgeon experience required | This is a routine hip surgery carried out by most orthopaedic surgeons in the UK | This technique is not widely used in the UK, so requires an experienced hip surgeon. |
| Duration of surgery | Approximately 60–90 minutes | 2–3 hours |

POST PROCEDURE

| | POSTERIOR | DIRECT ANTERIOR |
|--------------------------------|--|---|
| Mobilisation post surgery | Next day | Later that day |
| Hospital recovery | 2-3 days | 1-2 days |
| Personal outcomes | There is a risk of dislocation, typically when bending further than 90 degrees at hip. After a couple of months risk of dislocation is considered low. | Risk is considered very low. |
| Postoperative complications | All surgeries carry an element of risk. Risk of blood clots to legs or lungs, infection, anesthesia risks and death. | All surgeries carry an element of risk. Risk of blood clots to legs or lungs, infection, anesthesia risks and death |
| Use of medical equipment | A walker, cane or crutch may be used during recovery time. | A walker, cane or crutch may be used during recovery time. |
| Use of physical therapy | May be recommended by your doctor. | May be recommended by your doctor. |
| Return to sedentary work | 2-6 weeks | 1-2 weeks |
| Return to physical work | 3 months | 1-3 months |
| Return to light sports | 6 weeks | 1 month |
| Return to vigorous sports | 3 months | 3 months |
| Post surgery Sleeping Position | Sleep on back for 6 weeks | No restrictions |

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Tel: 01223 667 376

Email: enquiries@carrothersnorrish.co.uk