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 start 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 anterior, anterolateral or posterior?

Originally, I only performed Anterior and Anterolateral approaches as advocated by Heinz Wagner and Charles Townley. Both Amstutz and McMinn convinced me to move away from the anterior approach. All three approaches are quite satisfactory. I will follow a patient preference unless there are unique circumstances. Most patients seem to prefer the Superior Approach (see under patient education)

5.) What size do your incisions normally range in inches? They vary by size of my 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? For some patients I do favor the direct anterior approach but most do better with the Superior Approach.

7.) How long do you feel it takes for the bone to be fully healed, actually grow into the prosthesis? 2-3 months

8.) Barring any complications, how many days in the hospital will a patient normally stay? Most of our resurfacing procedures are done on a day case

basis (home same day as surgery). We have yet to have an infection or blood clot in an ambulatory surgery patient.

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. Usually just aspirin, No need for TEDS. Yes for PT and ICE. 90 degree flexion restriction benefits capsular healing in patients who want to pursue adventure sports later.

10.) How long before a typical patient is allowed to drive a car, return to work. Can work and drive as soon as off pain medication.

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 some of the sports they have returned to? Sports start at 3 months (gently). permanent restrictions including professional sports (golf, tennis semipro football and basketball).

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. I favor cementless fixation but also offer the cemented BHR.

13.) Do you have a cut off age for resurfacing patients or do you go on a case by case basis? See interview under News and Journals of hip resurfacing for resurfacing surgeon Dr. Fred Buechel (age 70).
14.) What type of anesthesia do you use general or epidural or? Mepivicaine Spinal15.) 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.

16.) Do you do bilateral surgeries same day, if not how far apart do you recommend? Not any longer. We have done about 200 and there did not see 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 the BHR or Synovo. I thought the ASR was a poor design and did no ca s with this device (I have revised a number of cases).

18.) If you can't perform a hip resurfacing - what THR device do you prefer and why? Often use a dual mobility hip because it is so stable.

19.) What do you consider an adequate number of surgeries for a doctor to be proficient at hip resurfacing? Minimum 300