Elder Femoral Neck Fractures: Replace

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Reduction

A new measurement for posterior tilt predicts reoperation in undisplaced femoral neck fractures
113 consecutive patients treated by internal fixation and followed for 1 year

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Objective

Internal Fixation of Garden I and II Femoral Neck Fractures: Posterior Tilt Did Not Influence the Reoperation Rate in 182
Consecutive Hips Followed for a Minimum of 5 Years:

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Background: To study the influence of posterior tilt in hip fractures treated nonoperatively.

Methods: Consecutive patients with dislocated femoral neck fractures were treated with traction and immobilization. Patients were followed for at least 5 years postoperatively.

Results: No statistical difference was found in the reoperation rate between patients with and without posterior tilt.

Conclusion: Posterior tilt does not influence the reoperation rate in dislocated femoral neck fractures managed nonoperatively.

Maintenance of Reduction

[Images of X-rays]
Are we accepting a malunion?

Bony union (compression)  Shortening

Are we accepting a malunion?

Bony union (compression)  Shortening
Implications of Shortening

Limitation of Current Implants
Evidence?

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Missing Ingredient?

• Continued compression?

• Resorption at fracture

• Something else altogether?
• Reduction
  • Limit morbidity
• Maintenance of Reduction
  • Osteoporosis
  • Worse biology
  • Compress ‘em
  • Keep ‘em compressed (resorption)
  • Proper implant

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**Missing Boat?**

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**AAGS Clinical Practice Guideline Summary**

**Management of Hip Fractures in the Elderly**

**Abstract**

The purpose of this clinical practice guideline is to help improve treatment and management of hip fractures in the elderly based on current best evidence. The guideline contains twenty-five recommendations. Of those recommendations, existing evidence supports regional analgesia in improving pain control and functional outcomes, post-operative use of amnestic for general or spinal anesthetics, prophylaxis for patients with anticoagulants (Warfarin) through peri-operative period, use of non-invasive and invasive for the treatment of patients with subtrochanteric or reverse oblique fractures, a closed reduction technique of less than 60% in asymptomatic postoperative patients, intensive physical therapy postdischarge, use of an interdisciplinary care program in patients with mild to moderate dementia, and multidisciplinary care management of hip fracture surgery. In addition to the recommendations, the work group highlighted the need for better research in the treatment of hip fractures.
Stable Femoral Neck Fractures

Moderate evidence suggests operative fixation for patients with stable (non-displaced) femoral neck fractures.

Implications: Practitioners should generally follow a moderate recommendation but remain alert to new information and be sensitive to patient preferences.

Displaced Femoral Neck Fractures

Strong evidence supports operative fixation for unstable (displaced) femoral neck fractures.

Implications: Practitioners should generally follow a strong recommendation unless a clear and compelling reason makes an alternative approach more appropriate.

Unipolar versus Bipolar

Moderate evidence supports that the use of unipolar and bipolar hemispherical cups for total hip arthroplasty is safe and effective as demonstrated in previously published studies. Evidence for bipolar versus unipolar approaches is limited.

Implications: Practitioners should generally follow a moderate recommendation but remain alert to new information and be sensitive to patient preferences.

Hemiarthroplasty versus Total Hip Arthroplasty

Moderate evidence supports the use of hemiarthroplasty in selected cases to achieve stable fixation and prevent complications for femoral neck fractures.

Implications: Practitioners should generally follow a moderate recommendation but remain alert to new information and be sensitive to patient preferences.

Cemented Femoral Stems

Moderate evidence suggests that the use of cemented femoral stems offers improved stability and reduced risks of dislocation and aseptic loosening.

Implications: Practitioners should generally follow a moderate recommendation but remain alert to new information and be sensitive to patient preferences.
Good Studies

- Better patient oriented outcomes
- Lower morbidity
- Earlier mobilization

Current State

- Under 65 - ORIF
- Over 65 Non/minimally displaced - ORIF
- Over 65 displaced active - THA?
- Over 65 displaced not active - Hemi
Need Technique/Implant

- Reduced
- Keep it reduced (without settling)
- Union
- Walk on right away
- Accessible
- Literature rivals that favoring arthroplasty