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1     **THE EFFECT OF CUP ORIENTATION ON OUTCOME FOLLOWING TOTAL**  
2     **HIP ARTHROPLASTY WITH SMALL DIAMETER HARD-ON-SOFT BEARING**

3

4     **ABSTRACT**

5     We assessed the acetabular orientation in 1,070 primary THAs with hard-on-soft, small  
6     diameter bearings, aiming to determine the size and site of the target zone that optimises  
7     outcome. Outcome measures included complications, dislocations, revisions and  $\Delta$ OHS  
8     (difference between pre-operative and at 5-year Oxford Hip Scores). A wide scatter of  
9     cup orientations was observed (2SD  $\pm 15^\circ$ ). Lewinnek's zone was not associated with  
10    improved outcome. Of the different zone sizes tested ( $\pm 5^\circ$ ,  $\pm 10^\circ$  and  $\pm 15^\circ$ ) only  $\pm 15^\circ$  was  
11    associated with a decreased dislocation rate. The dislocation rate of cups inside an  
12    inclination/anteversion zone of  $40^\circ/15^\circ \pm 15^\circ$  was four times lower than those outside.  
13    The only zone size associated with statistically significant and clinically important  
14    improvement in OHS was  $\pm 5^\circ$ . Best outcomes ( $\Delta$ OHS  $>26$ ) were achieved with a  $45^\circ/25^\circ$   
15     $\pm 5^\circ$  zone. This study demonstrated that with traditional technology surgeons can only  
16    reliably achieve a target zone of  $\pm 15^\circ$  (2SD). As the optimal zone to diminish dislocation  
17    risk is also  $\pm 15^\circ$ , surgeons should be able to achieve this. This is the first study to  
18    demonstrate that optimal orientation improves functional outcome. However the target  
19    zone is small ( $\pm 5^\circ$ ) and cannot, with current technology, be consistently achieved.

20

1 **INTRODUCTION**

2 Recent complications associated with hard-on-hard bearings have stimulated increased  
3 interest in optimal acetabular component (cup) orientation in hip arthroplasty<sup>1,2</sup>. Amongst  
4 all studies reported it is evident that a wide scatter of cup orientation is achieved even in  
5 the practice of experienced hip surgeons<sup>3</sup>. A recent study identified minimally invasive  
6 surgical approach, low-volume surgeons and obesity as factors increasing the risk of cup  
7 mal-orientation<sup>3</sup>. Component orientation is considered an important factor in improving  
8 range of movement, function and survival<sup>4-6</sup>, and minimising complications following  
9 Total Hip Arthroplasty (THA), although the evidence is weak for hard-on-soft bearings.

10 The most common early and mid-term THA failure mode is dislocation, with a reported  
11 incidence up to 10%<sup>7,8</sup>. Cup orientation has been shown in some<sup>9,10</sup>, but not all<sup>11,12</sup>,  
12 studies to influence stability and different safe- or optimal zones have been described in  
13 order to reduce dislocation-risk. The most commonly referenced zone is that described by  
14 Lewinnek<sup>9</sup>, which comprises an inclination/anteversion of 40°/15°(±10°) measured on  
15 post-operative supine radiographs. However, this study had small number of patients  
16 (n=122) and a 3% dislocation rate. A recent, larger (n=469), case-control study showed  
17 that although a safe zone for dislocation could not be determined, cups with inclination  
18 of 45° and anteversion of 15° had the lowest dislocation-risk<sup>6</sup>. Although various studies  
19 have attempted to define the location (on an inclination/anteversion plot) of an optimal  
20 zone, none have investigated different sized zones.

21 In addition to end-points such as revision and dislocation in the assessment of THA,  
22 patient-reported-outcome-measures (PROMs) have become more common and important

1 in recent years<sup>13</sup>. A validated PROM designed specifically for THA patients is the Oxford  
2 Hip Score (OHS), which assesses pain and function<sup>14</sup>. We are not aware of any previous  
3 studies that have attempted to correlate acetabular orientation with function.

4 The aims of the current study were firstly to identify factors influencing cup orientation  
5 following THA and secondly to investigate the relationship between cup orientation and  
6 complications (dislocation and revision) and mid-term clinical outcome (OHS), in order  
7 to identify the location and size of the zone for optimal cup orientation.

8

## 9 **METHODS**

10 The EPOS (Exeter-Primary-Outcome-Study) is a prospective, non-randomised, IRB-  
11 approved, multicentre study (7 centres), in which a cohort of 1,501 THAs (1,437 patients)  
12 was recruited between January 1999 and January 2002. The cohort has previously been  
13 reported with studies investigating the effects of obesity, approach and surgical grade on  
14 outcome post hip arthroplasty<sup>15</sup>.

15 Patients from the EPOS were included in this study if they had adequate radiographs  
16 (antero-posterior pelvis radiograph with minimal rotation and tilt with a corresponding  
17 lateral radiograph). 431 (29%) hips had no (n=377) or inadequate quality [e.g. hip only,  
18 (n=54)] radiographs and hence were excluded. The remaining 1070 formed the current  
19 study's cohort (Figure 1). There was no selection bias as evidenced by the fact that the  
20 cohort included in this study had similar gender mix (p=0.83), age (p=0.10), diagnosis  
21 leading to surgery (Primary OA: 84%, dysplasia: 5%, inflammatory arthropathy: 6%,

1 other: 5%) (p=0.4), OHS (p=0.53) and complication rate (p=0.45) as the cohort of  
2 patients excluded.

3 The majority of THAs were performed in females 668 (62%). The mean age at surgery  
4 was of 68 years (27 - 91 years) and primary osteoarthritis was the most common  
5 diagnosis (n=898, 84%). The mean body mass index (BMI) was 27.3 kg/m<sup>2</sup> (16 - 53  
6 kg/m<sup>2</sup>) (Table 1).

7

## 8 **Surgical Details**

9 Surgery was performed by numerous surgeons (>60) across different centres with  
10 majority performed by consultants (n=685, 64%). Surgical details are given in Table 2. In  
11 all cases a cemented Exeter femoral component (Stryker Howmedica, Newbury, UK) was  
12 used. A variety of cementless and cemented acetabular components were used including  
13 Trilogy (Zimmer, Inc, Warsaw, IN, USA), Elite Plus, Charnley Standard, Ogee and  
14 Flanged (DePuy, Warsaw, IN, USA), Exeter (Stryker Howmedica Osteonics, Newbury,  
15 UK) and Plasma Cup (Aescular, Tuttlingen, Germany). All bearing couples were hard-  
16 on-soft. Femoral head sizes used were either 22, 26, or 28 mm.

17

## 18 **Outcome measures**

19 The OHS (0–48 ,worst – best outcome) was used as a validated method for assessing  
20 patient-reported clinical outcome<sup>14</sup>. OHS was recorded pre-operatively, at 3 months, one-

1 year, two-years and five-years post-operatively. The power of the study was sufficient  
2 (85%) to detect a 2-point difference in the primary outcome measure, which was the  
3 change between the pre-operative and five-year post-operative scores ( $\Delta\text{OHS}$ ;  $\Delta\text{OHS} =$   
4  $\text{OHS}_{5\text{years}} - \text{OHS}_{\text{pre}}$ ). A two-point difference in  $\Delta\text{OHS}$  has been reported to be clinically  
5 important change from the patient's perspective<sup>14</sup>.

6 Pre-operative and five-year data were available for 818 hips (76%). Amongst the 252 that  
7 had no OHS available, 28 (3%) were lost to follow-up without implant status or outcome  
8 being known, 75 (7%) died, 45 (4%) refused further participation, 32 (3%) were  
9 withdrawn from study for other reasons (e.g. moved out of region), 11 (1%) had been  
10 revised. For 61 hips (6%), although not lost to follow-up, OHS data was incomplete.

11 Secondary outcome measures included complications such as dislocation and revision.

12 Secondary outcome measures were available for all but the 28 hips (3%) that were lost to  
13 follow-up.

14

#### 15 **Radiological assessment – cup orientation**

16 Standardised, supine antero-posterior (AP) pelvic and lateral hip radiographs were  
17 performed. The Ein-Bild-Roentgen-Analysis (EBRA) software, a validated method of  
18 estimating orientation with an accuracy of  $2^\circ$ , was used to calculate radiographic cup  
19 inclination and version from AP radiographs<sup>16,17,18</sup>. Lateral hip radiographs allowed  
20 determination of anteversion or retroversion. Measurements were performed

1 independently by two observers (omitted for review) blinded to outcome with excellent  
2 intra- and inter-observer correlation (interclass correlation coefficients>0.95, p<0.001).

3

#### 4 **Analyses**

5 The average orientation and the variability (defined as 2 Standard Deviations (SD)) in the  
6 orientation of all cases was determined. For the 18 surgeons who did more than 5 hip  
7 replacements the variability within the surgeons practice was also determined. The effect  
8 of different patient and surgical related factors including gender, diagnosis, BMI, patient  
9 position during surgery, surgical approach and surgeon's grade on acetabular component  
10 orientation and dislocation were assessed. In addition, it was determined whether the cups  
11 were in Lewinnek's Zone (LZ) or not.

12 Patients BMI was divided into two groups: non-obese (BMI<30, n=784) and obese  
13 (BMI≥30, n= 247). BMI was not available for 39 patients (4%). Patient position during  
14 surgery was divided into supine (213, 20%) or lateral (857, 80%). Surgical approach was  
15 divided into antero-lateral (n=787, 74%) and posterior (n=277, 26%); in 6 cases the  
16 details of approach used were missing. Patient and surgical factors were correlated to LZ  
17 inclination and anteversion angles independently. Cross-tabulation was used in order to  
18 identify which factors were associated with mal-orientation.

19 In order to determine the optimum orientation for improved ΔOHS and reduced  
20 dislocation and revision risk the following analyses were performed. As suggested by  
21 Lewinnek<sup>9</sup>, it was assumed that a surgeon can implant a component within ±10° of a

1 target. For every possible combination of inclination in the range (30°–60°) and  
2 anteversion in the range (0°–30°), a  $\pm 10^\circ$  zone about it was constructed; the mean  $\Delta$ OHS,  
3 dislocation and revision rates of THAs with cups within each zone were determined and  
4 compared with the mean  $\Delta$ OHS, dislocation and revision rates of THA with cups outside  
5 the zone. This was repeated for every possible zone and contour plots of the mean  $\Delta$ OHS  
6 and percentages of dislocation and revision rates as functions of inclination and  
7 anteversion were generated. The  $\Delta$ OHS, dislocation and revision rates within and outside  
8 the zones were compared statistically and p-values for  $\Delta$ OHS, dislocation and revision  
9 rates were plotted. The process was repeated for zones of  $\pm 5^\circ$ , and  $\pm 15^\circ$ . Analyses were  
10 performed using custom routines written in Matlab (version R2009a, The MathWorks  
11 Inc., Natick, Massachusetts, USA).

12 Statistical significance was defined as  $p \leq 0.05$ . For normally distributed outcome  
13 measures (OHS,  $\Delta$ OHS), ANOVA was used for data analysis. Non-parametric, scale data  
14 were analysed with Mann-Whitney U test, whilst categorical and frequency data were  
15 analysed with chi-square and Fisher's exact tests. SPSS 17.0.1 for Windows (IBM, New  
16 York, US) and Matlab Statistics Toolbox (v7.1) were used for all statistical analyses.

17

## 18 **RESULTS**

19 The acetabular component orientation showed a wide scatter (Figure 2). The mean  
20 inclination was  $45.7^\circ$  ( $20.7^\circ - 73.6^\circ$ ) and the mean anteversion was  $10.3^\circ$  ( $-33.0^\circ -$   
21  $39.3^\circ$ ). The variability, defined as 2SD, in both inclination and anteversion was about  
22  $15^\circ$ . The variability in orientation for individual surgeons was about  $13^\circ$ . 70% of cups



1 (n=749) were within LZ's inclination range, whilst 74% of cups (n=796) were LZ's  
2 anteversion range. 50% of cups were within both the LZ's inclination and anteversion  
3 ranges.

4 Cups inserted in the supine position and cementless cups had significantly higher  
5 inclination (Figure 2, Table 3). Significantly higher anteversion was observed in females,  
6 hips operated via the posterior approach (Figure 3, Table 3) and those operated on by  
7 consultants. Females and patients operated on via the posterior approach were more  
8 likely to have cups within the LZ's anteversion range.

9 Patients with cups within the LZ did not have better  $\Delta$ OHS (23.6 vs. 24.4,  $p=0.2$ )  
10 compared to patients with cups outside the LZ.

11 Twenty-two hips sustained a dislocation (2%) and 11 hips required revision (1%).  
12 Reasons for revision included: recurrent dislocation (n=4), infection (n=2), aseptic  
13 loosening (n=2) and fracture (n=3). Cup orientation was not different between dislocated  
14 and non-dislocated hips, or between hips that did or did not require revision (Table 4,  
15 Figure 4). Dislocated hips that had an antero-lateral approach had similar cup  
16 orientations to the dislocated hips that were operated via the posterior approach (Table 5).  
17 There were 4 patients with recurrent dislocations that subsequently underwent revision  
18 (0.4%), with satisfactory outcome. In two patients, the cup was retained  
19 (inclination/anteversion:  $48^{\circ}/14^{\circ}$  - posterior approach, inclination/anteversion:  $48/33^{\circ}$  -  
20 lateral approach) and the femoral component and liner were exchanged; one patient  
21 underwent cup-only revision for gross mal-orientation: (inclination/anteversion:  $59^{\circ}/-33^{\circ}$

1 (retroversion) – posterior approach) and one patient underwent exchange of both  
2 components (inclination/anteversion: 37°/9°– lateral approach).

3 There was no  $\pm 5^\circ$ , or  $\pm 10^\circ$  zones about any cup orientation with statistically reduced  
4 dislocation rate ( $p=0.06$  to  $1.00$ ). However, analysis with a size of zone of  $\pm 15^\circ$  showed  
5 a statistically reduced chance of dislocation about an orientation with  
6 inclination/anteversion of  $42^\circ/12^\circ$  (Figure 5). THAs with cups outside this wide zone had  
7 a significantly higher dislocation rate (7%) compared to THAs with cups within the zone  
8 (1.8%) ( $p=0.01$ ). There were no zones that had statistically different revision rates.

9 Optimal zone analysis findings are detailed in Table 6. There were many zones of  $\pm 5^\circ$ ,  
10  $\pm 10^\circ$  and  $\pm 15^\circ$  that had statistically significantly improved OHS. The p-values tended to  
11 be lower with smaller zone sizes, and were centred on  $45^\circ/23^\circ$  (Figure 6). The differences  
12 in  $\Delta$ OHS within and outside zones were small ( $<2$  points) for  $\pm 10^\circ$  and  $\pm 15^\circ$  zones. The  
13 contour plot for  $\pm 5^\circ$  zones (Figure 6) showed that the best outcome ( $\Delta$ OHS  $>26$ ) was  
14 with components with an inclination between  $40^\circ$  to  $50^\circ$  and anteversion between  $20^\circ$  to  
15  $30^\circ$ , whereas worst outcome ( $\Delta$ OHS $<22$ ) tended to be when both inclination and  
16 anteversion were at the extremes of the location of the plot. Orientations with statistically  
17 significant lower  $\Delta$ OHS had inclination/anteversion of  $57^\circ/30^\circ$  ( $\Delta$ OHS=18) and  $52^\circ/0^\circ$   
18 ( $\Delta$ OHS=21).

19

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21

22

## 1 **DISCUSSION**

2 In this large, multi-centre study of hard-on-soft THA we found that there was great  
3 variability ( $2SD \pm 15^\circ$ ) in acetabular orientation. It has generally been accepted that the  
4 optimal orientation is within Lewinnek's Zone. However, due to the variability in  
5 orientation, only 50% of cases were within this Zone. In addition we found that there was  
6 no advantage in terms of functional outcome or complications of being in this zone,  
7 suggesting that Lewinnek's Zone is of little relevance. We therefore studied all potential  
8 target zones to see if there was one that could be recommended.

9 Zones of  $\pm 5^\circ$  or  $\pm 10^\circ$  did not significantly reduce the dislocation or revision rate.  
10 However when zones of  $\pm 15^\circ$  were assessed a significantly reduced risk of dislocation  
11 was identified about an orientation of inclination/anteversion of  $42^\circ/12^\circ$ . For simplicity,  
12 and to take into account the observation that to achieve a specific orientation on post-  
13 operative radiographs surgeons should aim for slightly more anteversion and less  
14 inclination<sup>17</sup>, we recommend that surgeons should aim for  $40^\circ/15^\circ \pm 15^\circ$ . Using current  
15 technology, surgeons should be able to reliably achieve this orientation within the margin  
16 of  $\pm 15^\circ$ . If they do, the odd's ratio of the hip sustaining a dislocation is 1/4 ( $p=0.01$ )  
17 compared with when the cup is outside the zone. The absolute dislocation risk was 1.8%  
18 for cups within the zone and 7% for cups outside the zone.

19 This is the first study that we are aware of that has investigated the effect of cup  
20 orientation on functional outcome. It was found that there were statistically significant  
21 but small clinical advantages of achieving orientations in the region of  $45^\circ/25^\circ$ , with zone  
22 sizes of  $\pm 10^\circ$  or  $\pm 15^\circ$ . However with a zone of  $\pm 5^\circ$  there was not only a statistically

1 significant but also a clinically important advantage. Worse functional outcomes were  
2 obtained if the cups were in zones of  $\pm 5^\circ$  around  $57^\circ/30^\circ$ , and  $52^\circ/0^\circ$ . These zones with  
3 poor outcome fall within the  $\pm 15^\circ$  zone for reducing dislocation, and the zones with good  
4 outcome are near the edge of the dislocation zone. Therefore with current technology,  
5 which can only reliably achieve  $\pm 15^\circ$ , surgeons should focus on implanting the socket in  
6 a position that will minimise the risk of dislocation. If they aim for the optimal target for  
7 improved function they may end up outside the zone for minimising dislocation.  
8 However, with improved technology, the ability to accurately implant a cup within  $\pm 5^\circ$   
9 could potentially be achieved and surgeons should aim for  $45^\circ/25^\circ \pm 5^\circ$  as this would  
10 minimise dislocation and maximise outcome.

11 As most sockets were within the  $40^\circ/15^\circ \pm 15^\circ$  zone, most dislocations also occurred  
12 within this zone. For these dislocations the socket orientation probably had little  
13 influence on the dislocation and other factors were more important. Other factors that  
14 have been shown to influence stability, include head-neck-ratio<sup>8</sup>, leg-length discrepancy,  
15 soft-tissue balance<sup>19,20</sup>, capsular repair<sup>21</sup>, offset<sup>22</sup>, relative cup/femoral orientation<sup>23</sup>, and  
16 hip joint centre location<sup>24</sup>. It is likely that for an increased risk of dislocation at least two  
17 factors need to be involved.

18 The wide scatter of cup orientation suggests that, although surgeons aim for a specific  
19 orientation, they frequently fail to achieve it. This study identified various factors that  
20 influence orientation that surgeons should bear in mind when positioning a socket.  
21 Factors that increased inclination include cementless fixation and supine position during  
22 surgery. The native acetabulum has a higher inclination than the optimal for THA<sup>25</sup>.

1 Therefore to achieve better cementless fixation with greater peripheral bony contact  
2 surgeons may aim for an increased inclination. Alternatively, it may be because the  
3 cementless introducers are generally set to 45° inclination, whereas the cemented ones  
4 are usually set to less. Factors shown to influence anteversion included gender, surgical  
5 approach and surgeon's grade. The increased anteversion females possibly reflects the  
6 increased native anteversion or pelvic flexion seen in females<sup>25,26</sup>. The greater amount of  
7 anteversion seen with the posterior approach is not surprising given the historically  
8 increased risk for posterior dislocation using this approach<sup>8</sup>, and the consequently  
9 recommendation to increasing anteversion<sup>27</sup>. The difference in anteversion between  
10 surgeon's grades probably reflects the greater proportion of cases performed via the  
11 posterior approach amongst consultants (30%) in comparison to trainees (20%) (p<  
12 0.001).

13 The strengths of this study include its prospective nature with detailed data capture. It is  
14 adequately powered and the large multicentre cohort ensures adequate variability in  
15 patients' demographics and surgeons' practice, therefore representing general  
16 orthopaedic practice, including the training setting. It only includes hard-on-soft bearings  
17 and therefore only relates to hard-on-soft bearings as there are different failure  
18 mechanisms with hard-on-hard bearings<sup>28</sup>. Cup orientation measurement was performed  
19 with validated software (EBRA-cup) on appropriate radiographs improving accuracy of  
20 measurements. Limitations of the study include the small number of complications,  
21 dislocations and revisions. Lack of cross-sectional imaging prevented calculation of  
22 femoral stem version and the ability to evaluate the influence of combined anteversion on  
23 outcome and complications. However, surgeons tend to implant the acetabulum first so

1 they do it without knowing the femoral component anteversion. So surgeons need to  
2 know information about acetabular position independently of femoral component  
3 position, which is what this study provides. We did not know when offset liners were  
4 used. This would not have substantially affected the conclusions relating to the large  
5 ( $\pm 15^\circ$ ) zones, but might have influenced the orientation of the optimal zone for function  
6 as this was small ( $\pm 5^\circ$ ). Although this study was adequately powered, the lack of  
7 radiographs in a significant proportion of patients reduced the cohort available for  
8 analysis. However, the cases excluded had similar characteristics to those in the study so  
9 should not introduce a bias. We do not know the individual surgeons' cup orientation  
10 target; however as the variability in cup orientation in the whole cohort ( $2SD \approx 15^\circ$ ) was  
11 similar to that of individual surgeons ( $2SD \approx 13^\circ$ ) it would seem that the variability was  
12 not a result of surgeons aiming for different targets. Although different head sizes were  
13 used we did not analyse them separately as, in the cohort, the dislocation rate was not  
14 related to head size even when allowing for orientated within or outside LZ (Table 7).  
15 Lastly, the unavailability of longer than 5-year follow-up does not allow for conclusions  
16 on the effect of cup orientation on wear-related complications and revisions.

17 In conclusion, a wide scatter of cup orientation was observed suggesting that surgeons  
18 can only reliably achieve a target zone of  $\pm 15^\circ$ . We did, however, find that the optimal  
19 zone ( $40^\circ/15^\circ \pm 15^\circ$ ) to minimise the dislocation risk was of this size suggesting that  
20 current technology is good enough to achieve the target orientation that minimises  
21 dislocation rate. Our study is the first to demonstrate that function can be improved by  
22 optimising orientation; however the target is small ( $45^\circ/25^\circ \pm 5^\circ$ ) so it cannot be reliably

1 achieved at present. In the future, with improved technology, we should be able to  
2 improve the functional benefit achieved with hip arthroplasty.

3

4

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	Cohort	Gender			
		Male (n=402)	Female (n=668)	p Value	
<b>Age (Years)</b>	67.5 (SD:10.6)	66.5 (SD:10.9)	68.2 (SD: 10.3)	0.01	
<b>BMI (kg/m<sup>2</sup>)</b>	27.3 (SD:5)	27.4 (SD: 4)	27.2 (SD: 5)	0.12	
<b>Diagnosis</b>	1° OA	898	339	559	0.51
	2° OA	59	21	38	
	Inflammatory	64	20	44	
	Fracture	17	8	9	
	Osteonecrosis	28	11	17	
	Metabolic	4	3	1	
<b>OHS pre-op</b>	15.7 (SD:7.6)	17.3 (SD: 7.7)	14.8 (SD: 7.4)	<0.001	
<b>OHS 5 years post-operatively</b>	40 (SD: 8.8)	41.6 (SD: 7.9)	39.0 (SD: 9.2)	<0.001	
<b>ΔOHS</b>	24 (SD:9.7)	23.8 (SD: 9.6)	24.1 (SD: 9.7)	0.67	

2

3 Table 1. Patient demographics, pre-operative diagnosis and OHS.

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		<b>Cohort</b>
<b>Surgeons Grade</b>	Consultant	685
	Trainee	385
<b>Patient Position</b>	Supine	213
	Lateral	855
<b>Surgical Approach</b>	Anterolateral	787
	Posterior	277
<b>Cup Fixation</b>	Cemented	946
	Uncemented	124
<b>Acetabular Component implanted</b>	Exeter	416
	Elite Plus	317
	Charnley Ogee	112
	Trilogy	76
	Other	149
<b>Bearing couple</b>	Stainless Steel on Polyethylene	957
	Zirconia on Polyethylene	102
	Alumina on Polyethylene	11
<b>Cup Size/ mm</b>		46.8 (SD: 4.7)
<b>Femoral Head Size/ mm</b>	<b>22</b>	208 (20%)
	<b>26</b>	335 (31%)
	<b>28</b>	527 (49%)
<b>Cup Inclination/ degrees</b>		45.7° (SD: 7.4°)
<b>Cup Anteversion/ degrees</b>		10.3° (SD: 7.1°)

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3 Table 2. Surgical details of cohort.

	Gender			BMI			Diagnosis			Patient Position			Surgical Approach			Surgeon's Grade			Cup Fixation		
	Male n=402	Female n=668	p- value	Not-Obese n= 784	Obese n=247	p- value	1° OA n= 898	Other n= 172	p- value	Supine n= 213	Lateral n= 857	p- value	Anterio- Lateral n=784	Posterior n=277	p- value	Consul. n= 685	Trainee n= 385	p- value	Cement n=946	Cement-less n=124	p- value
<b>Cup Inclination (RCI)/°</b>	45.2 (24 - 74)	46 (21 -70)	0.14	45.7 (24-74)	46.2 (21-67)	0.17	45.6 (21 - 72)	46.5 (27 -74)	0.39	47.9 (24-74)	45.2 (21 -69)	0.001	45.5 (21-74)	46.3 (26-68)	0.12	45.7 (24-74)	45.8 (21-68)	0.65	45.6 (24 - 74)	46.8 (21 - 64)	0.03
<b>Cup Anteversio n (RCA)/°</b>	9.5 (-33 - 39)	10.7 (-4 - 37)	0.02	12.7 (1 - 39)	10.1 (-16-33)	0.46	10.2 (-32 - 39)	10.5 (-4 - 30)	0.65	11 (-4 -30)	10.1 (-33- 39)	0.15	9.4 (-16-39)	12.9 (-33 - 34)	0.001	10.8 (-16-34)	9.3 (-33-39)	0.001	10.1 (-33 - 39)	11.4 (-2 - 34)	0.06
<b>% within LZ RCI (30 - 50°)</b>	n= 284 71%	n= 465 70%	0.72	n=659 84%	n=169 68%	0.69	n=635 71	n= 114 66%	0.03	n=128 60%	n=621 72%	<0.01	n= 561 72%	n=183 66%	0.10	n=484 74%	n=265 69%	0.53	671 71%	78 63%	0.07
<b>% within LZ RCA (5 - 25°)</b>	n=286 71%	n=510 76%	0.06	n=585 75%	n=177 72%	0.11	n= 665 74%	n= 131 76%	0.56	n=165 78%	n= 631 74%	0.25	n=554 70%	n= 237 86%	0.001	n=519 76%	n=277 72%	0.17	695 74%	101 82%	0.06
<b>% within LZ</b>	n= 191 48%	n= 343 51%	0.22	n=384 49%	n=122 49%	0.91	n= 450 50%	n= 84 49%	0.76	n=95 45%	n=439 51%	0.08	n=374 47%	n=156 56%	0.01	n=355 52%	n=179 46%	0.09	472 50%	62 50%	0.3

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2 Table 3: Patient and surgical factors and their effect on acetabular component orientation. LZ: Lewinnek Zone

	Dislocated			Revised		
	Yes (n=22)	No (n=1048)	p value	Yes (n= 11)	No (n= 1059)	p value
<b>Cup Inclination/°</b>	47.2 (37 – 64)	45.7 ( 21 – 74)	0.53	47.2 (35 – 59)	45.7 (21 – 74)	0.46
<b>Cup Anteversion/°</b>	7.2 (- 33 – 20)	10.3 (- 16 – 39)	0.29	7.7 (-33 – 33)	10.3 (-16 – 39)	0.89
<b>% within LZ RCI</b>	82% n= 18	84% n=882	0.85	73% n=8	70% n=741	0.84
<b>% within LZ RCA</b>	68% n= 15	75% n=781	0.50	82% n=9	74% n=787	0.57
<b>% within LZ</b>	45% n= 10	50% n= 524	0.67	64% n=7	50% n=527	0.36
<b>Head Size/mm</b>	25.7 (22 – 28)	26.2 (22 – 28)	0.61	25.1 (22 – 28)	26.2 (22 – 28)	0.31
<b>Cup Size/ mm</b>	49.9 (43 – 60)	46.7 (38 – 70)	0.007	48.3 (43 – 56)	46.7 (38 – 70)	0.4

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2 Table 4: Cup orientations grouped by dislocation and revision. LZ: Lewinnek Zone

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	<b>Approach of Dislocated Hips (n = 22)</b>		
	Anterio-Lateral (n =16)	Posterior (n=6)	p value
<b>Cup Inclination/°</b>	46.9 (37 – 64)	48 (40 – 59)	0.86
<b>Cup Anteversion/°</b>	8.6 (1.3 – 20)	3.3 (-33 – 14)	0.69
<b>Within LZ RCI</b>	n= 11	n=4	0.93
<b>Within LZ RCA</b>	n= 10	n=5	0.35
<b>Within LZ</b>	n= 6	n=4	0.22

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2 Table 5: Cup orientations of dislocated cases by surgical approach. Statistical values derived  
3 from chi-square tests from the cross-tabulation table. LZ: Lewinnek Zone

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	Zones of $\pm 5^\circ$		Zones of $\pm 10^\circ$		Zones $\pm 15^\circ$	
	p-values	Optimal RCI°/RCA°	p-values	Optimal RCI°/RCA°	p-values	Optimal RCI°/RCA°
<b><math>\Delta</math>OHS</b>	0.001 – 1.00	45°/25°	<0.001 – 1.00	48°/27°	0.01 – 1.00	38°/20°
<b>Dislocation</b>	0.06 – 1.00	n/a	0.06 – 1.00	n/a	0.01 – 1.00	42°/11°
<b>Revision</b>	0.07 – 1.00	n/a	0.06 – 1.00	n/a	0.06 – 1.00	n/a

2

3 Table 6: Statistical values obtained from scatter plot analysis using Mann-Whitney U test for  
4 comparing  $\Delta$ OHS and Fisher's exact test for dislocation and revision rates. In addition the  
5 orientation with the minimal p-value was documented as optimal. The difference in  $\Delta$ OHS was  
6 numerically significantly different for many zones tested; however the clinical difference is  
7 minimal (0.9 – 1.8) for  $\pm 10^\circ$  and  $\pm 15^\circ$  zone tested. Clinically significant difference ( $\Delta$ OHS >2) was  
8 only seen in zones of  $\pm 5^\circ$ .

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Head size	Zone	Dislocation	
		No	Yes
22	Within LZ	107	5
	Outside LZ	94	2
26	Within LZ	164	1
	Outside LZ	167	3
28	Within LZ	253	6
	Outside LZ	263	5

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3 Table 7: Number of dislocations for the different head sizes as per cup orientation within or  
4 outside Lewinnek zone (LZ) (p=0.7).

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