Multiple Technology Appraisal (MTA)

Total hip replacement (Review guidance 2 and 44):

Arthritis Care submission

Arthritis Care

Arthritis Care is the UK's leading organisation working with and for people with all forms of arthritis. People with arthritis are at the heart of our work. We have around 13,000 members, who are involved in all of our activities and direct what we do.

We believe that people with arthritis are entitled to receive the best possible treatment and support, and to have their voice heard in decisions affecting their health and well-being. We publish booklets, a magazine, run a website and national telephone helpline, all aimed at enabling people with arthritis to make positive choices about their condition.

We have a network of 190 local groups across the country, which together with our internet forums and self management programmes bring people together to support one another in living life to the full. Our campaigning work promotes civil rights, better access to health and social care provision, fights for a fair disability benefits system and tackles issues important o people in their local area.

Our Patient Expert submission

Background to the operation

Our patient expert (PE) is 55 years old in otherwise reasonable health. She reported the following history of trouble with her right knee joint:

September 2009: PE started to experience pain in the right knee. She repeatedly went to see her GP, who prescribed pain killers, but no other intervention. During this period PE took the following: diclophenac, tramadaol, cocodamol and, ibrupfrofen.

December 2009: after taking NSAIDs/pain killers for three months there was no improvement in PE's condition. She arranged to see a physiotherapist, which resulted in the pain easing for a short period.

June 2010: the pain moved to her groin, resulting in PE developing a limp and having very restricted movement in the whole left side of her body, e.g. she could not bend down to dry herself properly after bathing, considerable pain walking even short distances and could only ascend stairs one at a time. At this time (nine months post-onset) PE reported these symptoms to her GP, who continued to not recommend any other intervention.

Sept 2011: PE was by experiencing severe, disabling pain while walking. She refused to leave the GP's surgery until they prescribed a new course of action. Her GP prescribed some exercises to do, but to no effect.

October 2011: PE demanded more help from her GP. With reluctance on the GPs part, they referred her to private treatment (she had private, employment - based, medical insurance, which she had repeatedly mentioned to the GP). Within 3 weeks of the referral PE saw a specialist orthopaedic consultant including a scan and X - Ray. The consultant then informed her that she needed an operation, *but not for her knee*: instead, she required a replacement operation for her left hip.

Nov 2011: 14 months after initial presentation and a week after the previous appointment, PE saw a hip replacement specialist, who told her that her case was at worst end of the spectrum of hip problems.

The operation

Subsequent to the final consultation "it all went like clockwork": PE booked in for a total hip replacement operation at a private hospital (ultimately funded through the NHS rather than private insurance).

One week prior to the operation PE underwent a pre - operative check –up, where she was given a comprehensive amount of information, including leaflets, which she found very useful. On medical advice, she measured the seating furniture in her house, as she was advised that she might lose some height. She was provided with cushions and toilet seat adjusters. Again, PE cannot fault her treatment, describing it as "absolutely 1st class."

3/2/12: PE had a total hip replacement operation. An uncemented, ceramic coated titanium implant was used; PE described the hospital procedure as "fantastic". She spent 3 ½ days in hospital, and was up and walking on her hip 12 hours after surgery. The surgery resulted in the immediate cessation of the pain in her hip: "it was brilliant, as soon as I had the op the pain went as if someone had flicked a switch."

PE had physiotherapy twice a day whilst in hospital. She was given notes on what to do and not to do, and a list of exercises from the physiotherapist.

Post discharge from hospital

3 weeks after the operation PE started follow up physiotherapy at the hospital. She had 3 physiotherapy outpatient appointments altogether and was given exercises to do twice a day, which she did religiously.

PE spent 7 weeks on crutches, and a subsequent week using a stick. She was on crutches for longer than normal to ensure it healed properly. The longer recovery was caused by a problem with the hip

bone: during surgery it became apparent that the bone quality was poor and it cracked during the operation. PE speculates that this poor bone quality may have been exacerbated by the delay she experienced in getting referred for surgery.

After 8 weeks PE saw the consultant, and was told to phone the hospital if she had any problems; she did, but on a different but related matter: she continued to experience pain in her R knee, the original cause of her pain. This was caused by osteoarthritis, which has since been diagnosed in both knees. PE believes her knee problems were the cause of the problem with her L hip, as it caused her to attempt to keep weight off the R knee.

PE was given a phone number to ring if she had any problems, and was advised she could make an appointment to see the consultant again if any problems arose. As with the operation, she cannot fault the post – discharge treatment: whenever she has asked a question it has been answered.

Current status

Movement: PE now has no limp, can bend down & clean feet, uses stairs normally and walk normal distances.

PE has had no adverse symptoms as a result of the surgery and continues to be pain fee in her hip.

Concluding comments

PE feels that the stumbling block in her treatment was her GP's reluctance to refer her to a specialist, resulting in a delay in the surgery. She feels that this may be down to the fact that at 55, she is relatively young for a knee procedure. PE expressed concern that her GP's reluctance to refer her to a specialist resulted in a delay in identification of the need for a hip replacement, which in turn may have contributed to the cracking of her bone during surgery and the subsequent extra - long period of recovery. Her GP is the only GP in her medical practise and has no colleagues, so asking to see a different GP would have required changing practices, which she was on the verge of doing before she was finally referred to a specialist.

[redacted]
Arthritis Care
31/1/13

Companion statement from the Arthritis Care Clinical and Medical Advisory Board

This patient's story represents a thoughtful and real-world example of a typical patient presentation and the consequent clinical decision making process in the area of total joint replacement. PE presented initially with knee pain and so conservative options were explored by her GP prior to referral for consideration for joint replacement surgery. This reflects, appropriately, the current guidance and thinking on total knee replacement (TKR), a procedure which has generally poorer outcomes than total hip replacement (THR). It is less common for patients having undergone TKR to

experience a return to complete normality in function, when compared to the outcomes of total hip replacement and longer term survival of TKR is, on average, poorer than for hips. This watchful approach to her initial knee symptoms appears therefore to represent best practice. Similarly, having continued to experience knee pain despite pharmacological and physical interventions, PE has since been considered for TKR which appears to be the appropriate next step. Finally, It is common for knee pain to occur as a referred symptom arising from hip pathology. Care should be taken to exclude hip pathology early in the assessment process and where both joints may be affected, to address hip problems first.

In the interim PE had developed frank hip symptoms, representing a common clinical picture of multiple joint involvement. Whether this is related to either a concomitant failure of biology or to increase in mechanical demands remains unclear. Notwithstanding, she was given a rapid diagnosis and referred in an apparently timely fashion for total hip replacement. As noted above, successful THR is generally associated with a return to something approaching "normal" function post-operatively and long term survival is excellent, and so a rapid referral for surgery seems appropriate in this case. It is also appropriate that the hip surgery was undertaken prior to considering the knee pathology further.

The patient's account of the operative process surrounding the THR also appears to represent current best practice. She was provided adequate pre-operative information, the minor intra-operative complications were dealt with appropriately and she was provided with both outpatient and home-based physiotherapy. During follow-up she also reported having been given an appropriate avenue to make contact should further problems arise.

In summary, Arthritis Care would wish to use this case to highlight the following principles to considered in the formulation of the technology appraisal:

1. Referral decisions should continue to be made on an individual case basis.

2. Outcomes for differing types of joint replacement vary and the care pathways should be considered independently.

3. Notwithstanding point 2 above, multiple joint involvement is common and should be considered in the care pathway.

4. Hip pathology can give rise to referred knee pain and where pathology is present at both sites the hip should be addressed prior to the knee.

5. Patients value and derive benefit from good-quality pre-operative information.

6. Patients understand that intra-operative and peri-operative complications do occur and can be managed effectively without complications representing a significant failure of either the procedure or related processes.

7. Postoperative physiotherapy, supplemented by home-based exercise are an important part of the rehabilitative process and are valued by patients.

8. Information provision and reflective listening throughout the episode of care is key. In this case adequate information about self-referral back into care in the post operative period was excellent while poorer information was provided regarding the relative outcomes of THR vs TKR

surgeries. This led to easily avoidable misconceptions and dissatisfaction on the part of the patient.

[redacted]

[redacted] on behalf of the Arthritis Care Clinical and Medical Advisory Board.