

Total Hip Arthroplasty (THA)

Pre-Operative Details

Name (Arabic): _____ Patient ID: _____

Name (English): _____

Date of Birth: _____ Male Female

Address: _____

Occupation _____ Tel: _____

Next of Kin: _____ Tel: _____

Joint

Side Left Right Bilateral

Complaint: Pain Stiffness Fracture Deformity Shorting Instability

Since: _____

Present History: _____

Past History and Family History: _____

Other Joints

Previous Arthroplasty: _____

Other Pathology: _____

Examination

Inspection & Palpation Scars Wasting Inflammation

Movements:

Flexion: (Active _____) (Passive _____) Extension: (Active _____) (Passive _____)

Abduction: (Active _____) (Passive _____) Adduction: (Active _____) (Passive _____)

Int. Rotation: (Active _____) (Passive _____) Ext. Rotation: (Active _____) (Passive _____)

Deformities:

<input type="checkbox"/> Valgus	<input type="checkbox"/> Varus	<input type="checkbox"/> Flexion (Thomas test)	<input type="checkbox"/> Adduction / Abduction
Degree	Degree	Degree	Degree

Leg length discrepancy Apparent (_____ cm) True (_____ cm) Above the trochanter Below the trochanter

Trendlenburg test: _____

Spine & Knee Examination:

Distal Pulsation: _____

Investigations Results

Hemoglobin:

X-ray: Osteoporosis Dysplasia Narrowing femoral canal
 Deformity (_____) Bone defect (Acetabular /Femoral) Massive Osteophytes

Pathology:

Osteoarthritis AVN Post-traumatic Previous infection Previous arthrodesis
 Inflammatory arthropathy (RA AS Seronegative Psoriatic)
 Pediatric Hip disease (DDH Perth's disease SUFE Other (specify: _____)

Remarks: _____

Doctor's Signature (_____)

Operative Details (THA)

Name: _____ **Patient ID:** _____

Hospital: _____ **Operation date:** _____ **Time:** _____ to _____ (total _____ min)

Anesthetic types: General Regional-Epidural Spinal

Patient physical status (ASA grade): P1 P2 P3 P4 P5 **BMI:** _____

Operation funding: MoH funding (*karar*) Hospital Case Private

Referral: No Yes (_____) **Laminar flow theatre:** Yes No

Surgeon: _____ **Assistant:** _____

Anesthetist: _____ **Scrub Nurse:** _____

Side: Left Right Bilateral Contra-lateral THA

Procedure: Primary Complex primary

Previous operation:

Arthroscopy Osteotomy: (Femoral Pelvic)

Hemiarthroplasty Adductor tonotmy Other (specify _____)

Examination under Anesthesia:

Default Technique: Yes No **Position:** Lateral Supine

Approach: Lateral Posterior Other (_____)

Minimally invasive: No Mini MIS **Templating:** No Yes **Navigation:** No Yes

Bone defects: No Femur Acetabulum

Bone grafts: No Femoral Acetabulum

Pulse lavage: No Yes

Stability: Poor Satisfactory Good

ROM: _____

Intraoperative Complications: No Yes (Specify: _____)

Implant:

◆ **Manufacturer:** _____ **Model:** (Femur _____)(Cup _____)

Cemented Uncemented Hybrid

◆ **Femur:** Size: (Stem: _____) (Head: _____) Offset: Standard High Others

Cementing: Cemented Uncemented

◆ **Acetabulum:** Shell Size: (_____) Bearing surface: (Polyethylene: Ceramic Metal _____)

Cementing: Cemented Uncemented (Press fit Screw fixation, No: _____)

◆ **Cement:** (Make: _____) Low High Antibiotic

Thromboprophylaxis regime: Chemical (_____) Mechanical (_____)

Post-Operative Medication: Antibiotic (_____)

Analgesia (_____)

Others (_____)

Remarks: _____

Doctor's Signature (_____)

POST OPERATIVE COMPLICATIONS

Infection (early / Late)	Haematoma	Instability	DVT / Pulmonary Embolism	Metal Hypersensitivity
Dislocation	Loosening	Leg length	Neurovascular Injury	Periprosthetic Fractures
Others (Specify)				

CLINICAL ASSESSMENT

<p>Pain (check one)</p> <p><input type="checkbox"/> None or ignores it (44)</p> <p><input type="checkbox"/> Slight, occasional, no compromise in activities (40)</p> <p><input type="checkbox"/> Mild pain, no effect on average activities, rarely moderate pain with unusual activity; may take aspirin (30)</p> <p><input type="checkbox"/> Moderate Pain, tolerable but makes concession to pain. Some limitation of ordinary activity or work. May require Occasional pain medication stronger than aspirin (20)</p> <p><input type="checkbox"/> Marked pain, serious limitation of activities (10)</p> <p><input type="checkbox"/> Totally disabled, crippled, pain in bed, bedridden (0)</p> <p>Limp</p> <p><input type="checkbox"/> None (11)</p> <p><input type="checkbox"/> Slight (8)</p> <p><input type="checkbox"/> Moderate (5)</p> <p><input type="checkbox"/> Severe (0)</p> <p>Support</p> <p><input type="checkbox"/> None (11)</p> <p><input type="checkbox"/> Cane for long walks (7)</p> <p><input type="checkbox"/> Cane most of time (5)</p> <p><input type="checkbox"/> One crutch (3)</p> <p><input type="checkbox"/> Two canes (2)</p> <p>Distance Walked</p> <p><input type="checkbox"/> Unlimited (11)</p> <p><input type="checkbox"/> Six blocks (8)</p> <p><input type="checkbox"/> Two or three blocks (5)</p> <p><input type="checkbox"/> Indoors only (2)</p> <p><input type="checkbox"/> Bed and chair only (0)</p> <p>Sitting</p> <p><input type="checkbox"/> Comfortably in ordinary chair for one hour (5)</p> <p><input type="checkbox"/> On a high chair for 30 minutes (3)</p> <p><input type="checkbox"/> Unable to sit comfortably in any chair (0)</p>	<p>Enter public transportation</p> <p><input type="checkbox"/> Yes (1)</p> <p><input type="checkbox"/> No (0)</p> <p>Stairs</p> <p><input type="checkbox"/> Normally without using a railing (4)</p> <p><input type="checkbox"/> Normally using a railing (2)</p> <p><input type="checkbox"/> In any manner (1)</p> <p><input type="checkbox"/> Unable to do stairs (0)</p> <p>Put on Shoes and Socks</p> <p><input type="checkbox"/> With ease (4)</p> <p><input type="checkbox"/> With difficulty (2)</p> <p><input type="checkbox"/> Unable (0)</p> <p>Absence of Deformity (All yes = 4; Less than 4 =0)</p> <p>Less than 30° fixed flexion contracture <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Less than 10° fixed abduction <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Less than 10° fixed internal rotation in extension <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Limb length discrepancy less than 3.2 cm <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Range of Motion (*indicates normal)</p> <p>Flexion (*140°) _____</p> <p>Abduction (*40°) _____</p> <p>Adduction (*40°) _____</p> <p>External Rotation (*40°) _____</p> <p>Internal Rotation (*40°) _____</p> <p>Range of Motion Scale</p> <p>211° - 300° (5) 61° - 100 (2)</p> <p>161° - 210° (4) 31° - 60° (1)</p> <p>101° - 160° (3) 0° - 30° (0)</p> <p>Range of Motion Score _____</p> <p>Total Harris Hip Score _____</p>
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RADIOLOGICAL ASSESSMENT

	Femoral Component	Acetabular Cub
Alignment	Centered Valgus Varus	Inclination: Bone-cup coverage:
Fixation	Press-Fit: Cement*: A B C D	Press-Fit: Cement* : A B C D
Failure (loosening)	Position change >4mm Lucent line: total – partial Scalloping Cement Fracture	Migration >4mm - Tilting >4° Lucent line Scalloping
*Barrack's Classification : A(White-out) – B(Slight radiolucency) – C(Defective or incomplete 55- 99%) – D(100% radiolucency or tip of the stem uncovered)		