



The Latest in Joint Replacement Surgery

Webcast

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Introduction

Andrew Schorr:

Golf, skiing, tennis, biking, jogging. These are all activities many of us enjoy and want to continue as we age; however, sometimes joint pain begins to get in the way, and it could even get in the way of everyday activities like sleeping.

When are you a candidate for joint surgery, and how do you find the right surgeon for you? So let's learn what to expect during and after surgery as well as the innovations helping to preserve bone and get you moving faster. All this and more coming up on Patient Power brought to you by UW Medicine.

Hello and thank you for joining us for Patient Power as we delve into something that affects a lot of us as we get older, and as we want to stay active it becomes really a critical situation to talk about and that is joint replacement surgery, and what are the latest innovations to help keep you moving so you can lead the full life that you want to lead? That's what we're going to discuss tonight, and we've assembled sort of a "dream team" from the renowned Orthopedics Department at the University of Washington, and we're going to discuss three key joints and some commonalities related to innovations in surgery.

We're going to talk about shoulder joint replacement and surgery there. We're going to talk about hip surgery and innovations, and we're going to talk about knee replacement surgery. When it comes to the knee we're not talking about ACL surgery or those kinds of sports injuries. We're going to talk about when arthritis has developed so far in the joints and you're just in extreme pain, what are the options now to get you back in the game, if you will.

Bob's Story

Andrew Schorr:

I want to tell you about a powerful patient who's going to help me as we go down this road, and that's sixty-one-year-old Bob Sandoz who's from Camano Island just north of

Seattle, Washington, and he is in commercial real estate there, a father of two active kids who are a fourteen-year-old boy and a twelve-year-old girl, but he's a very active guy himself. At sixty-one he is not a man who wants to slow down.

So as he grew up in California one of the things he did was bodysurfing. He got really good at it. Twenty-five years ago he was in Hawaii bodysurfing, something he knew how to do well, and a wave came along that was not good for him. It slammed him against the beach and really injured his shoulder. It was dislocated, separated, he tore the cuff of the shoulder, went through months of rehab, and he ended up with some reconstructive surgery on the rotator cuff, but that's not the end of the story.

As you know, sometimes when you have an injury what sets in is arthritis, and that can be really painful. So here's a guy who likes fly fishing, skiing, weight lifting, hunting, and he was having trouble doing that. It got so bad that at one point, as we'll tell you about, he had trouble sleeping.

Bob, ten years ago when it got bad, you went around to various doctors. You were a very active guy. What options were they giving you?

Bob:

Well, Andrew, it was an interesting time because I had an MRI, which showed an irreparable cuff tear and significant arthritis, and basically what I was told ten years ago was the only people that were even looking at doing shoulder replacement was Dr. Stedman over in Vail, and it was very early in the game, and the orthopedists that I met with highly recommended that I do nothing. Cortisone shots, antiinflammatories such as Celebrex were really the solution and basically live with what you have.

Andrew Schorr:

But that's a lot of pain. So as I mentioned just a moment ago, it got worse to the point where just a year or so ago you were in a situation where it just woke you up, what, seven or eight times a night. Is that right?

Bob:

That's correct. You go down this road with an injury like this, and you walk away and you go okay, I'm going to live with it, but I'm going to remain active. So at least from my perspective what you do is you work out regularly, you keep as much flexibility as you can, as much strength as you can, you build up the surrounding muscles to compensate for a cuff that's missing, and you take things like ibuprofen and Celebrex to find some relief.

Over time the arthritis progresses, and at least from my experience with it what that progression meant was more and more limited range of motion with the shoulder and more and more continuous pain, particularly in cold, wet weather, which living in the Pacific Northwest, being an active skier, a white-water rafter, duck hunter, I am out in those conditions all the time.

Andrew Schorr:

Now it got to the point, being an active guy, that as you said duck hunting where there you have to lift the gun to aim at the bird, you couldn't do it really. It was really difficult wasn't it?

Bob:

It was. At the end I was on a hunting trip and standing at the lodge; I shoot left-handed, and it's my right shoulder, but you still have to raise the front of the gun, and I literally could not raise the front of the gun. I had to basically shoot one-handed. It was kind of a realization for me that I could no longer put off the surgery. So it really was the trigger for me to start pursuing different orthopedic surgeons and getting second, third, and fourth opinions because I believe that there was a solution for me out there. I didn't know what it was, and the ones that have been offered me were unacceptable to me in terms of the lifestyle that it would have given me.

Andrew Schorr:

Right, and so as you went to doctor number one and doctor number two, good surgeons, but these were options that might benefit somebody less active than you.

Bob:

The bottom line as a patient is I believe you have to advocate for the lifestyle that you individually value, and what is important to me certainly may not be important to many people that had arthritis and a torn cuff in their shoulder. They may be very happy with the kind of joint replacement and the standard procedures that were out there whether it was a reverse shoulder or a CTA ball, which is an oversize ball with no cuff on top. Those were really the only choices, and one of the pieces with a ball replacement was a plastic cup on the glenoid side that everyone told me with this you cannot be lifting weights, you shouldn't be skiing, you probably shouldn't play golf because they're very vulnerable to either catastrophic failure when you have loosening of the plastic or it will just wear out, and you'll have to have it replaced again.

Andrew Schorr:

So that brings you to the University of Washington where you heard well maybe there was an option that would not have those concerns, and you ended up having the "ream-and-run" procedure. When was that?

Bob:

I actually had the surgery in June of 2008. So June of last year, June 1st.

Andrew Schorr:

Now you had searched from doctor to doctor looking for a better option. When you got to the UW how did you know you had found it?

Bob:

I think it took me about three minutes with Dr. Warme to know that I had found the right surgeon. I had done some research on it. I really believe that as a patient you have to

advocate for yourself. You're the only one that really knows your lifestyle and what's important to you, so I did the research. I looked at the ream-and-run. I liked what I saw. I liked the fact that instead of using a plastic cup they actually ground out the glenoid side, got rid of the arthritis, and created a new bone joint for that titanium ball. That made a lot of sense to me.

The fellow doctor that I initially met with prior to meeting with Dr. Warne made me very comfortable with the procedure. He took a lot of time to explain it and talked about my particular needs and felt that I was a good candidate for it. In meeting Dr. Warne I instantly felt a level of confidence that he understood what was important for me and was going to help me to the best of his ability to achieve that.

Andrew Schorr:

We're going to meet Dr. Warne in just a second, your doctor, but we're kind of holding our breath. How has it worked out?

Bob:

Well, I'm what, six-months post surgery, and I'm kind of a zealot at doing my physical therapy. I do my work on my shoulder at least once a day and oftentimes twice a day. This season has been one of my best duck hunting seasons. I have to thank the snow around Camano Island for helping us out with the snow goose population, but I've probably been hunting twenty-five times. I've been skiing three times already. I sleep literally pain-free, and I was truly waking up six, seven, eight times a night prior to this surgery from the pain of the arthritis in my shoulder.

My range of motion prior to the surgery I'm going to guess was less than fifty degrees. I literally had a frozen shoulder. I now have a one-hundred-forty-degree range of motion. I am continuing to gain strength in the surrounding muscles. My shoulder is still compromised in that I had an irreparable tear on the top of my cuff. That's a piece of the shoulder that you really would like to have for full range of motion. That said, I'm going to be surprised if I don't have full range of motion by June of 2009.

Andrew Schorr:

That's our wish for you.

Bob:

I see progression in it on a weekly basis. It's getting stronger, and it's getting more range of motion every week.

Andrew Schorr:

That is so cool. Now everything you've told us, a very positive story, raises questions. We have three leading orthopedic surgeons from UW Medicine and UW Medical Center we're going to talk to as we progress. So we're going to talk about not only shoulders, but we're going to talk about innovations in hip surgery and also knee replacement, but I want to take just a couple of minutes to start with your surgeon, the Chief of Shoulder Surgery at the UW Medical Center, Dr. Winston Warne.

We'll take a quick break, and after we come back from our break we'll have Dr. Warme, and we'll talk about shoulders, and then we'll go on with hips and knees. We'll be right back with much more of Patient Power.

Hip Replacement and Hip Resurfacing

Andrew Schorr:

Welcome back to our live webcast as we discuss innovations in joint replacement surgery. We're going to meet Bob Sandoz' doctor in just a minute, Dr. Winston Warme, and talk about this ream-and-run procedure, which I should tell you was developed at the University of Washington. There were other orthopedic doctors around the country who said that it won't work, it will be painful, etc. Well they've proved that it does work, and it preserves the range of motion, the hope for a big range of motion, as you heard about for active people like Bob Sandoz. So it's certainly something that's worked out for Bob, but I want to talk now about hips for a bit, and then we'll come back to shoulders.

We have with us Dr. Jason Weisstein. Dr. Weisstein's been on Patient Power before. He can tell us about innovations for active people when it comes to hips. Now my mother-in-law in her seventies had a total hip replacement, and we'll talk about that as well, but there were some people younger where maybe you weren't sure that was such a good idea because you'd feel that the joint might wear out and they still had many years to go.

So Dr. Weisstein, tell us about hip resurfacing. What is it, who is it right for, how is it different?

Dr. Weisstein:

So hip resurfacing is essentially an arthroplasty of the hip that involves essentially the same procedure on the socket side of the hip, the hip being a ball-and-socket joint, but the real difference involves the ball side. It is popularized as a bone-preserving procedure. In traditional hip replacement a portion of the femoral neck, the portion of the bone to which the ball essentially is attached to, is cut and the head is replaced with an implant. In hip resurfacing, the bone is basically reshaped and preserved and capped with a metal ball.

So essentially the main difference between traditional hip replacement and total hip resurfacing involves bone preservation in the hip resurfacing and removal of a more significant amount of bone in traditional total hip replacement.

Andrew Schorr:

Who is a candidate for this procedure versus the traditional way of doing it?

Dr. Weisstein:

The best patients by far are young men with osteoarthritis that has been refractory to conservative treatments, younger than age fifty-five. The reason that this population of individuals is considered probably an optimal population is because they have a good bone

stock. Good bone stock is really an important aspect of being appropriately selected for hip resurfacing arthroplasty because patients with poor bone stock have an unacceptably high risk of fracture.

So the main difference early on between traditional hip replacement and hip resurfacing is that the risk of fracture is higher in hip resurfacing during the first few years, and men in general tend to have better bone stock than women. So men less than age fifty-five tend to be the ideal population for this procedure.

Andrew Schorr:

Dr. Weisstein, now does it kind of preserve your options? So let's say a younger man, and I've met some men in their forties who had just severe arthritis in their hips and needed hip replacement, so this might be an option for them. If they later need the traditional approach has the bridge been burned or is that still an option?

Dr. Weisstein:

The bridge has not been burned. That's one of the appealing things regarding total hip resurfacing. By preserving the femoral bone stock should future revision be required it's essentially a straightforward procedure as if no bone had been sacrificed in the first place. So essentially you're going to be getting during revision of a hip resurfacing much kind of the same bone scenario as you would getting a first time, traditional, total hip replacement.

Innovations in Shoulder Surgery

Andrew Schorr:

All right. We're going to talk more about hips and understand more about where you are now with the traditional approaches too in a minute, but we do have Dr. Winston Warne, Bob Sandoz' shoulder doctor, with us, and we were talking not as clinical people but as consumers about ream-and-run, and I was talking about the shoulder joint and trying to preserve as great a range of motion as you can. Dr. Warne, so this was developed at the University of Washington, and it's working out isn't it?

Dr. Warne:

That's correct Andrew. We started playing around with this concept back in 1992. Actually my partner Rick Matsen was the primary innovator of this concept, and what we had found in several people in which the glenoid component had become loose (as Bob had mentioned that plastic socket can sometimes get loose, especially in active patients) and he had had to remove those on many patients and then ream the socket because it wouldn't take another implant. Many of these patients have gone on to do well.

So he thought about this and said, 'Well why don't we try this without putting the socket in on people who we know are going to be so active that it's going to become loose? It's going to be a problem. Then subsequently over time we've done some research in the lab

working on some laboratory animals etc. to make sure that this actually works and a new cartilage surface grows, and it's been really very satisfactory. We've gotten a lot of people like Bob back to very active lifestyles.

Andrew Schorr:

Now this procedure then allows people to be more active. How do you determine who is it right for?

Dr. Warme:

I think Bob had mentioned how important it is for us as doctors to listen to our patients and find out what it is they want to do. When people come to me and say listen I love to kayak, I love to lift weights, I want to ski, and I want to play aggressive singles tennis and these types of things. We would like to talk to them about a procedure like this where we're not going to have to worry about the glenoid component becoming loose-- because we don't use one.

Andrew Schorr:

Now, what about pain? So it sounds like when somebody is a candidate for shoulder surgery the pain has gotten really bad, and Bob mentioned along the way frozen shoulder, and I had that at one point. Fortunately it got better. The pain was terrible. When is surgery indicated at all for the shoulder?

Dr. Warme:

It's a combination of things. First we have to nail down the diagnosis of arthritis, and that is shown on x-rays, and you were mentioning earlier that the surface of the shoulder joint goes from a smooth, frictionless surface to a very rough and pitted surface more like the surface of the moon than a perfectly smooth sphere, and so with this increase in roughness comes a lot of abrasion and friction and pain.

So when the x-rays show us that they have bad arthritis and their examination also demonstrates to us that they have limited motion then they've moved into a category where they are a joint replacement candidate.

The Latest in Knee Replacement Surgery

Andrew Schorr:

Okay, we're going to talk more about that as we go on. As I said we've sort of got a "dream team" of orthopedics with us. We do have some e-mail questions we'll pose to the doctors along the way, but let's move down the body further.

There have been innovations in knee joint replacement as well and doing it in a much less invasive way for a quicker recovery, and I can think of no one better to tell us about it than Dr. Seth Leopold who we've had on Patient Power a couple of times before, and he's also Vice-Chair of the Department of Orthopedics and Sports Medicine at the University of Washington Medical Center.

Dr. Leopold, so tell me. You're able to help some people anyway get back in the game quicker with joint replacement. How does that work with knees?

Dr. Leopold:

Knee replacement has been done in ways that you would call a traditional approach in this country and in Europe for more than three decades and going on four decades. There have been slow changes in evolutions in the kinds of prostheses, that's the implant that goes into the body, although if I were to hold a prosthesis or an implant from twenty years ago against one from today, I would say that most people looking at them would be hard pressed to tell the silhouette apart. So the big innovations in the last couple of decades actually haven't been the implants because the implants themselves are so very reliable.

I would say the most exciting areas in knee replacement surgery that have evolved over the last decade or so have had to do with the surgical techniques for putting them in.

With some newer instrumentation and some novel surgical approaches we've been able to get the same implant, in other words a reliable implant that has a good track record over time, into the joint in a way that's less traumatic to the tissues around the joint so that the postoperative pain seems to be less, the recovery seems to be quicker, and people are getting back to their work or to their play that much sooner. That's what minimally-invasive or less-invasive knee replacement is.

Andrew Schorr:

All right, so give us an idea or maybe compare let's say the recovery time, or I saw a picture I guess of one of your patients where she was walking with a cane but it was after maybe ten days or so. What would it have been otherwise?

Dr. Leopold:

At this point with the less invasive approach, which is sometimes called a quadriceps-sparing or an MIS, that's minimally invasive surgery approach, these are all the same names I think for the procedure or variations on it, the typical recovery now after a total knee replacement is something on the order of a week or ten days on a walker being very average followed by a week or ten days on a cane so that most patients are getting off of their cane between two and three weeks and beginning to walk independently, that is without anything at all, by two to three weeks at least around the house.

More typically with a traditional approach you'd see getting off a cane something on the order of about five weeks. We've done a study comparing the recovery and the pain and the convalescence as well as the accuracy and the safety of the traditional approach versus the less invasive approach, and we've published that in the leading journal or orthopedics, and we found that the recovery was something on the order of about fifty percent of what it had been with the traditional approach, so about twice as quick.

Andrew Schorr:

Wow. I should mention to people that of course the UW Medical Center is an academic medical center so it is often where these procedures are developed, where they're studied, where they're documented. These are the teachers, and so when you go to UW Medicine, and Bob I think you'd agree with me, you're sort of going to the mountaintop, and as I mentioned the UW Medicine Orthopedics Department is ranked as one of the leading ones in the country. Did you find that? Did you feel that when you were there Bob?

Bob:

Absolutely. As we discussed about this whole procedure the attention to detail I think it's because it's a teaching facility, but every part of my experience from my preop-type workups, the extensiveness, and the thoroughness of it was absolutely remarkable.

I've had three shoulder, two knee, a sinus surgery, and I've been through a fair amount of these, and this was by far the most complete and collective effort that I have ever seen, and what it gave me was a level of confidence that what was going to be done was going to be absolutely the best and that the result was going to be the best I could hope for, and I believe that was the outcome.

Andrew Schorr:

Okay, well we're going to understand more about whom these various procedures are right for as we go on, and we'll talk about that with Seth Leopold related to knees in just a minute. We're going to find out of course what are the risks, what are the complications? It does happen sometimes in orthopedics that people need revision surgery, you hear about that sometimes, and hips. When does that happen or how often and how does somebody determine when surgery is needed? We talked about that a little bit related to shoulders, but what about in hips or knees, or when are other approaches maybe the way to go at least first?

Much more to come. We're discussing the innovations in joint replacement surgery at the University of Washington Medical Center, and you're listening to Patient Power. We will be right back.

Welcome back to our live webcast. We've done earlier programs with Dr. Seth Leopold, Dr. Jason Weisstein, and now we have Dr. Warme joining us. For the earlier programs just go to www.patientpower.info/uw, and there's a wide array, and the replays will be posted there as well.

When is Surgery an Option?

Andrew Schorr:

Dr. Leopold, you're the Vice-Chairman. Let's ask you this question. Now you have a wide array of surgeons in your department, but surgery is not always the answer and not always the first answer. How do you help patients understand when is it an option, and what are some of the other things to try first?

Dr. Leopold:

Andrew, that's a great question. That's the key question as a surgeon that we've got to answer. As it turns out in orthopedic surgery almost everybody in our group, and I would say this is probably broadly true, sees many more patients that they don't operate on than who they do operate on. I know in my own practice I probably see eight or nine patients for every patient who I operate on, and that's a little bit the nature of the practice.

Recognizing that what we've tried to do is to set up a program in concert with our rehab doctor partners, and there's something called the University of Washington Sports and Spine Physicians. So these are nonsurgical musculoskeletal specialists.

So if somebody is coming in and they're not sure what they've got, but it's a musculoskeletal or bone or joint pain often the first stop is with one of the rehab doctors, but even with that in place many patients come in to see me with knee pain and leave with something other than a knee replacement. In fact, as I said, the large majority do.

We decide to do surgery on patients when we've tried nonsurgical interventions, but the pain from arthritis persists. The kinds of things we'll try might be activity modifications, might be various kinds of arthritis braces or joint injections with cortisone type shots or joint lubricants, and if somebody is still having activity-limiting symptoms despite having tried nonsurgical interventions along the lines of what I just described then that's when we begin to explore surgical options together.

Andrew Schorr:

Now in listening to one of our recorded messages on the program I think it talked about you all having done like four thousand procedures, so there's a lot of activity there, but people watch TV as well, and now for the first time in the last couple of years I guess the orthopedic device companies have been advertising, and I think there are even advertisements for joint replacements for women.

Now, from where you sit and doing lots of knee surgery and hip surgery I know you do too, tell us is there some hype that we need to be wary of, or what really matters? Is it the surgeon or is it the device?

Dr. Leopold:

That's the sixty-four dollar question for sure, or at least it's one of them. The gender-specific joint replacements are very, very new. They've only been out a couple few years. The early research on them seems not to show any dramatic difference compared to, oh I don't know what you'd call it, gender nonspecific or the more standard joint replacement. In fact the differences among them and between them, between the gender specific or the female knee replacements and the nonspecific ones, are extremely subtle, and from where I sit I'm not sure they're entirely well thought out.

If we look at who does better after a knee replacement whether its men or women, historically in almost every study that's been done on this women fare better than men to begin with, and that's with the traditional or non-gender-specific implant, so I'm questioning the underlying need for this avenue of implant development at all, but I'm open to the possibility that as they get studied they may show some benefit, but so far in the first couple of years they've been out they really haven't.

I think that the key to success after joint replacement is finding somebody who does a good job at joint replacements, which is usually somebody who does a lot of them, who's done a lot of them for awhile, who's had some subspecialty training like a fellowship in that kind of surgery, and then mating that with a patient who has expectations that can be met where that patient's been counseled as to what to expect and how hard they may have to work in order to get the desired result because a huge part of the outcome is really in the patient's own hands and how hard he or she will push through in physical therapy to get the desired result.

Andrew Schorr:

Let's talk about that for a second about the desired result. Bob, you mentioned physical therapy and rehab and expanding your range of motion in your shoulder. It's not a walk in the park is it? So you have the surgery and it gives you an opportunity for recovery and a full life, but it requires things of the patient doesn't it?

Bob:

I think the way it was put to me, which is very succinct, was the day of my surgery I believe I was told that Winston had just given me one-hundred-and-forty degrees range of motion. That was his job. My job was to keep it, and I take that pretty seriously, but I've done that my whole life. As we talked about being an advocate for your lifestyle going into it I think that a patient also has a responsibility to be an advocate for the results of the surgery to a certain extent. How hard you're willing to work to reclaim the use of that joint is really a huge part of success or lack of success with the surgery, and it isn't a painless road. It's a grind. They're not exciting, fun exercises necessarily to do. At times there's pain to be pushed through. At other times you have to be conscious enough to back away from it and not basically aggravate the joint to let it calm down, but you have to continue doing the work.

So there's a long road. There are some great physical therapists. I tend to do a lot of the work myself. I've got a personal trainer I use, but for a person that isn't particularly athletic, I think that really doing work with a professional physical therapist who understands and can help that patient with the discipline it takes to do it is really critical to the outcome.

Risks of Hip Replacement versus Resurfacing

Andrew Schorr:

Okay. I want to also just talk about what are the risks of any of these surgeries or when you undergo surgery. Dr. Weisstein, tell us what you tell patients. So if you want to talk about hip replacement or resurfacing or even how it may relate to these other procedures too, what are some of the risks?

Dr. Weisstein:

The way I counsel patients is basically I try to give them a realistic appraisal of the differences between a traditional total hip replacement and total hip resurfacing arthroplasty. Specifically a main difference that jumps out is really the early what happens basically in the first couple of years.

The risk for fracture has been born out to be higher in the resurfacing group as opposed to the traditional total hip group, and this probably has a lot to do with patient bone stock but also the nature of the procedure. Other risks that I think are important to counsel patients regarding resurfacing arthroplasty include concern regarding metal ions. The resurfacing involves metal components, so the articulating surface is metal against metal, and there is a theoretical risk of metal ion release, and it's really not well understood what risk that might actually have.

Certainly patients with bad kidneys, for example, should not be considered for a hip resurfacing procedure because of the metal ion affect on kidneys. The other issue would be women of childbearing age. Those metal ions are thought to cross the placenta, and it's unknown what affect those ions have on fetal development. So women of childbearing age, patients with poor kidney function, patients with poor bone stock probably are not good candidates for this procedure.

The traditional total hip replacement and hip resurfacing both have a risk of dislocation. It's thought that with hip resurfacing because we tend to use much larger components the risk of dislocation is smaller, but again long-term data for hip resurfacing is not available. This is a new procedure that's been available in the United States for just a little over two years. There is a larger experience overseas, but the bottom line is that when we talk about hip resurfacing much of our data is in the intermediate term, and I say intermediate term; we have data extending out about nine to ten years whereas for traditional hip replacement, a very tried and true method, we have data that extends out significantly longer.

So when I'm counseling patients I encourage them to weigh the pros and cons of hip resurfacing and traditional hip replacement and give them an honest appraisal of the risks. That's pretty much it Andrew.

Andrew Schorr:

Okay and I'll just mention across all surgeries there's a small risk but there's always, you have to consider the risk of infection.

Dr. Weisstein:

Sure.

Andrew Schorr:

And so that's something. So nobody should go into surgery lightly. We're going to take a short break, and when we come back we're going to talk further with Winston Warme and understand about shoulder surgery and also what are other options for people, and in all the cases we've got some questions that you've sent in we're going to pose to the doctors. Marie in Seattle sent one. Jim sent one from Berkley, California, so we'll be right back with much more of Patient Power as we discuss innovation in joint replacement surgery with three experts and an expert patient as well all associated with UW Medicine and UW Medical Center. We'll be right back.

We're covering a lot of ground orthopedically. I just want to mention with Dr. Winston Warme we talked about the ream-and-run procedure. Any other innovations you want to mention Winston related to shoulders?

Dr. Warme:

There are other things that we do that are not quite as invasive in terms of topics that you've brought up recently. You talked about frozen shoulder, and that's one particular problem that can affect a lot of people. Some people don't just get better as you did, and they get stuck with very limited range of motion and really an inability to get back to their normal lifestyle, and in those patients we've been able to do an arthroscopic surgery, which is not replacing the joint but just loosening up all the really scarred down tissue to allow them to get back their range of motion, and similar to what Bob had to go through with his rehabilitation, patients also have a long road to maintain that motion if they've had surgery, but that has been a rather encouraging treatment to an otherwise very difficult problem.

Questions from Listeners

Andrew Schorr:

That's good to know. I guess I was a lucky guy there. Okay, we've got some questions that came in primarily about knees first, so we'll address this to Dr. Leopold. This one came from Marie in Seattle. She said, 'I understand it isn't an exact science, but what guidance can you offer as far as the pain level one should be experiencing when considering having a total knee replacement?' Then she wonders if it is time for surgery is it better to get both knees done at once if both need surgery. Dr. Leopold?

Dr. Leopold:

Those are two great questions, and the first one as you'd imagine occupies a great deal of a great many of the visits that a knee surgeon has. It's really not about treating the x-ray. Probably ninety percent of the people coming in to see me have the right x-ray for a knee replacement, but as I said earlier in the show I operate on maybe one or two out of ten who come in because for almost all of them we can either find something else to do or they're not a suitable candidate for an operation or not at that time in the person's life.

So I think really the best way to make this decision is to arm the patient with the information that she or he needs to make the good decision. I love that your show is called "Patient Power" and the theme is that "Knowledge is Power." We think the same thing, especially at the University of Washington, and so what we spend a lot of time doing, my partners and I, in the visits with the patients is to give them really what's at stake when one has an operation. What are the risks not just in the generic case but in the case of the person in front of us because each person's counseling for surgery is different. Some people's risks are lower and some are higher.

So really to answer Marie's questions you've got to lay it out in the context of Marie. You've got to know something about her health. You've got to know what sorts of risks she's comfortable taking, how much time she can put into the rehabilitation. In general we find that risks of a real complication from a major surgery is on the order of a couple of percent, and the chance that somebody might have persistent pain after a knee replacement, even after full recovery, might be ten or twenty percent; in other words, better than before the surgery but not pain free; and most patients, eighty to ninety percent, really get just what they want out of the operation in terms of becoming pain free.

So Marie, or whoever is answering a question for herself, would have to decide is that set of risks worth taking in the context of the pain or the limitations that I'm experiencing? Every patient answers that question differently. Usually we find patients who are still going several miles and find that that tradeoff, that set of risks is too great for them, whereas patients whose distance limitation, let's say on level ground for example, might be measured in blocks and not miles, are usually more comfortable taking risks in that order of magnitude.

Now that's a very, very generic statement. It's a generalization, so take it for what it's worth.

Andrew Schorr:

The other part of her question related to having both knees done at once?

Dr. Leopold:

One at a time or two at a time? This is a point on which well-meaning knee surgeons still disagree, but what I would say is if you look carefully at what's been published, the science on this, I would say in the last five or six years the literature on this has moved well away from supporting this as a good general approach. I would say this used to be done much more commonly than it's done anymore. The risks of a major complication following a same-day, both-knee surgery are much more than doing one at a time. In fact you'd accept a doubling of the risk, right, because you've got to come back a second time anyway. It turns out that the risks more than double, and so a lot of people have moved away from considering this a safe operation or a safe approach for most people. I know that I have.

When I started out doing this and let's say ten years ago about a third of my practice was patients having both knees done at the same time, and now I would say I'd do that once or twice a year in extraordinary personal circumstances for the patient.

Andrew Schorr:

Okay, here's a question for Dr. Weisstein. Jim in Berkeley wants to know, he says, 'I'm fifty-three and in good health. If I get my hip replaced, how long would I have to wait before going back to a job that requires that I walk about three miles a day?' And I would ask would it be any different with either the resurfacing or the traditional procedure?

Dr. Weisstein:

I don't think there would be a difference. It would be hard to know without meeting this gentleman, but one of the questions you'd want to know is how much is he walking now prior to any type of hip surgery, but I don't think in terms of getting back to activity it's really been born out very convincingly in the literature that there's any advantage of one over the other.

Hip resurfacing tends to give patients a little bit better range of motion, at least in the patients that I've been able to care for, but in terms of getting back to walking several miles a day I would probably call that a draw.

Andrew Schorr:

And the length of time? I know it's going to vary by somebody's condition, but let's say that he used to walk three miles a day and then the pain got too great, but he wants to get back to that job. Assuming all other things are ready to go just from the point of view of the joint, how long might it be before he's doing that?

Dr. Weisstein:

Our best guess would be around three to six months. Much like Winston's patients who's with us now I think a lot of that would come down to how motivated that patient is after the surgery. Whereas one patient who is incredibly motivated might be back much earlier, maybe at three months, maybe the average would be more towards a length of around six months.

Andrew Schorr:

Dr. Warme, I've got a question for you. So you've been in orthopedics a long time, and I know you're a very active guy, and you work in a great department. So as I mentioned, we in the public, not in the medical field, see ads now and we hear this hospital or this practice advertising "We do this" and somebody else says "We do that" and it's hard for us to make sense, but there is innovation certainly in orthopedics. What would you say to us or family members or friends to counsel them so that we can be smart consumers, if you will, when we're wondering do we need an orthopedic procedure?

Dr. Warme:

I think it's always good to inform yourself as much as possible, and looking at the web there are lots of resources out there. The University of Washington has a very large

supply of information that's available on the web that tells the patient or prospective patients a little bit about the doctors, their philosophies, and also the type of procedure they're doing and their areas of expertise. There are links on the website there for various aspects of research that are ongoing and studies and new innovations that the University is heading forward and leading the way in trying to develop new ways to do surgery with less morbidity or less pain afterwards and getting people back going quicker.

Andrew Schorr:

Yes, I would say that the UW Medical Center and the Department of Orthopedics website is a great one, and as I've noticed not only do you have information on all the doctors' procedures and philosophies, but also it links to a lot of independent resources that put these various approaches in perspective. Here's the web address: www.orthop.washington.edu or orthop.washington.edu, and we'll have a link on the Patient Power site.

So Bob Sandoz I want to give the last couple of minutes to you. So you've lived it Bob, and you've been a very proactive consumer. I'm going to give you a "Powerful Patient" award. You suffered with pain, tried to work through it, you've done a lot of nonsurgical approaches, and then finally when you concluded that you needed surgery you really worked hard to find somebody you trusted and a whole team.

What advice would you give, what tips would you give and maybe based on what you've heard tonight too to people listening who are wondering not just about specific procedures but finding the right answers for them as they may have very severe, debilitating arthritis pain?

Bob:

For those that haven't experienced arthritis, it's the real deal. I have a high pain threshold. I've been active in sports and some level of extreme activities my whole life, and arthritis is the equalizer in all of that, so finding relief from it is important. I think it really comes down to understanding that not all orthopedists are created equal. There are many, many very good orthopedists in this country available to every patient. The question is to get really clear about what your lifestyle and your goals and your expectations are around your physical being and then try to match them up with an orthopedist that one understands and is in alignment with those goals, and I think that's really what drove me ultimately to work with Dr. Warme and the UW. I got there through a challenging route, but I never gave up sight of my goals of what I wanted out of this, what I wanted to achieve.

It's interesting because in listening to the questions for Dr. Leopold I've also met with Dr. Leopold. I have a knee that's compromised that has arthritis, and as he described it if you look at my x-rays I'm a great candidate for a knee replacement, but he counseled me to not do a knee replacement at this point, and I believe his counsel was absolutely correct. I'm not ready for it because I can modify my lifestyle and move forward with a lot of activities that I still love to do, and when the times comes for that knee replacement I will

know it because it will be driven by pain, and I can say with every bit of confidence that when that time comes Dr. Leopold will be the doctor I use for that replacement.

Timing is a big part of this choice. I don't think anyone gets to the decision of having a joint replacement when you're on a winning streak. When it's still working is not the time to be getting a joint replacement. It's when you've exhausted alternative methods of relief of that pain that you have to look at it because as Dr. Leopold said so well, you don't know exactly what you're going to get as a result of it. You can hope for the best and you can work towards it, but I think that's the responsibility of the patient, and I think that's what I'd encourage patients who are listening to this to get really clear about their goals, what they're looking for out of it, and what they're willing to do to get that, and then look for the right partner.

Andrew Schorr:

Well said. Well whether you have knee surgery at age eighty or whatever, I hope you ski until your dying day and fly-fish and bird hunt and all the things you love to do, and as those kids get older have them right along side you.

Bob Sandoz, thank you for being with us. I want to thank Dr. Seth Leopold again being Patient Power, Seth thank you. I want to thank Dr. Jason Weisstein who is with us as well, and I want to thank also Dr. Winston Warme, great team members, and there is a huge, very skilled team at UW Medicine Orthopedics and at the UW Medical Center there.

Now it may not be for the people with arthritis, but on Thursday, January 29, 2009, maybe for your kid or your niece or nephew or grandchild, we're going to have another UW Medicine sponsored program when we discuss the latest in asthma in children. So that's Thursday, January 29, 2009, asthma in children with leading asthma experts from UW Medicine.

I want to mention also that the whole library is on our website, www.patientpower.info/uw. I think we've done programs with about eighty UW Medicine faculty members. Also I'll mention their orthopedic website again, www.orthop.washington.edu.

Thank you for joining us tonight. Thanks to Bob. Thanks to the doctors. I'm Andrew Schorr. Remember, knowledge can be the best medicine of all. Good night.

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