Deformità complesse: sempre a cielo aperto? (subspine e global)

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Struttura Complessa
Ortopedia e Traumatologia
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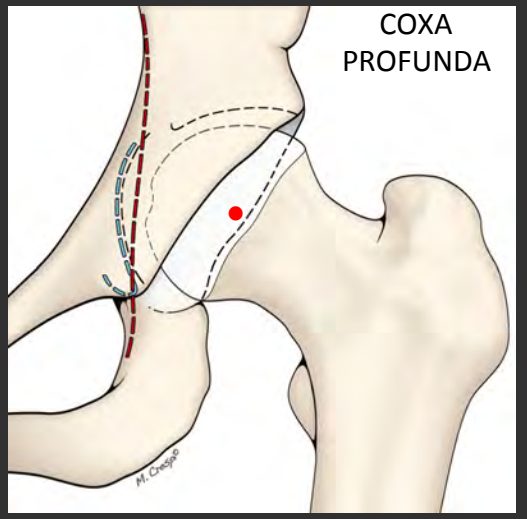
SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Ospedaliera di Reggio Emilia

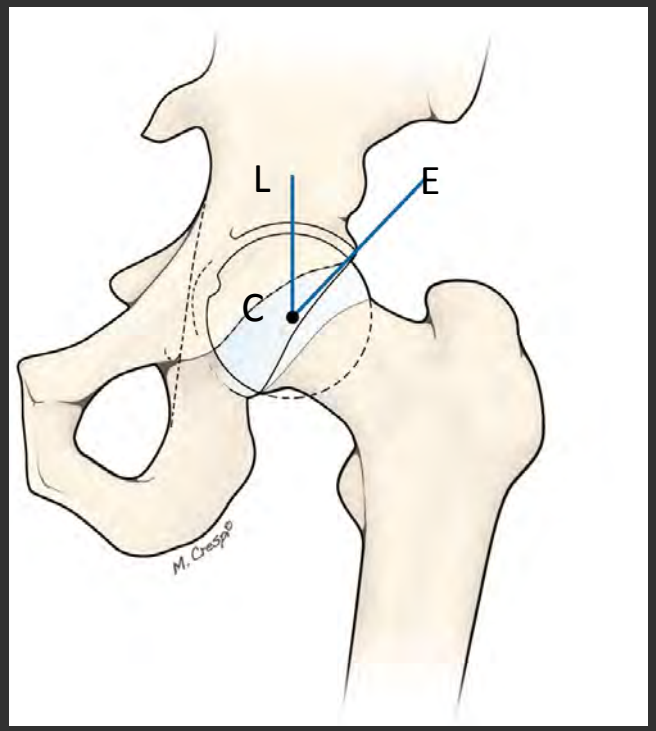
PINCER

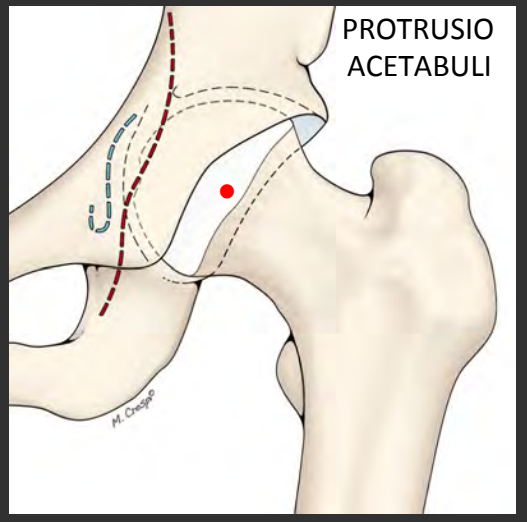
- FOCALE: angolo CE Wiberg 25° - 39°
- GLOBALE: angolo CE Wiberg ≥ 40°



LCE angle: 25° - 35°

(25° - 40°)





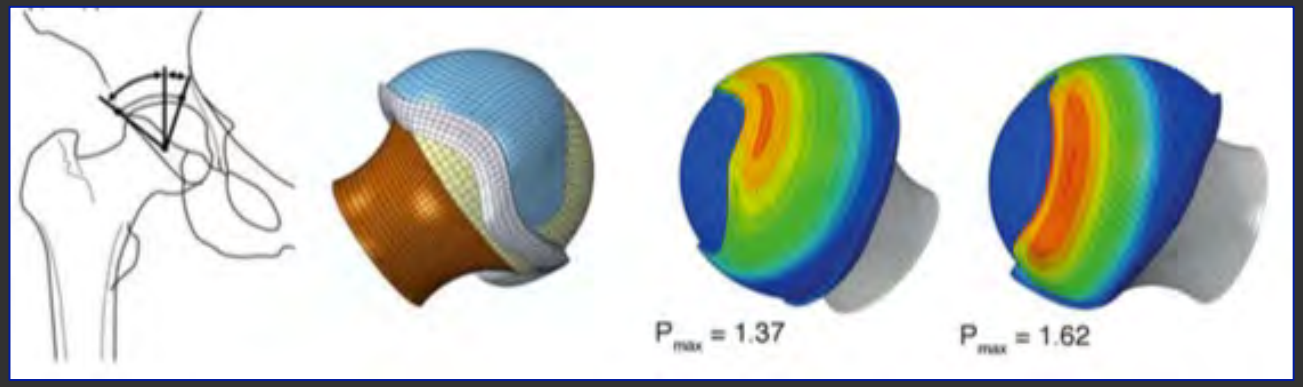
CONTROINDICAZIONI ALL'ARTROSCOPIA

- Anchilosi
- Protrusio acetabuli

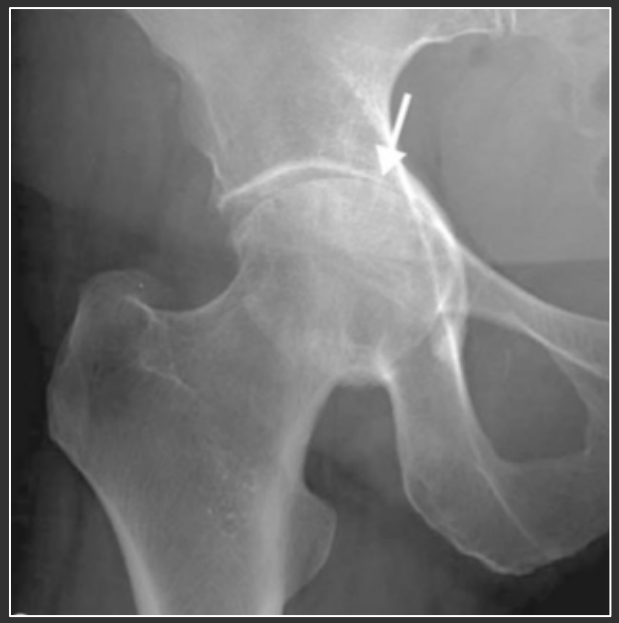
- *Distrazione articolare insufficiente*
- *Difficoltà ispezione comparto centrale*
- *Difficoltà trimming acetabolare posteriore*
- *Difficoltà sutura labbro*

Meglio la CHIRURGIA OPEN

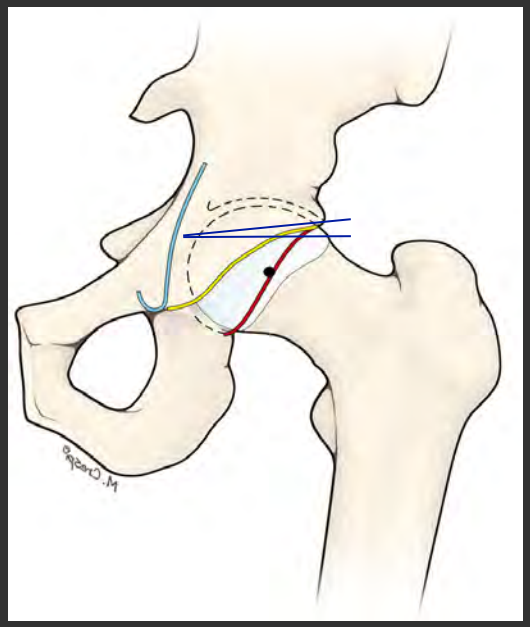
CONTROINDICAZIONI ALLA CHIRURGIA DEL F.A.I. NELLA PROTRUSIO



Liechti EF et al 2014



Tönnis angle
(0-10°, <15°)



DEFORMITA' COMPLESSE: PINCER GLOBALE
(COXA PROFUNDA – PROTRUSIO ACETABULI)

- Difficoltà ingresso in articolazione ➔ *accesso nel comparto periferico senza trazione*
- Capsulectomia/capsulotomia ampia per visione e lavoro
- Distacco completo e reinserzione labbro *(a volte è ossificato ➔ asportazione + event. ricostruzione)*
- Trimming acetabolare globale

Case Report With Video Illustration

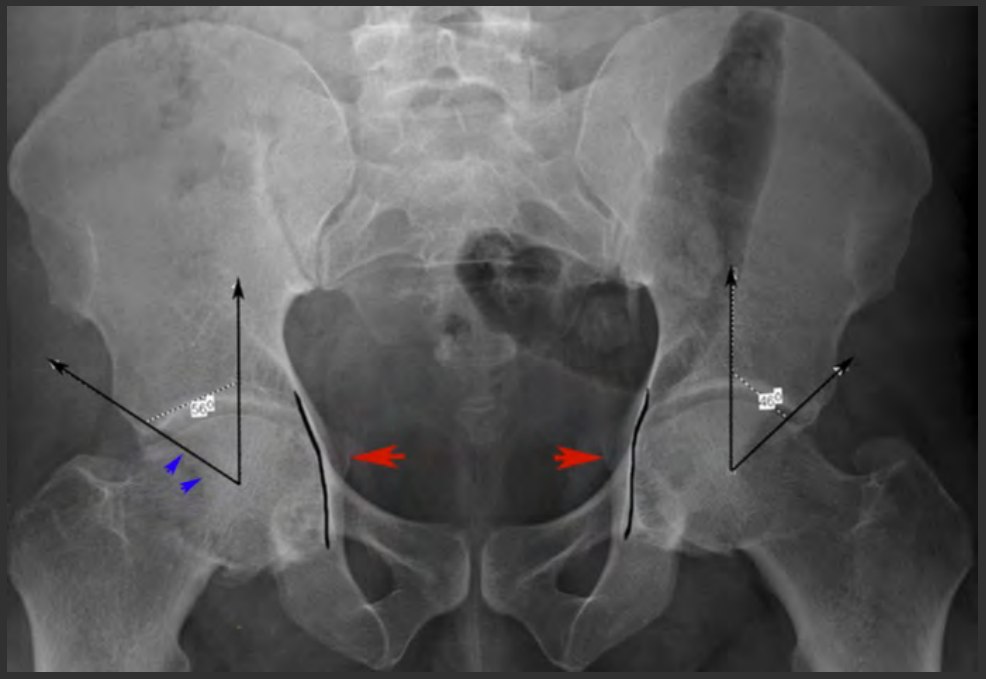
Protrusio Acetabuli: Contraindication or Indication for Hip Arthroscopy? And the Case for Arthroscopic Treatment of Global Pincer Impingement

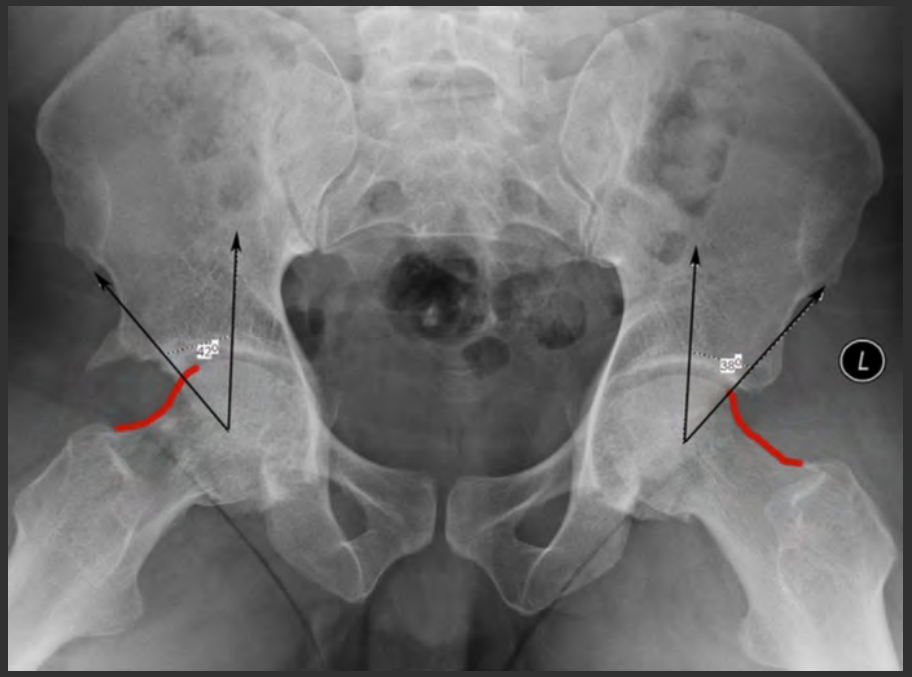
Dean K. Matsuda, M.D.

Arthroscopy: The Journal of Arthroscopic and Related Surgery, Vol 28, No 6 (June), 2012: pp 882-888

Abstract: Protrusio acetabuli has been considered a contraindication for hip arthroscopy. We present the case of a 33-year-old man with bilateral symptomatic protrusio acetabuli—the most extreme form of global pincer femoroacetabular impingement—and cam femoroacetabular impingement. We demonstrate the feasibility of the arthroscopic correction of severe deformities and describe key surgical steps permitting central compartment access, subtotal acetabuloplasty, labral reconstruction, and femoroplasty of the right hip, followed by later subtotal acetabuloplasty, labral refixation, and femoroplasty of the left hip, with improved outcomes at 2 and 1 years, respectively, as measured by the nonarthritic hip score. Though challenging, global pincer impingement, even acetabular protrusion, may be successfully treated with dual-portal outpatient hip arthroscopy. The modified midanterior portal enables central compartment access and extended posterior "reach" in the arthroscopic treatment of major global pincer femoroacetabular impingement, potentially making this contraindication a historical one while respectfully challenging the "global" recommendation for open surgery in this setting.

Uomo 33 aa, dolore da 4 anni





POST-OP

- Neuroaprassia del pudendo per 3 mesi
- Ossificazione eterotopica Brooker grado 2

Arthroscopic Management of Protrusio Acetabuli

Marc R. Safran, M.D., and Noah P. Epstein, M.D.

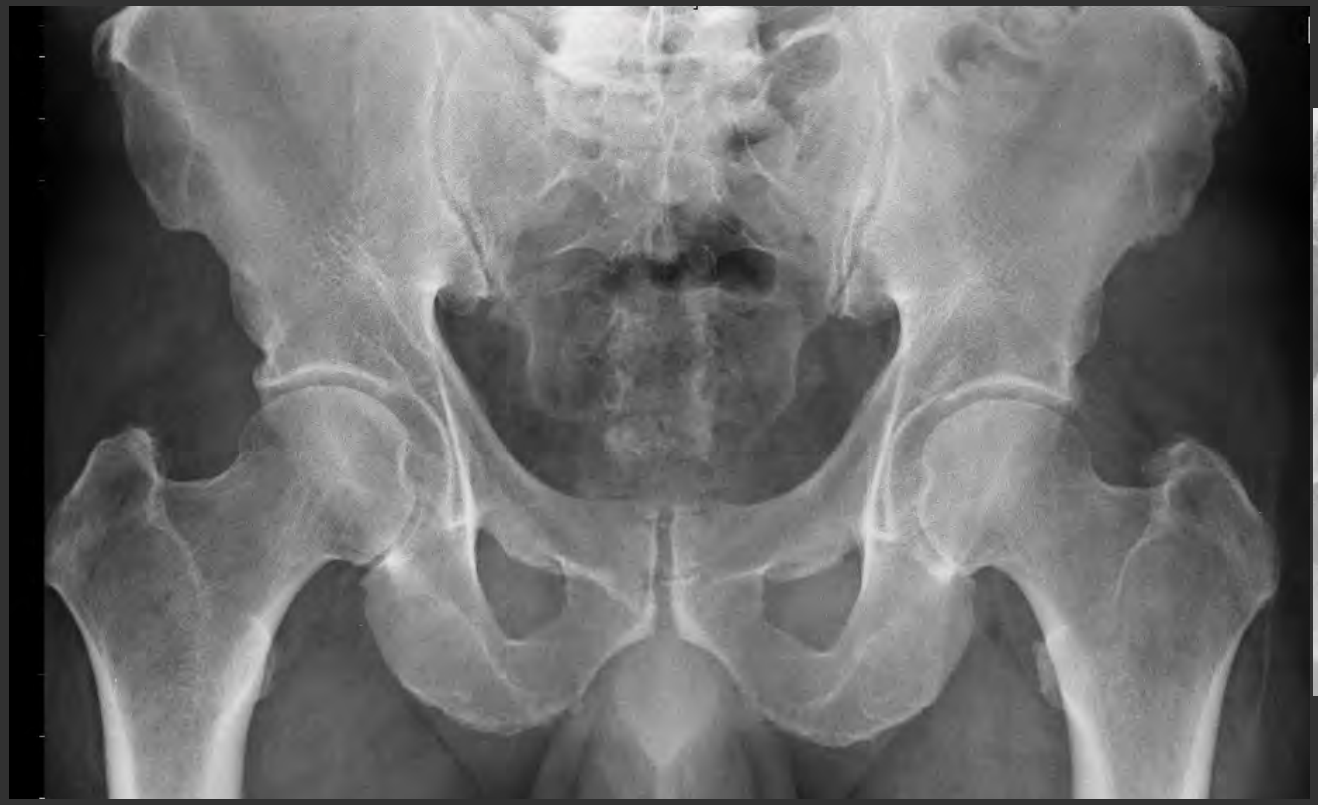
Arthroscopy: The Journal of Arthroscopic and Related Surgery, Vol 29, No 11 (November), 2013: pp 1777-1782

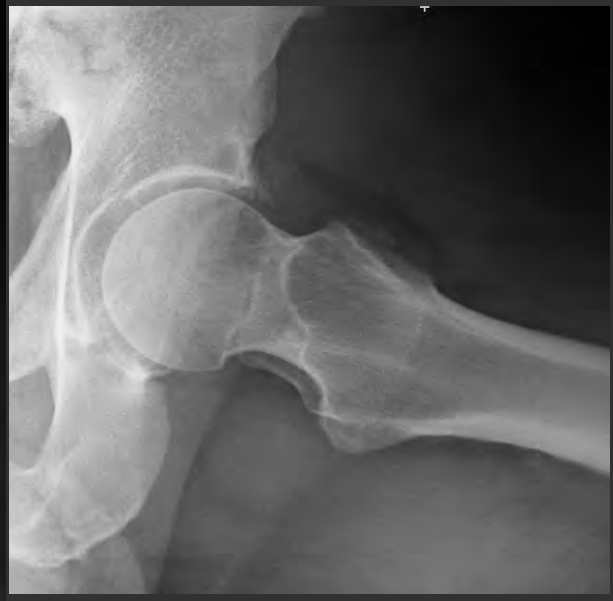
not necessary in this small series of patients. Furthermore, whereas the acetabular overcoverage was global, the majority of the patients complained of groin pain and their symptoms were reproduced with flexion and/or flexion–adduction–internal rotation of the hip. Thus the goal of the surgery was not to perform a global acetabuloplasty or resection of the entire acetabular rim, but just the anterior and lateral acetabulum.

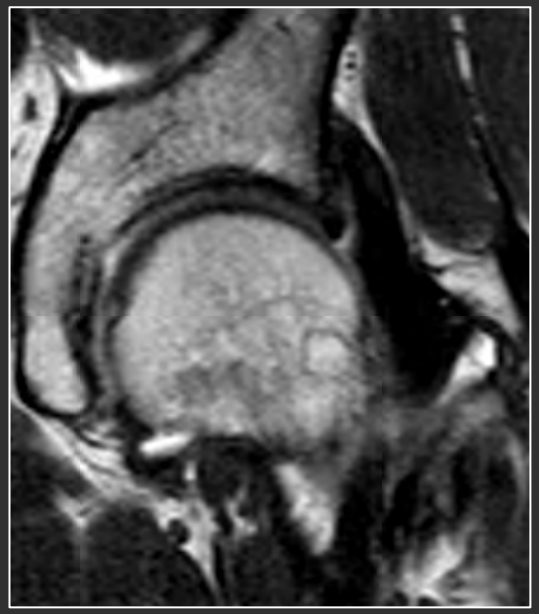
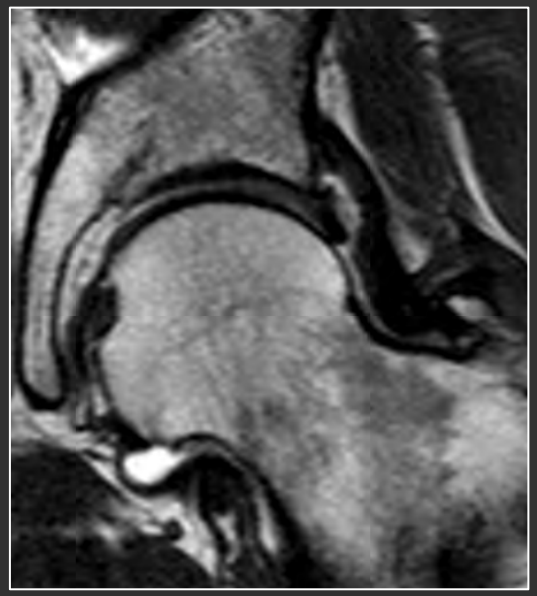
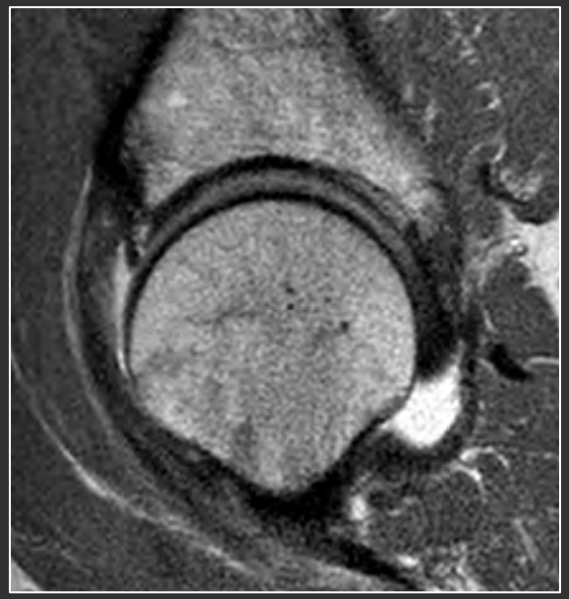
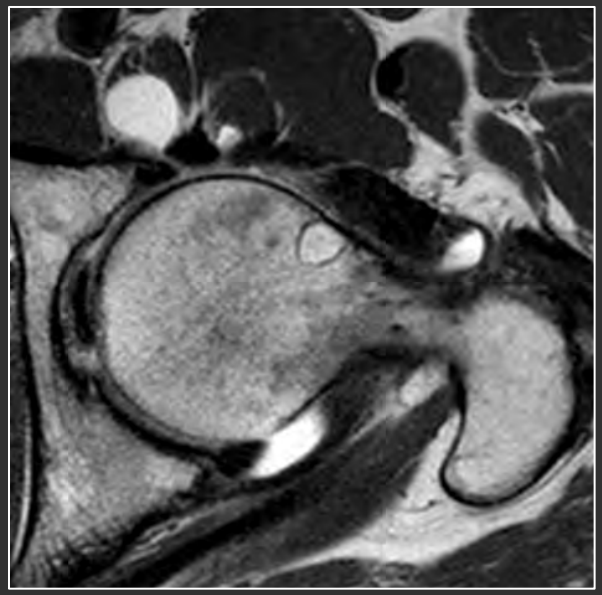
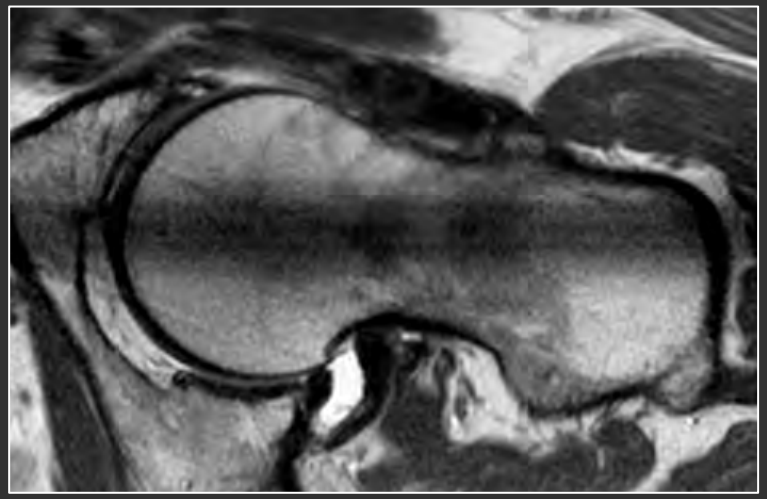
Removing a few millimeters of bone from the anterior and lateral acetabular rim improves the patient's clearance with hip flexion and rotation maneuvers, eliminating the pain and improving range of motion.

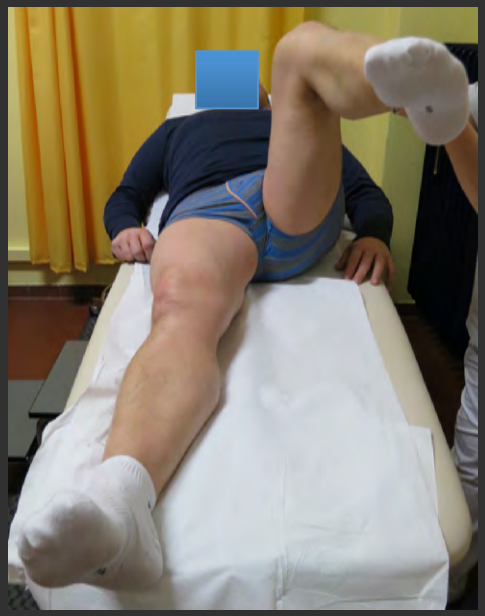
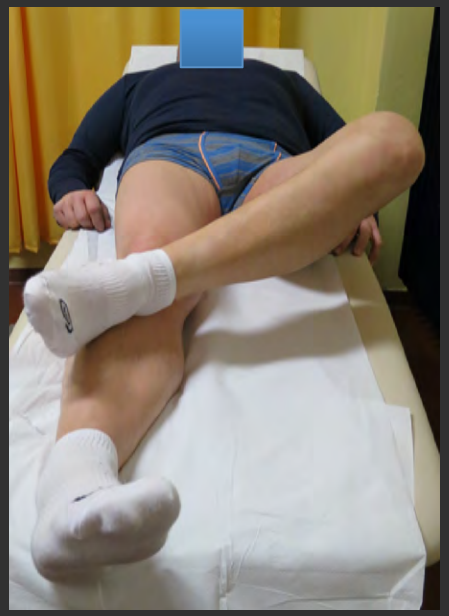
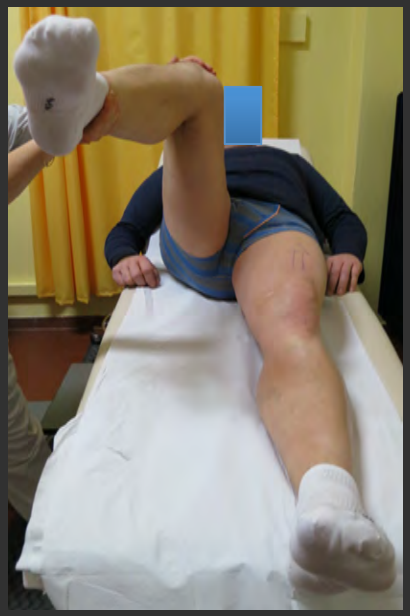
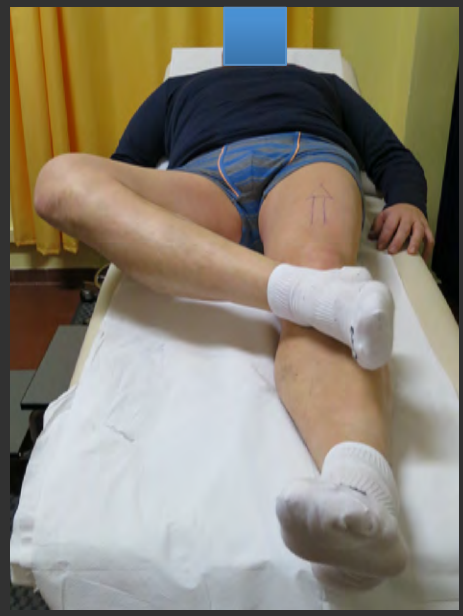
years for the other. It is not clear whether it is necessary to reduce the center-edge angle to "normal" (<35°). The goal of the surgery in this series was just to reduce the center-edge angle by 5° to 10° because these patients have been living all of their skeletally mature lives with such overcoverage, and this amount may be all that is necessary for them to reduce impingement.

Uomo 46 aa, coxalgia sinistra da 2 anni. H 175 cm, 103 kg, BMI= 33,6.
Dolore in F.ADD.IR, F.AB.ER negativo

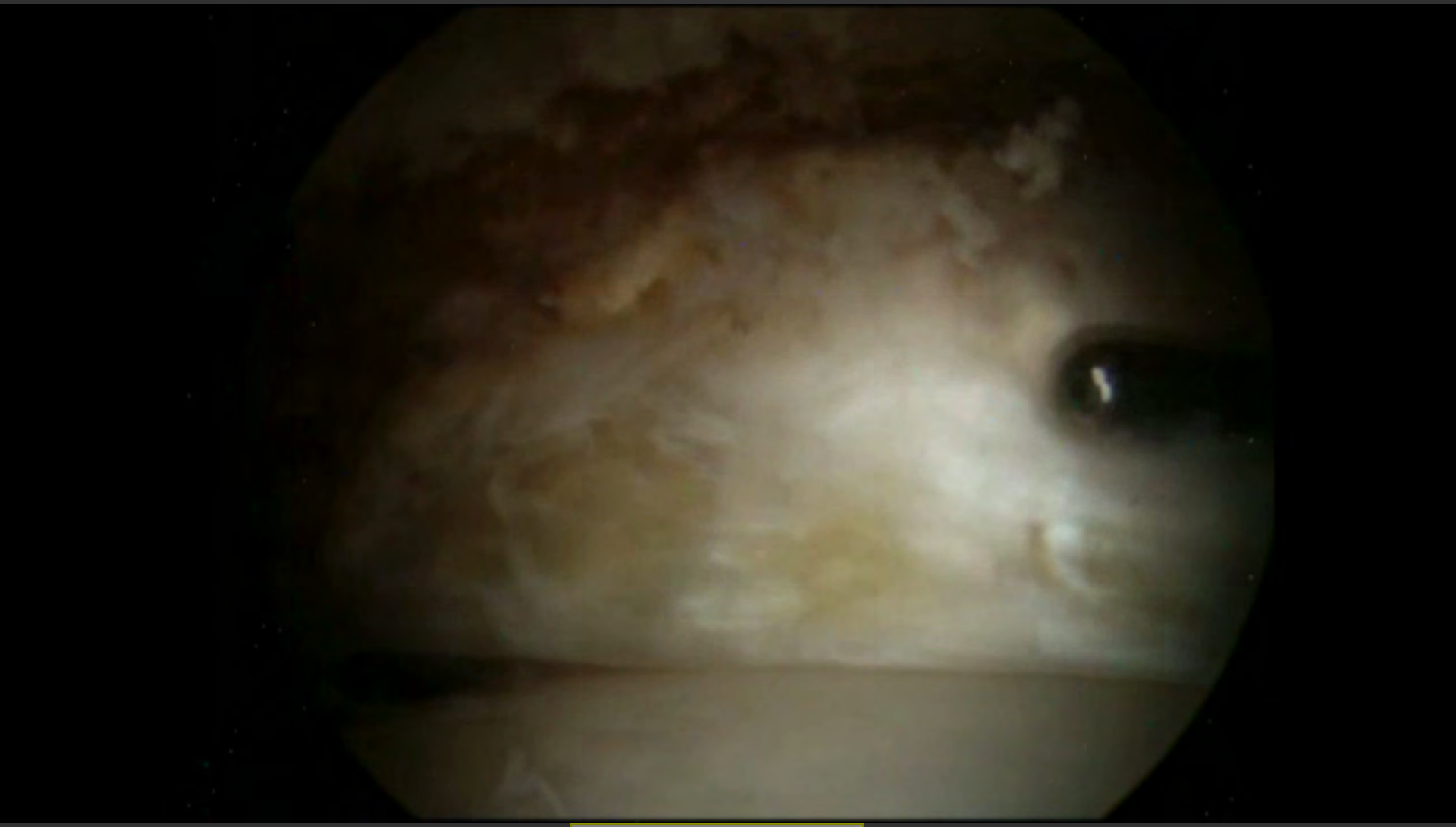




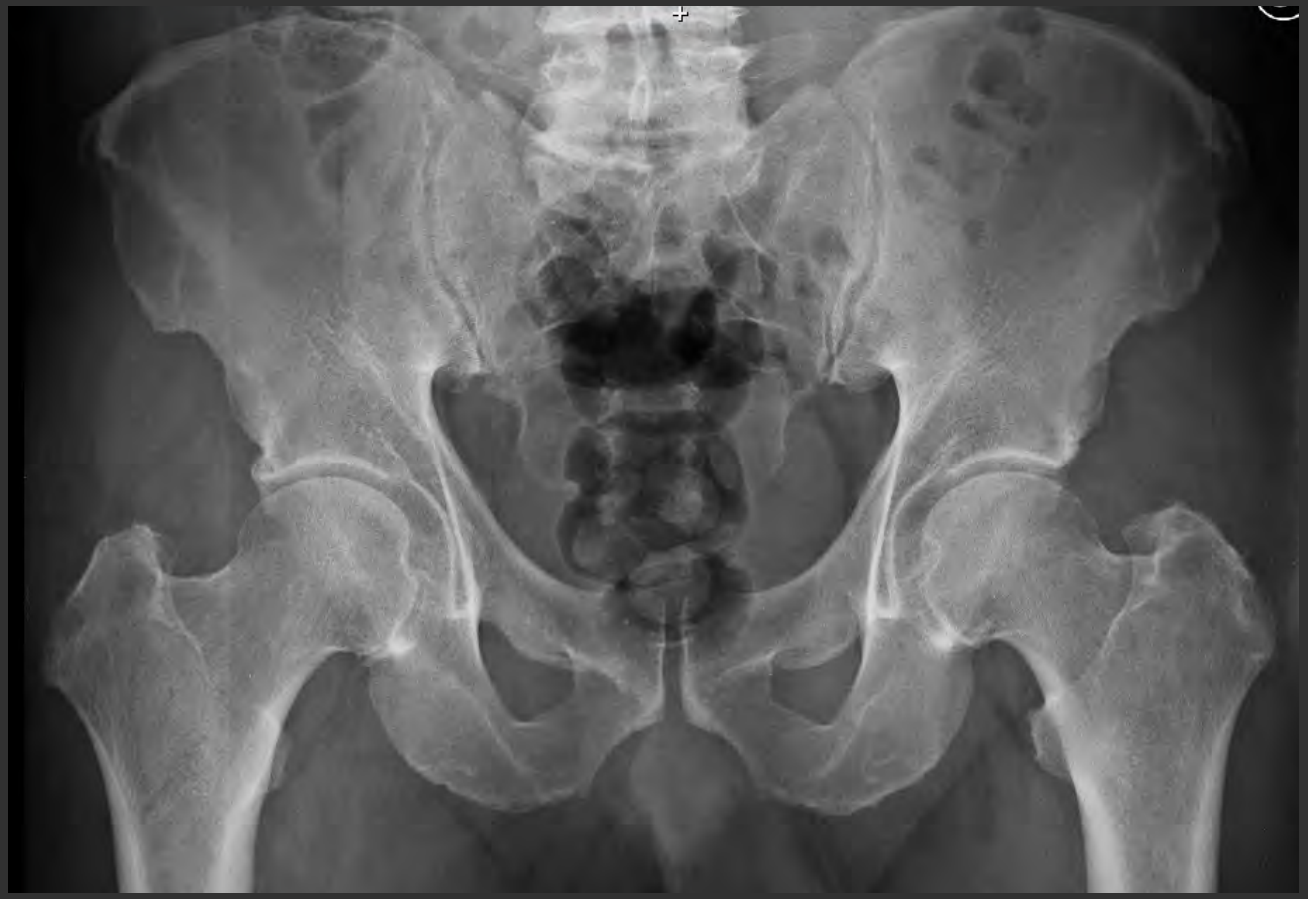





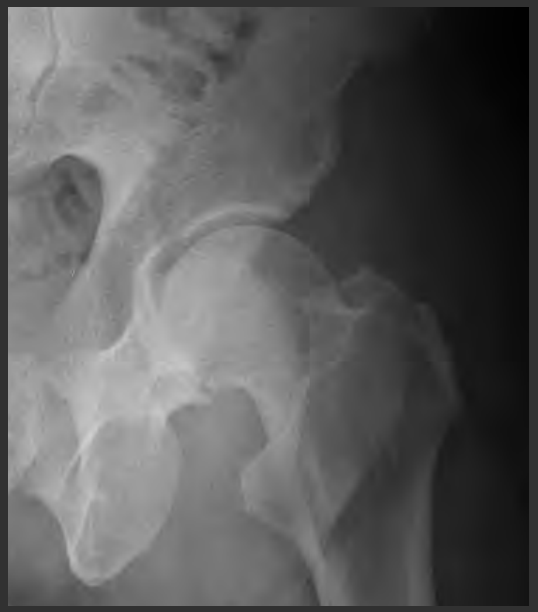
Trimming acetabolare da ore 9 a ore 13. Sutura labbro con 4 ancore



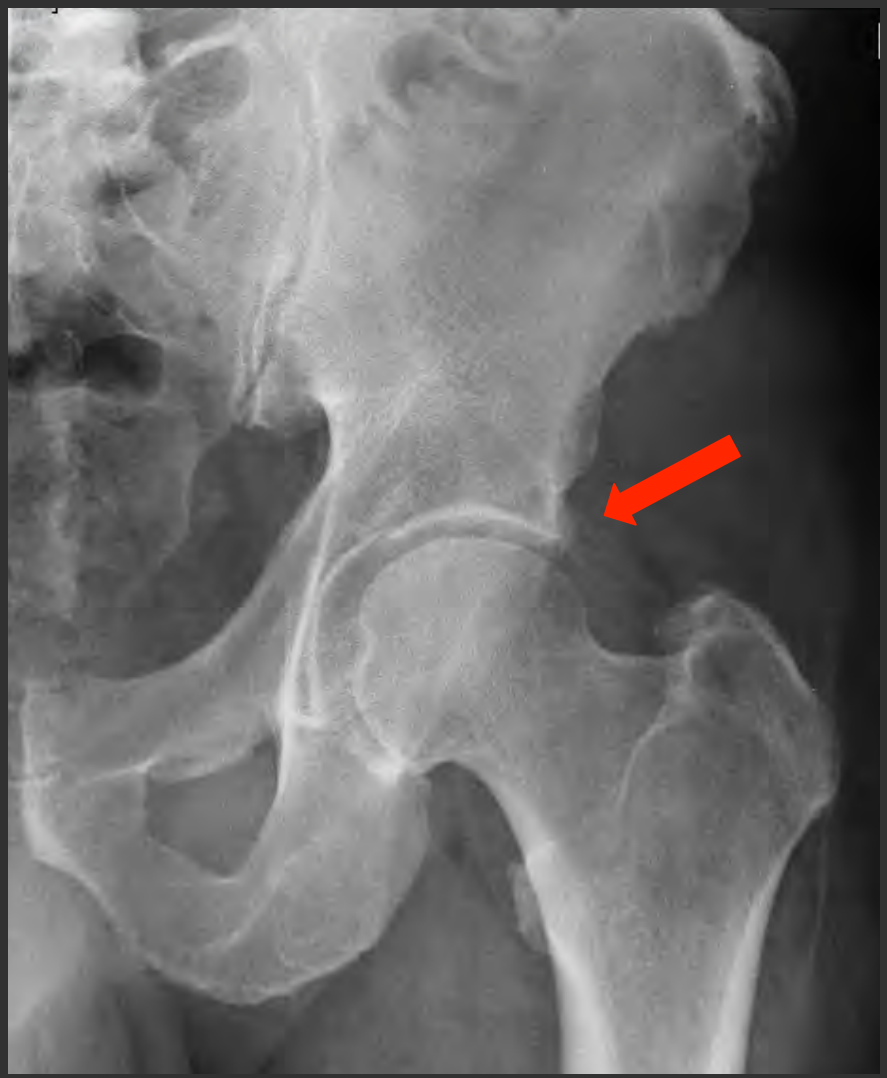
GUARDA IL VIDEO

Post-op

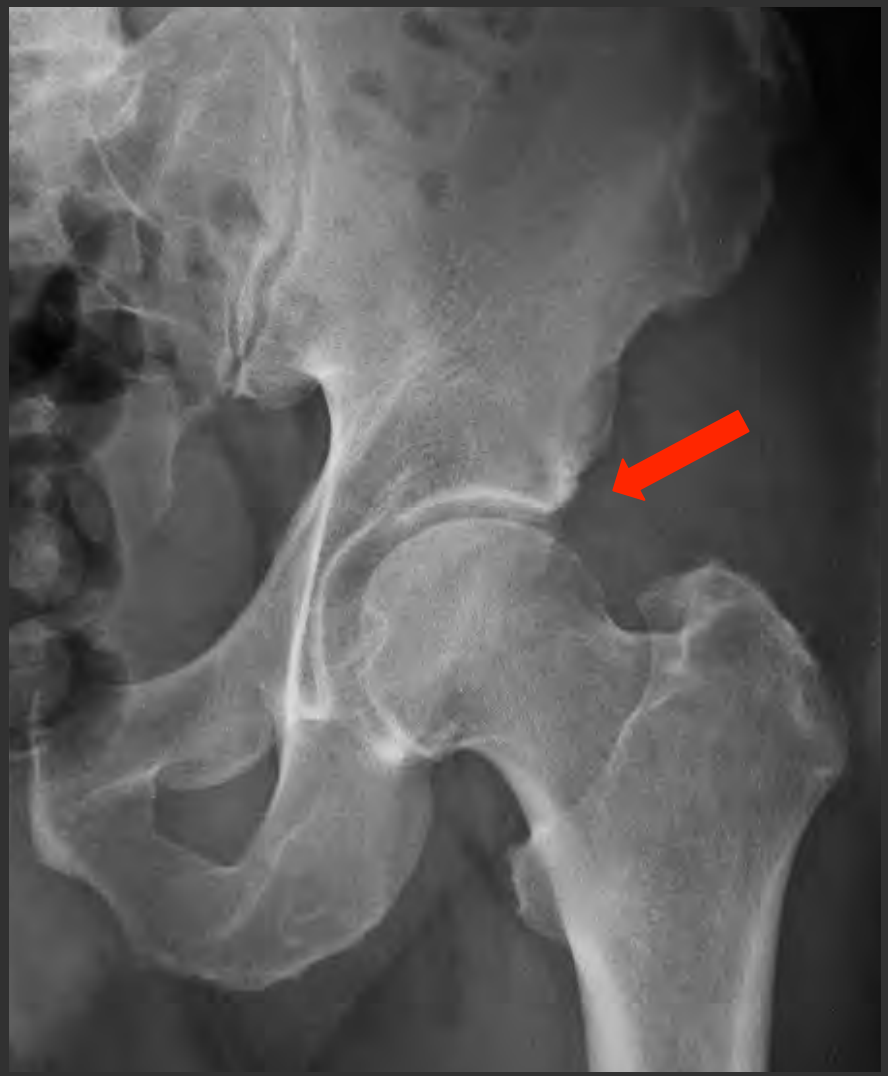




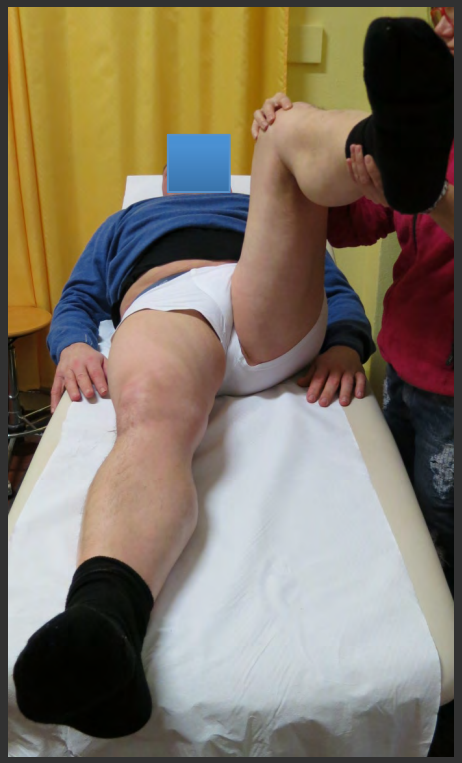
Pre-op

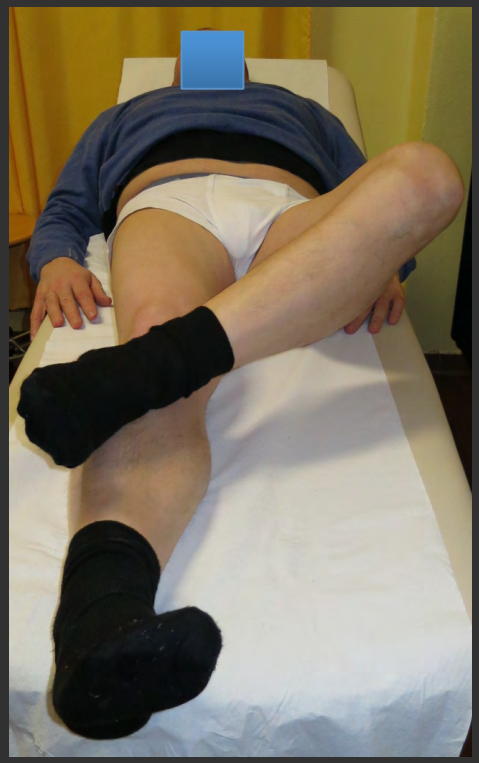


Post-op

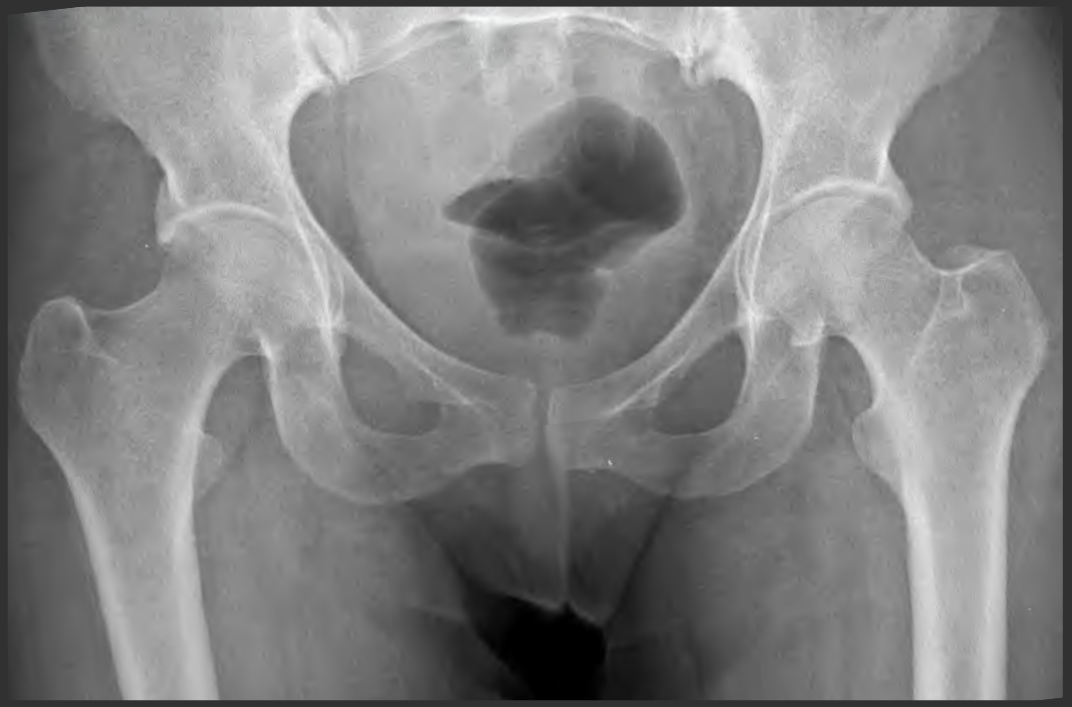


1 mese post-op

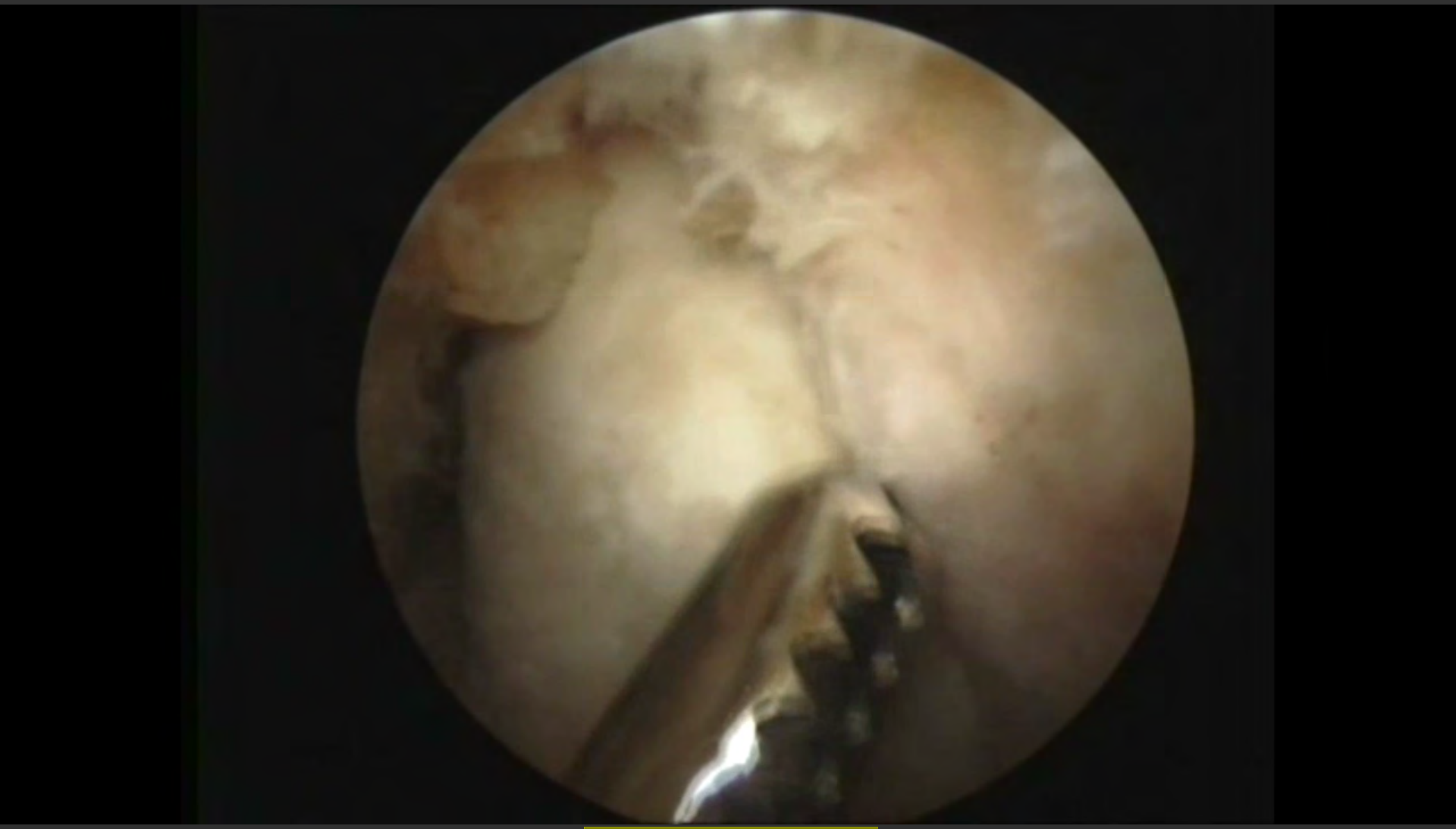




Donna 46 aa., coxalgia sinistra da 6-7 aa, H 162, 70 kg.
F.ADD.IR +, F.AB.ER. + Tendinite trocanterica (fascia lata)

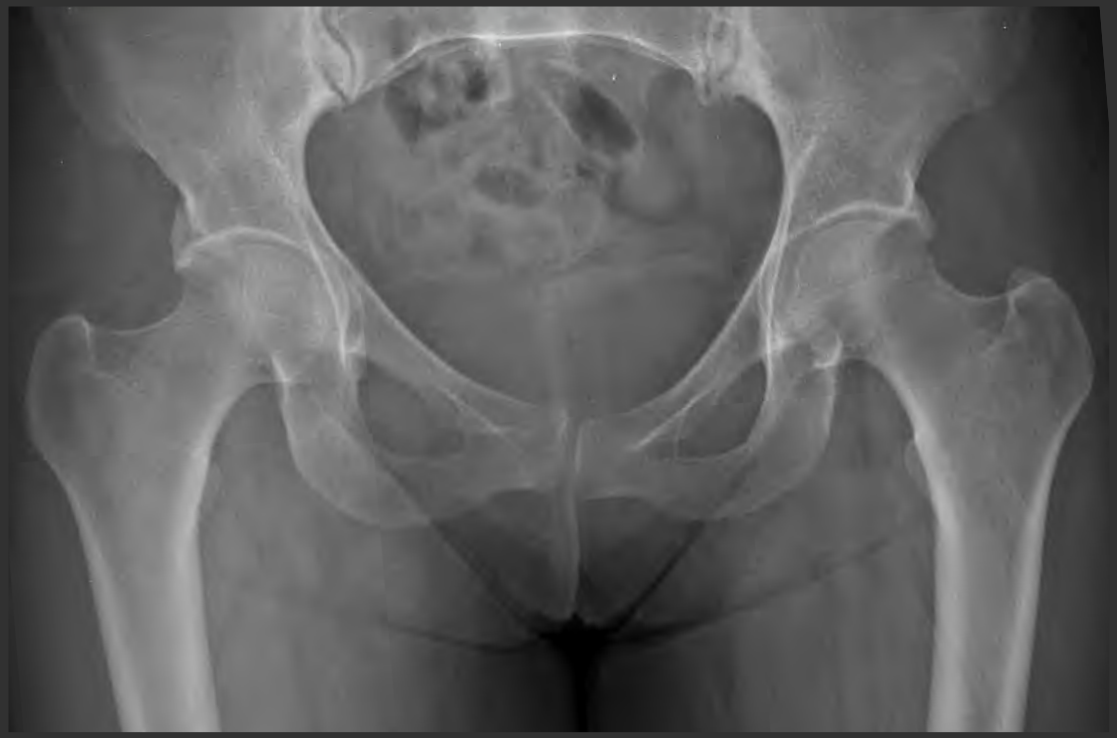


Labbro in buona parte ossificato. Trimming acetabolare da ore 14 a ore 9, + osteocondroplastica femorale + bursectomia trocanterica e release tensore fascia lata



GUARDA IL VIDEO

Post-op



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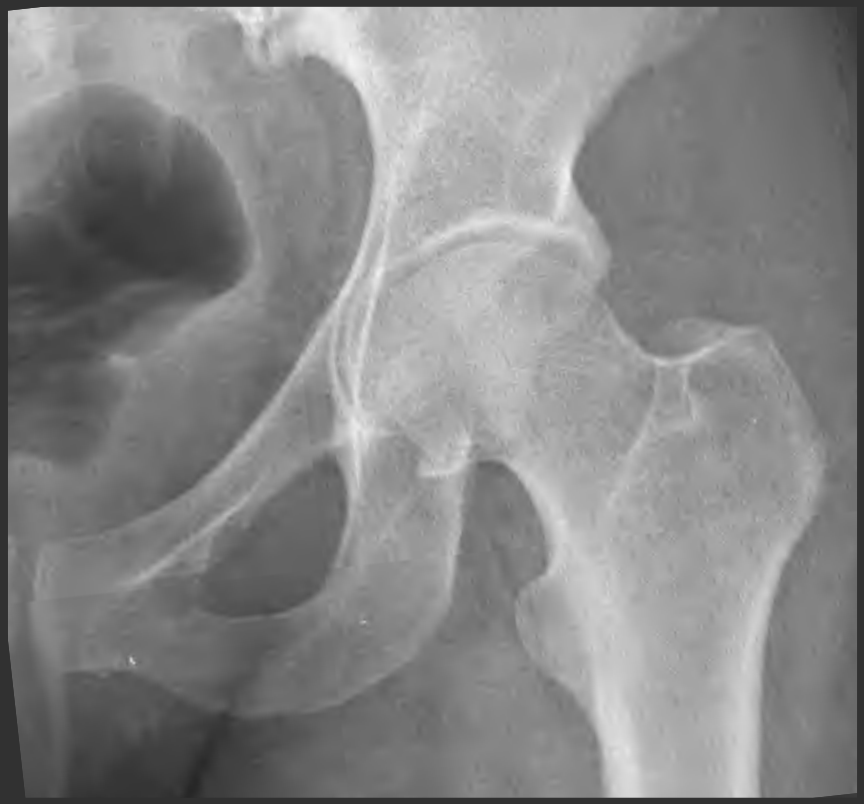

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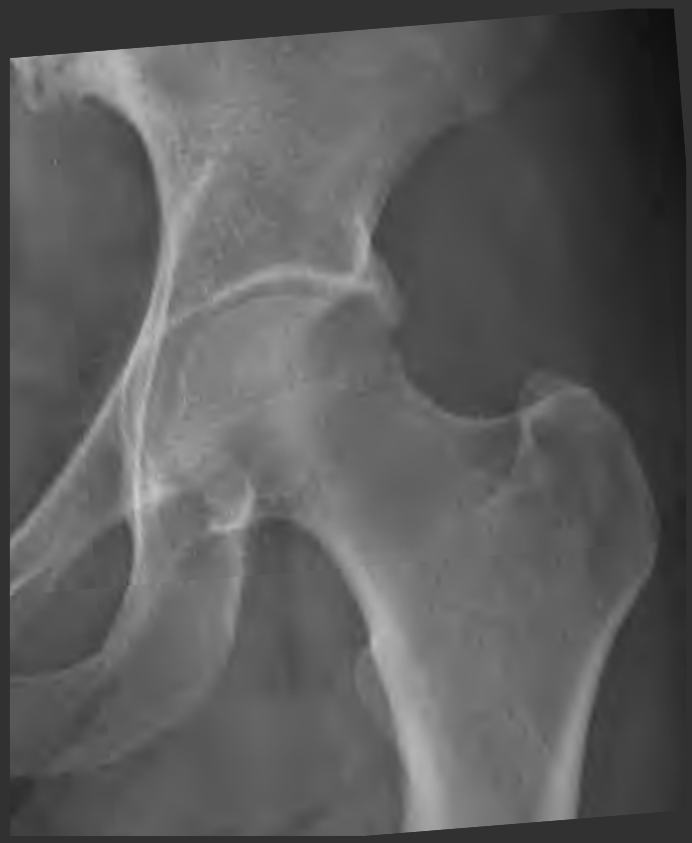
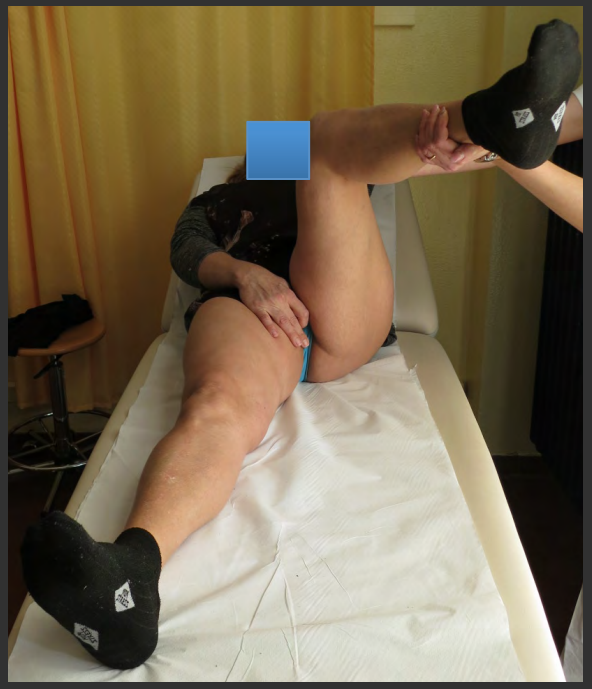
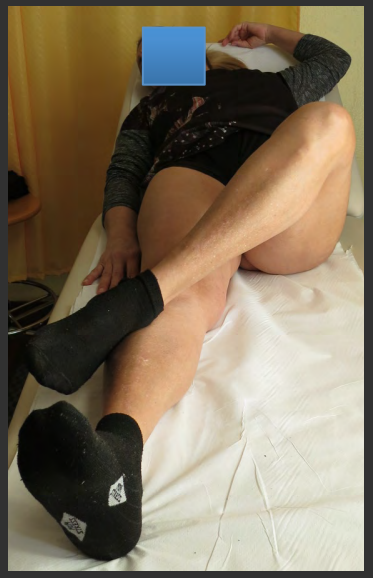
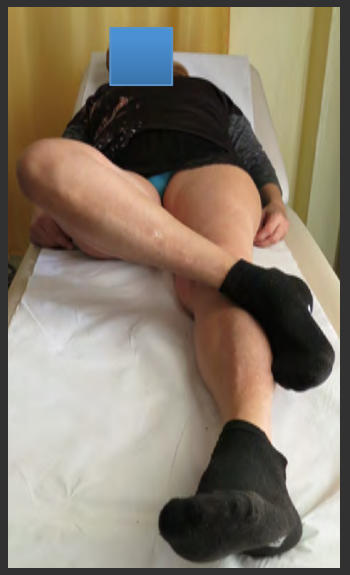
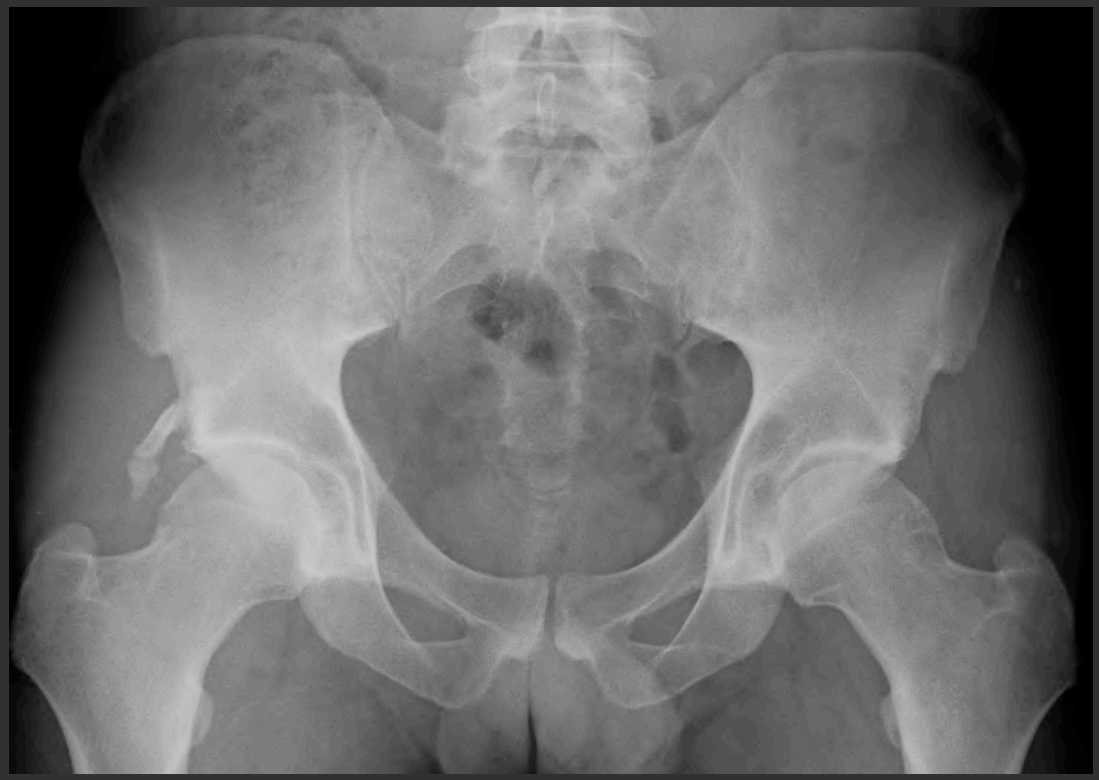


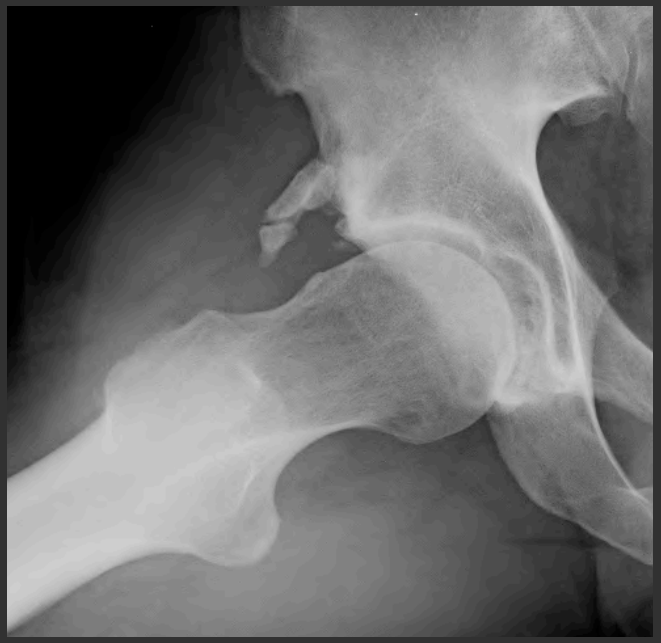
2 mesi post-op

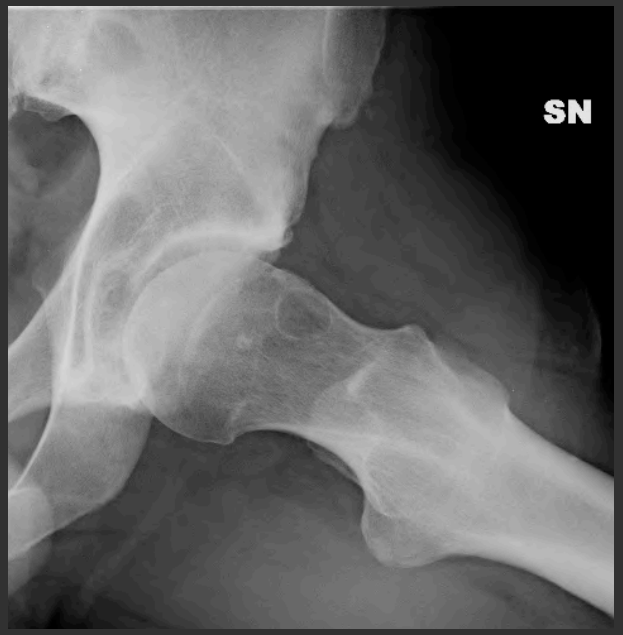


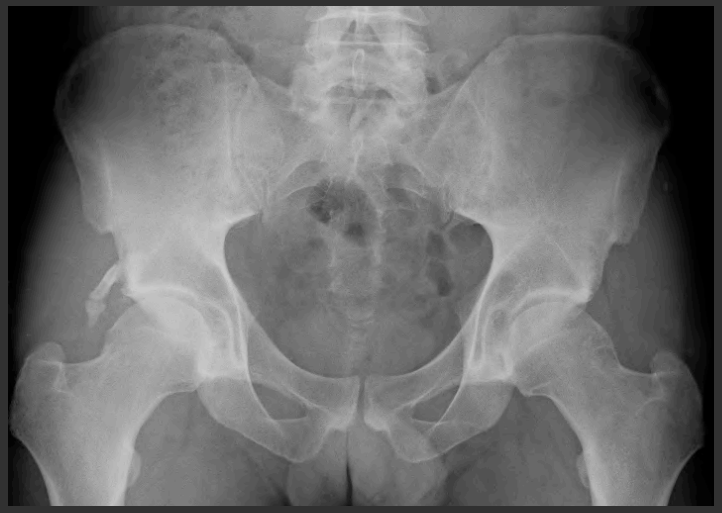
29/01/2015. Uomo 47 aa. Coxalgia inguinale DX da alcuni anni. Ciclismo (anche gare), sci. H 178 cm, 74 kg. Episodi saltuari di coxalgia SIN.

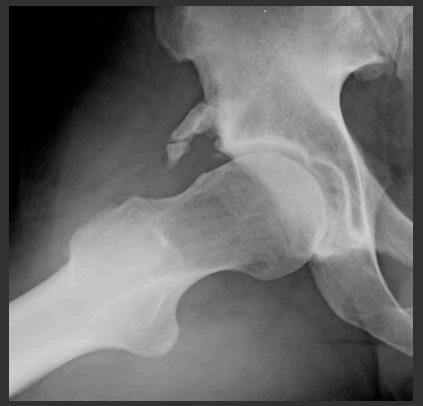


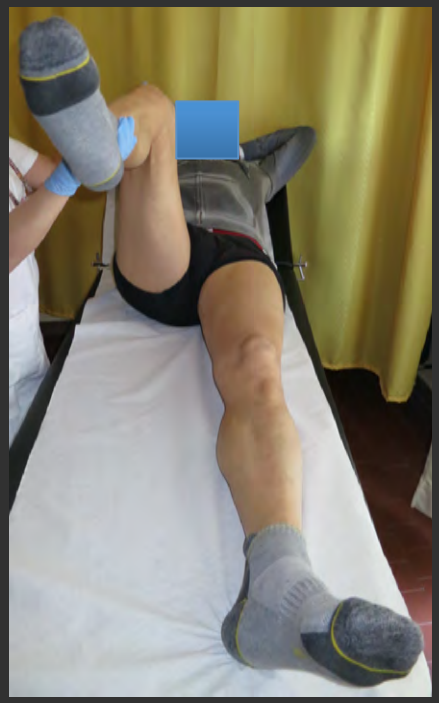


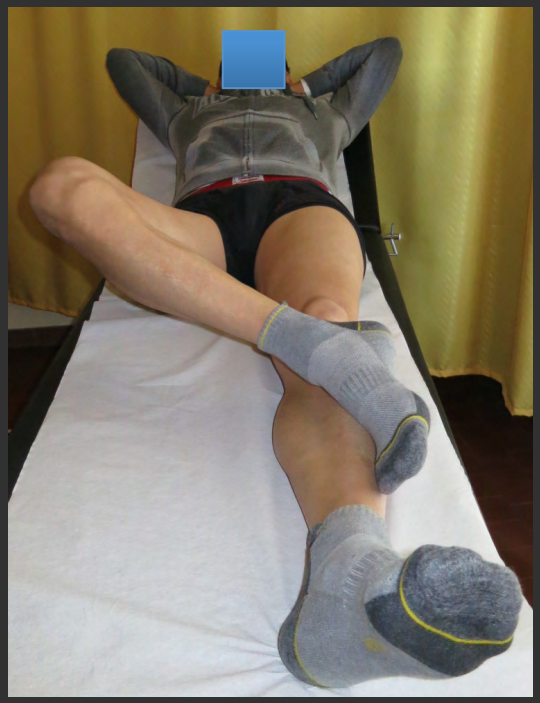


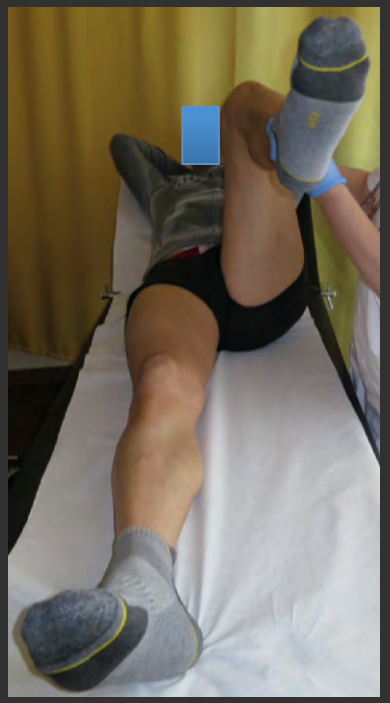
29/01/2015. Uomo 47 aa
ANCA DX: rotazioni non dolenti in supino; dolore inguinale in F.ADD.IR. No intrarotaz. a 90° di flessione. F.AB.ER. positivo. In prono: rotazioni simmetriche con modico dolore inguinale sia in intra che in extra.
Anca SIN: sovrapponibile ma non dolente.



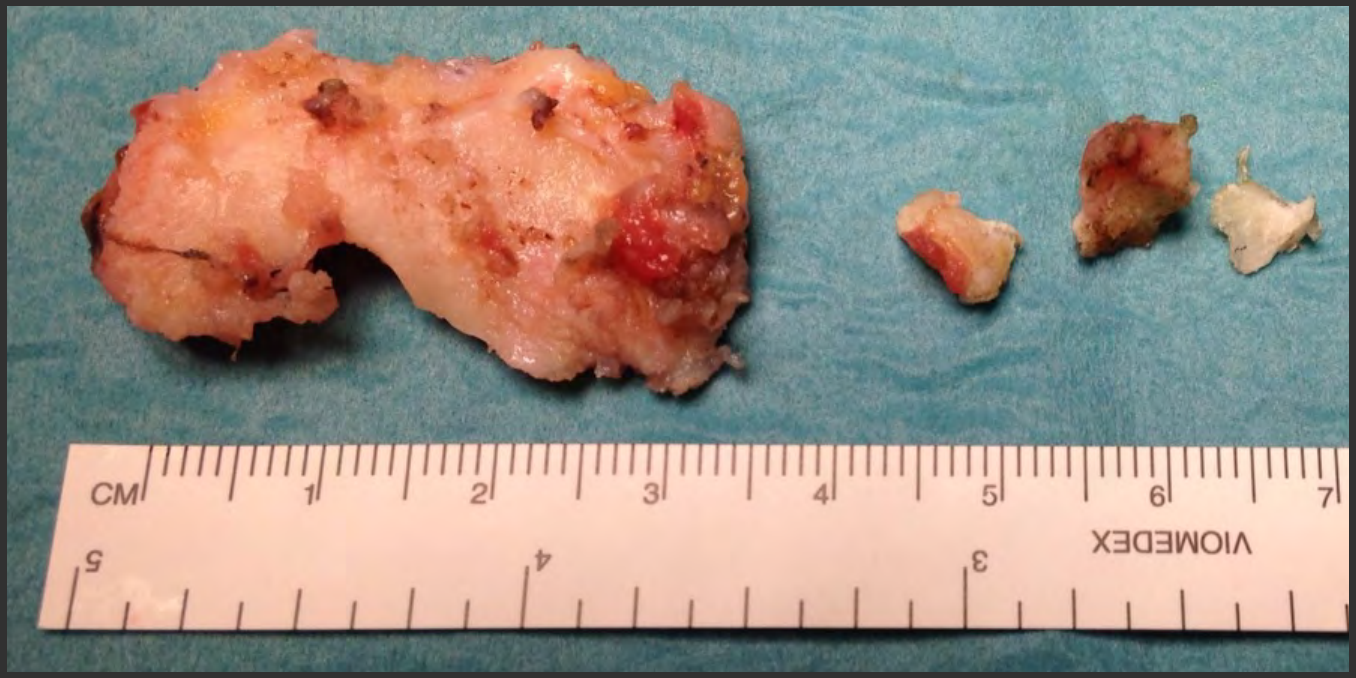




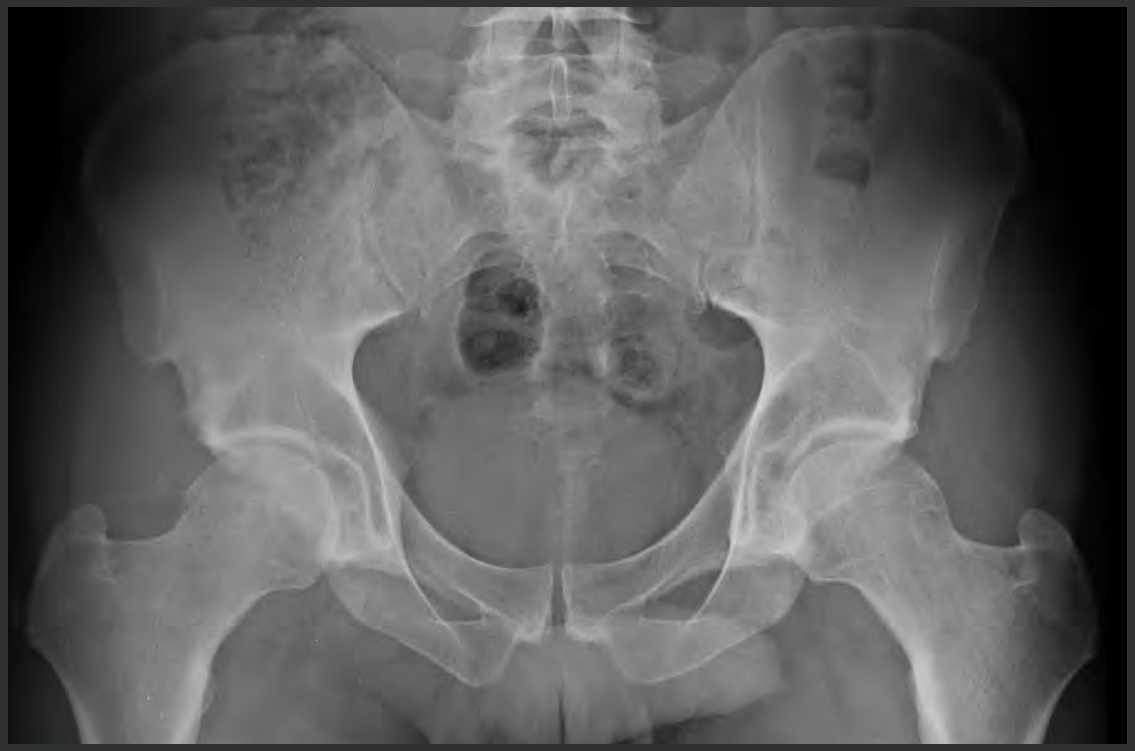


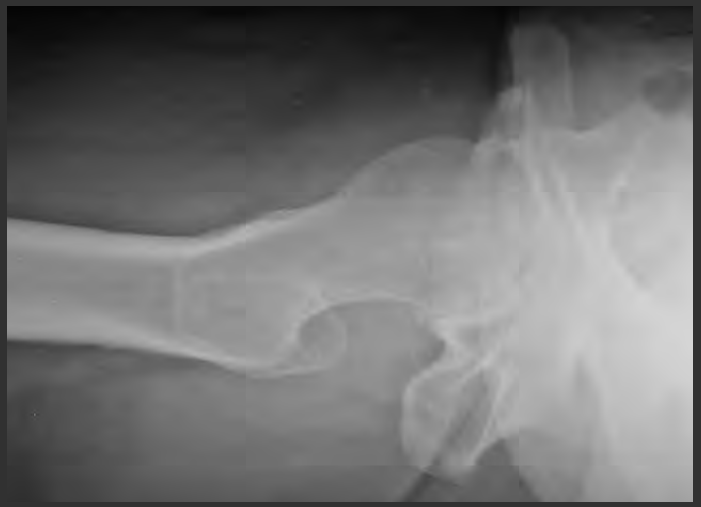


Intervento endoscopico 08/04/2015



Post-op





CONCLUSIONI

Deformità complesse sempre a cielo aperto?

- Esperienza del Chirurgo
- NO se trattabili come deformità semplici (pincer globale → pincer focale)

GRAZIE

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