

POSIZIONAMENTO E ACCESSI ARTROSCOPICI NELL'ANCA

E. SABETTA

ARTHRO  **meeting**
aggiornamenti in chirurgia artroscopica

anca

**Il ruolo
dell'artroscopia
nell'anca
dolorosa**

Catania - 24 settembre 2011

UNA Hotel Palace
via Etna, 218

Chairman
Angelo Di Giunta



*Struttura Complessa
Ortopedia e Traumatologia
Direttore: Ettore Sabetta
Arcispedale S. Maria Nuova
Reggio Emilia*

 **SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA**
Azienda Ospedaliera di Reggio Emilia

POSIZIONAMENTO

Dienst Michael

Positioning Traction & Distraction Portals Techniques / Indications

Supine or Lateral Position?



personal experience

ISAKOS 2007

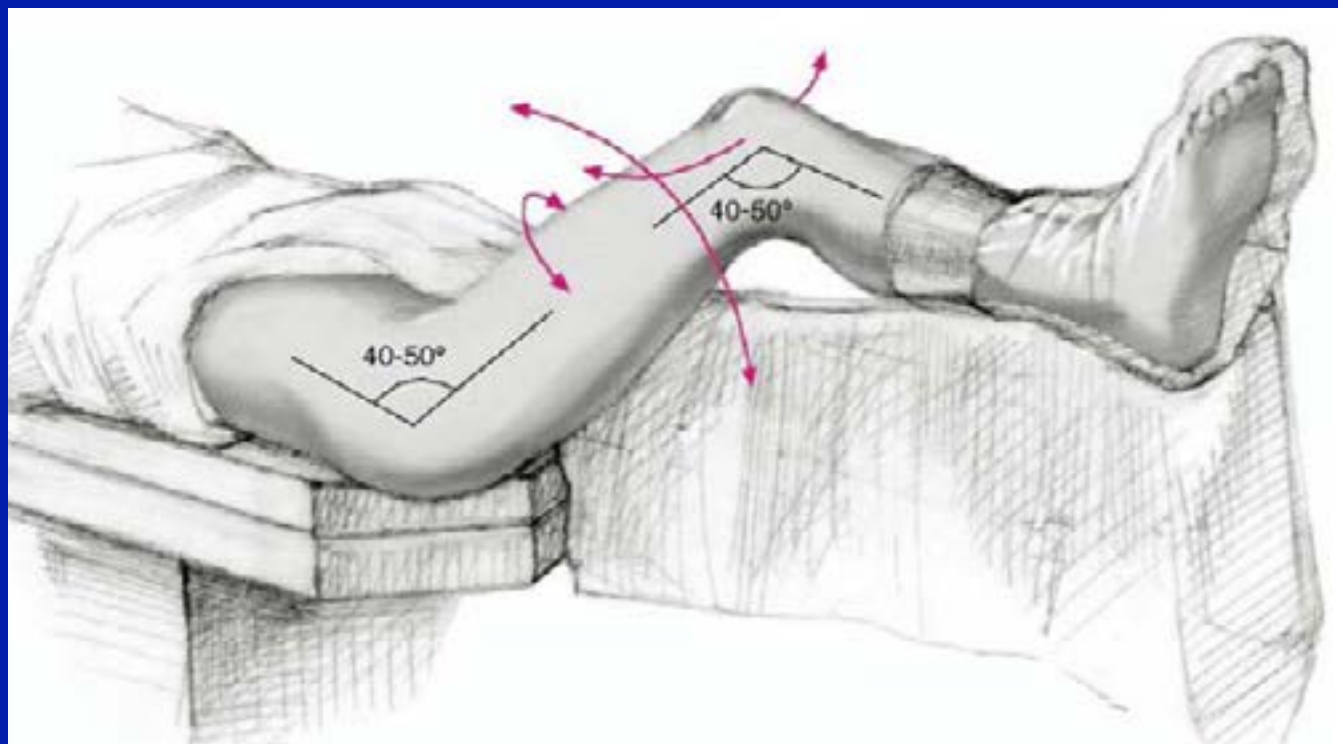
Dienst Michael

Positioning Traction & Distraction Portals Techniques / Indications

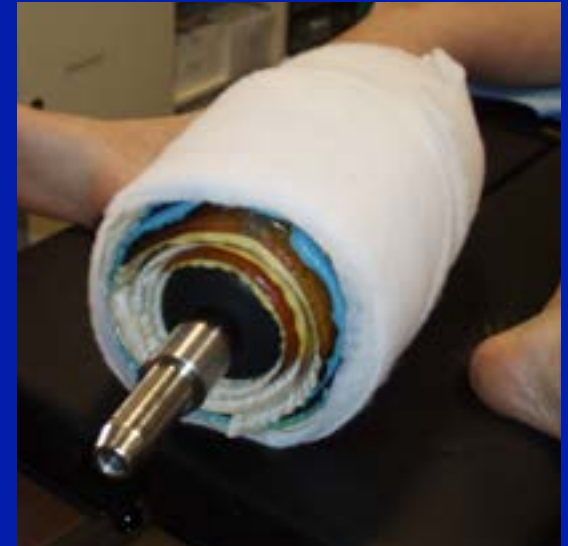
Supine or Lateral Position?

- **Supine**
 - Byrd, Nashville
 - Dorfmann/Boyer, Paris
 - Phillippon, Pittsburgh
 - Dienst, Homburg
- **Lateral**
 - Villar, Cambridge
 - Glick, San Francisco
 - McCarthy, Boston
 - Sadri, Geneva/Riaz (Ex Fix)

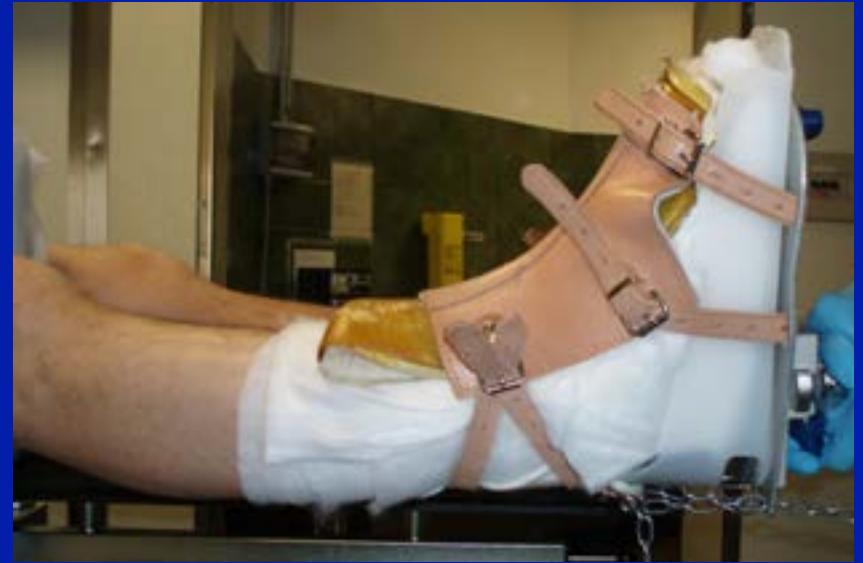
POSIZIONAMENTO



Perineal Post?



Imbottitura dei Piedi



POSIZIONAMENTO



POSIZIONAMENTO



POSIZIONAMENTO



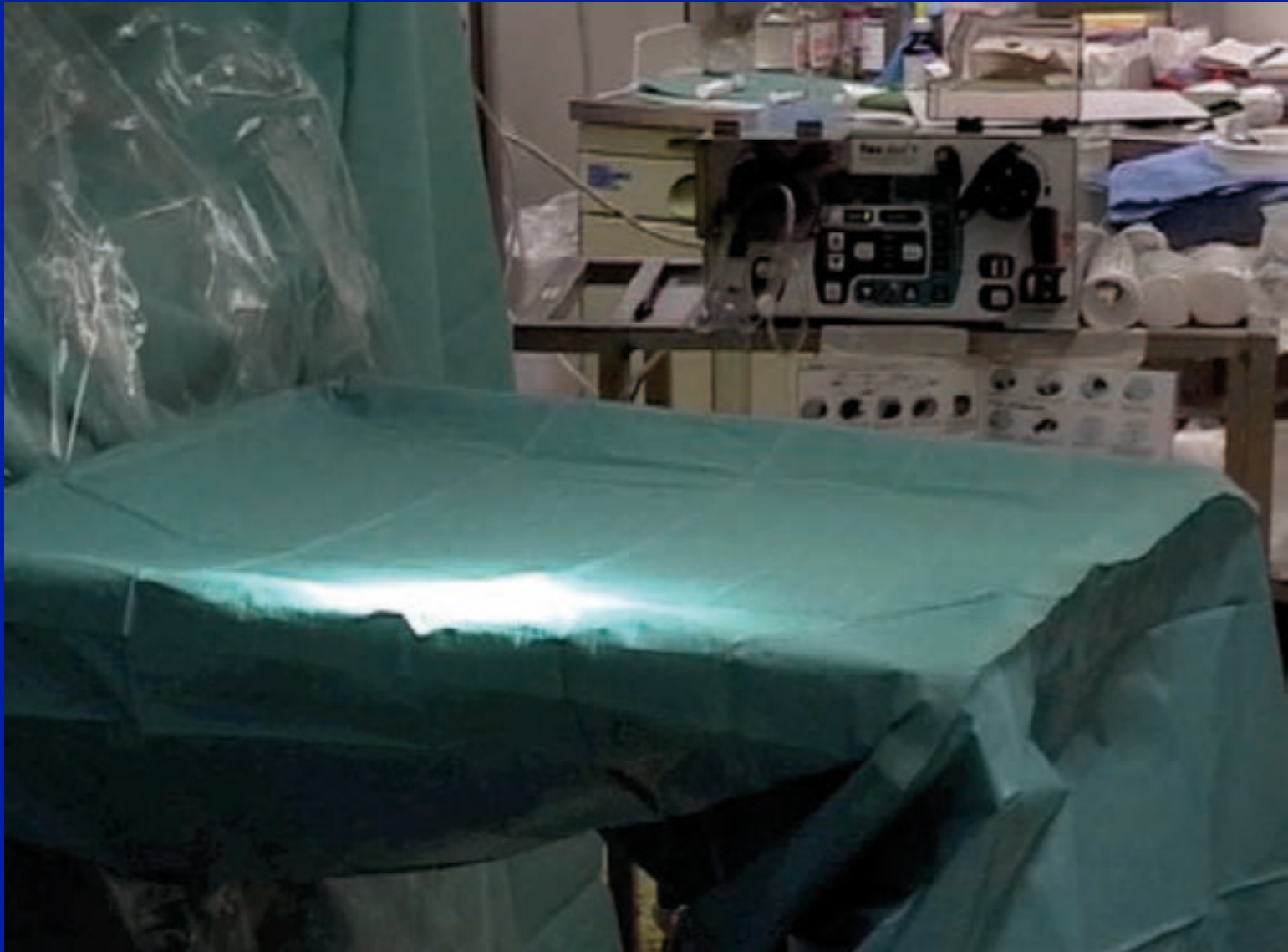
POSIZIONAMENTO



Campo Operatorio



Strumentario



Strumentario



Strumentario



Strumentario



⊙ 4,5-5-5,5

Strumentario



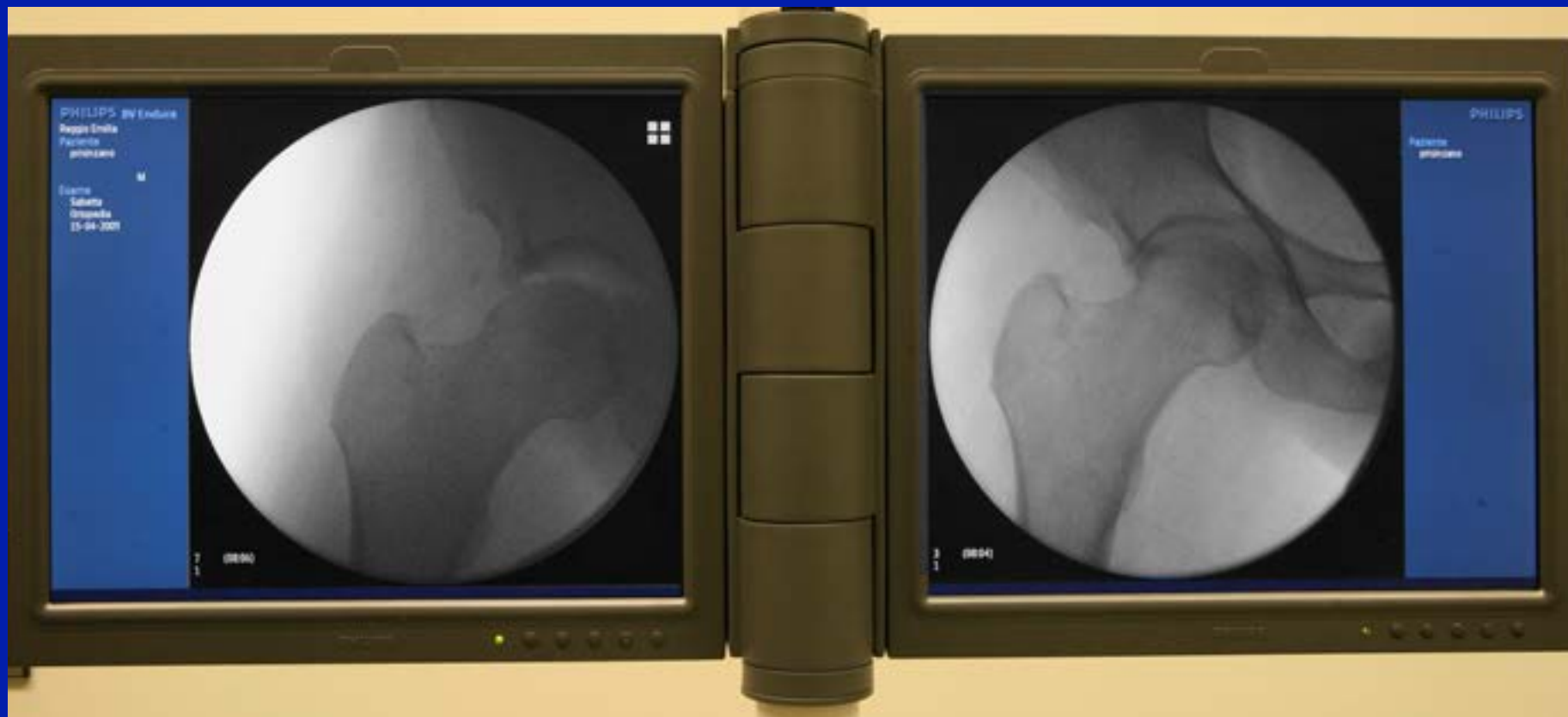
Strumentario



Trazione

- Rilassamento muscolare completo
- 25 – 40 kg (Dienst 2002)
- Gentile contro-trazione
- Limite massimo: 2 ore

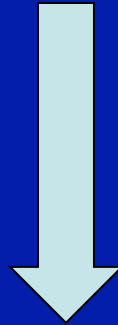
Trazione



- Visualizzare falce aria
- Distrazione minima 8-10 mm

Trazione

- Trazione “massima” per il primo portale artroscopico
- Ridurre la trazione dopo 15 min circa (fisiologico cedimento della resistenza dei tessuti)
- Alternare le procedure in trazione con quelle senza trazione

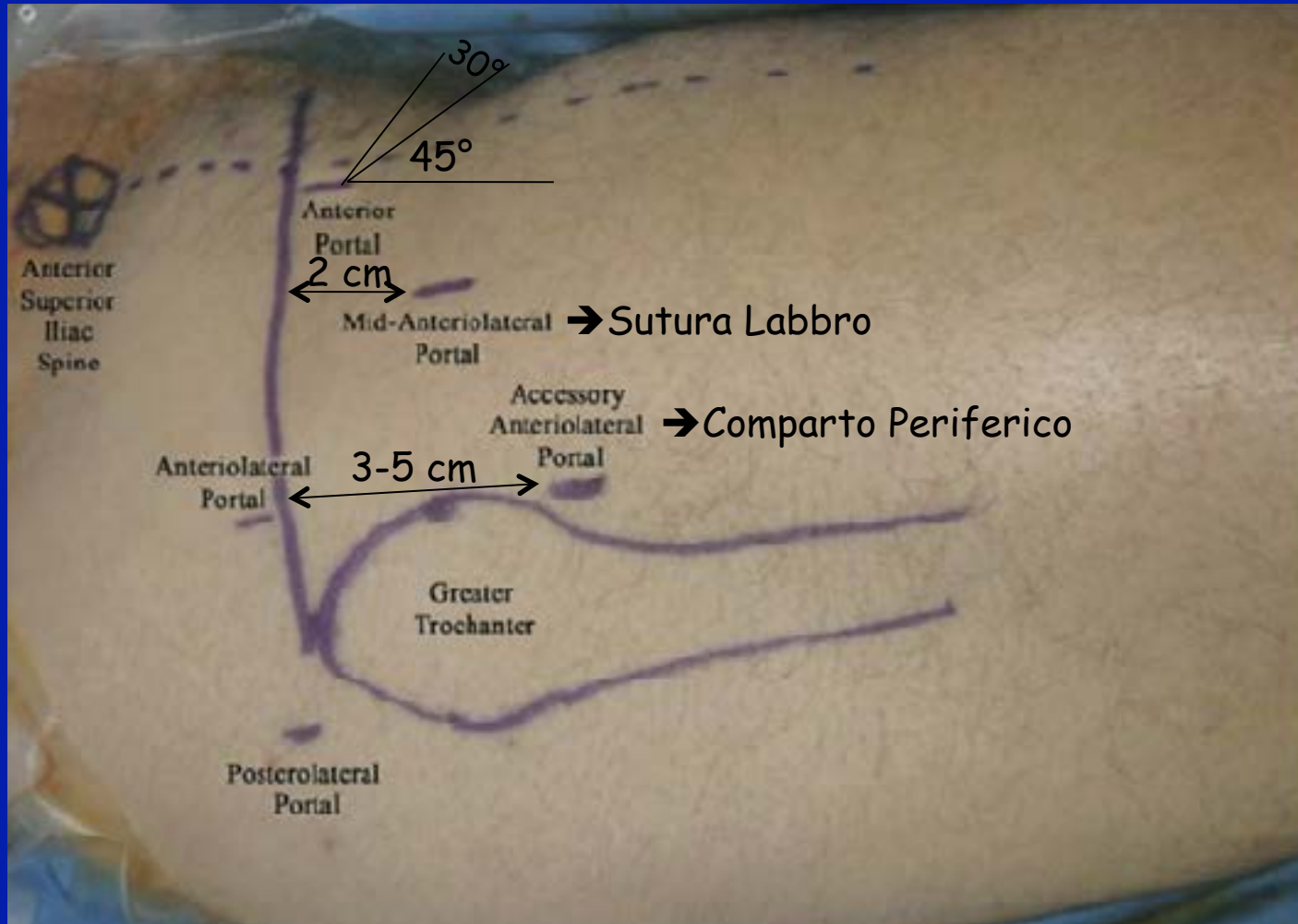


RIDUZIONE RISCHIO COMPLICAZIONI DA TRAZIONE

Amplificatore Brillanza - Monitor - Schermo RX

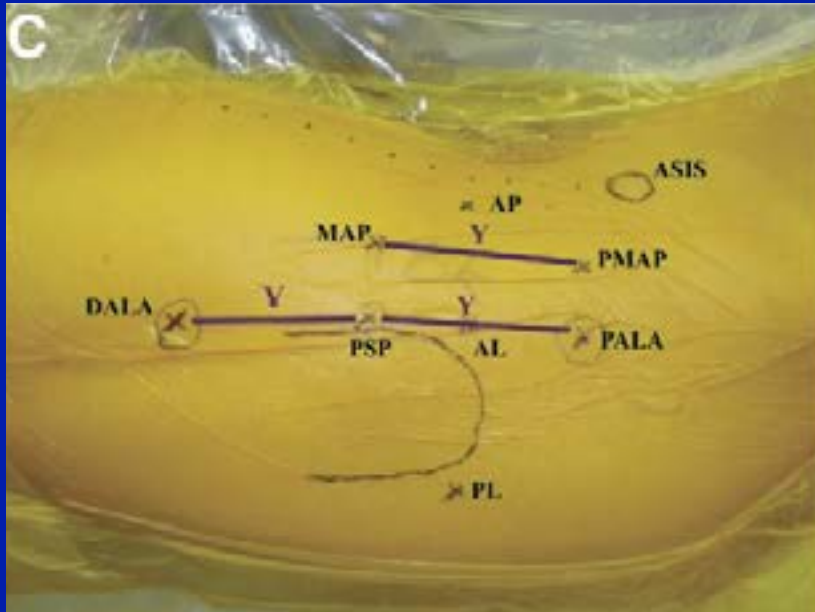
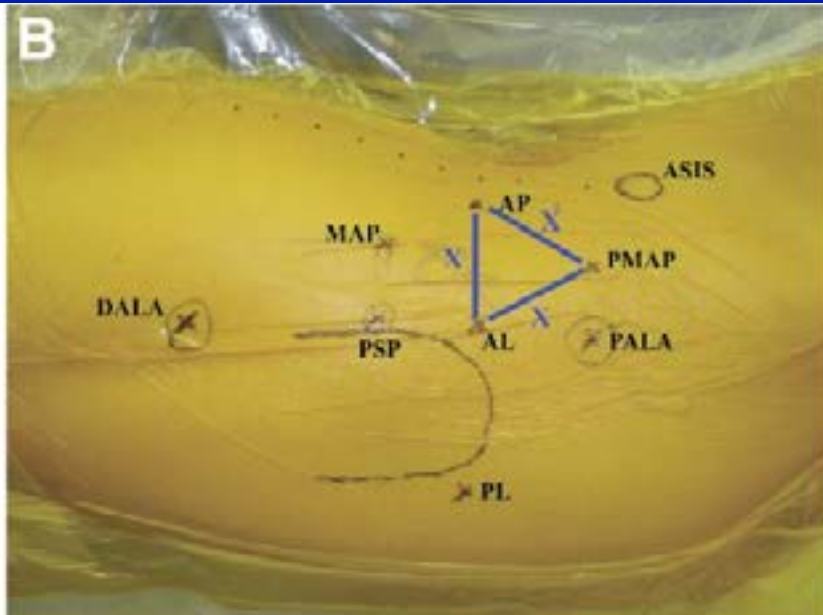
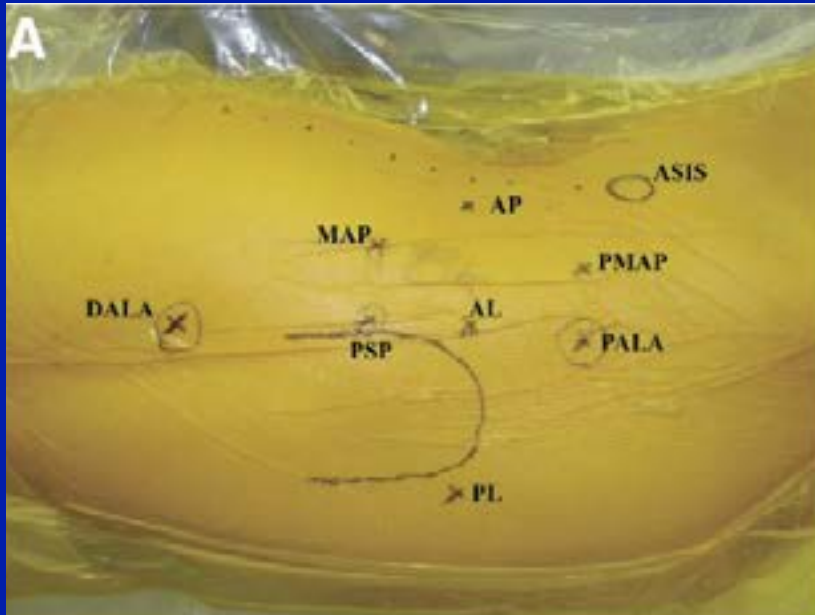


PORTALI ARTROSCOPICI



Bond et al. 2009

PORTALI ARTROSCOPICI (8 incisioni \ 11 accessi)



MAP= mid-anterior

PMAP= proximal mid-anterior

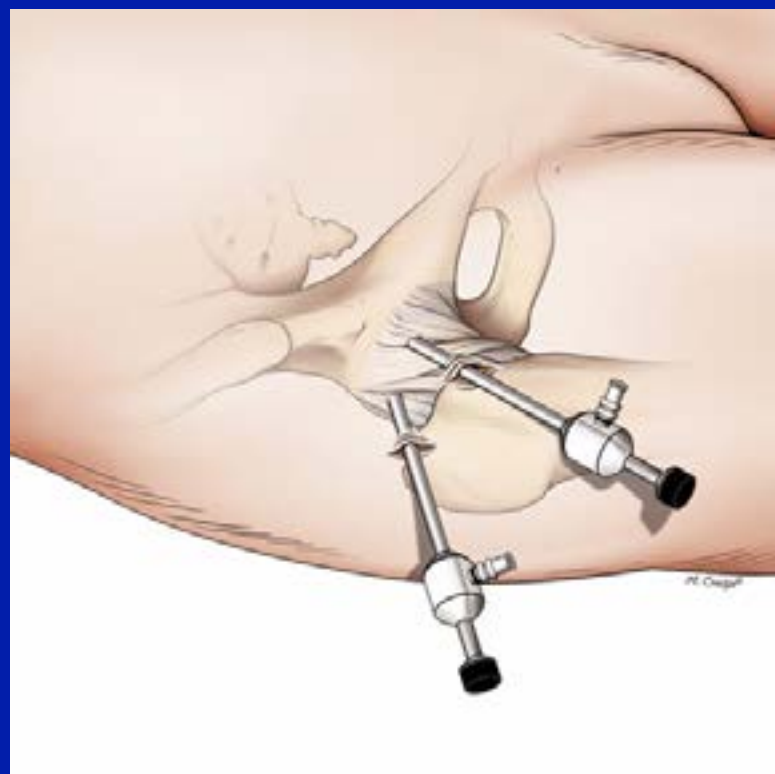
Accessi Spazio Peritrocanterico:

PALA= proximal AL accessory (post a PMAP)

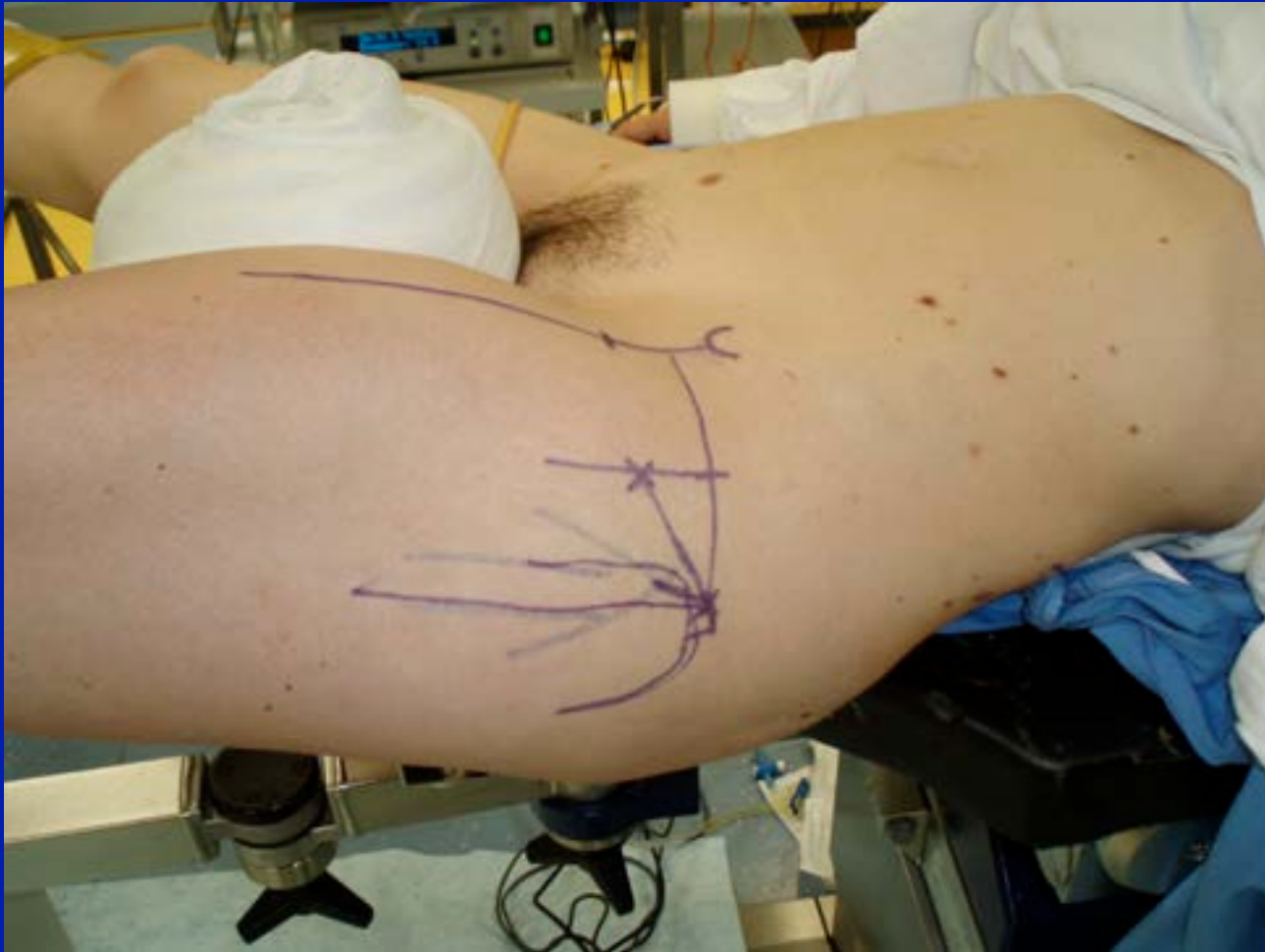
PSP= peritrochanteric

DALA= distal AL accessory

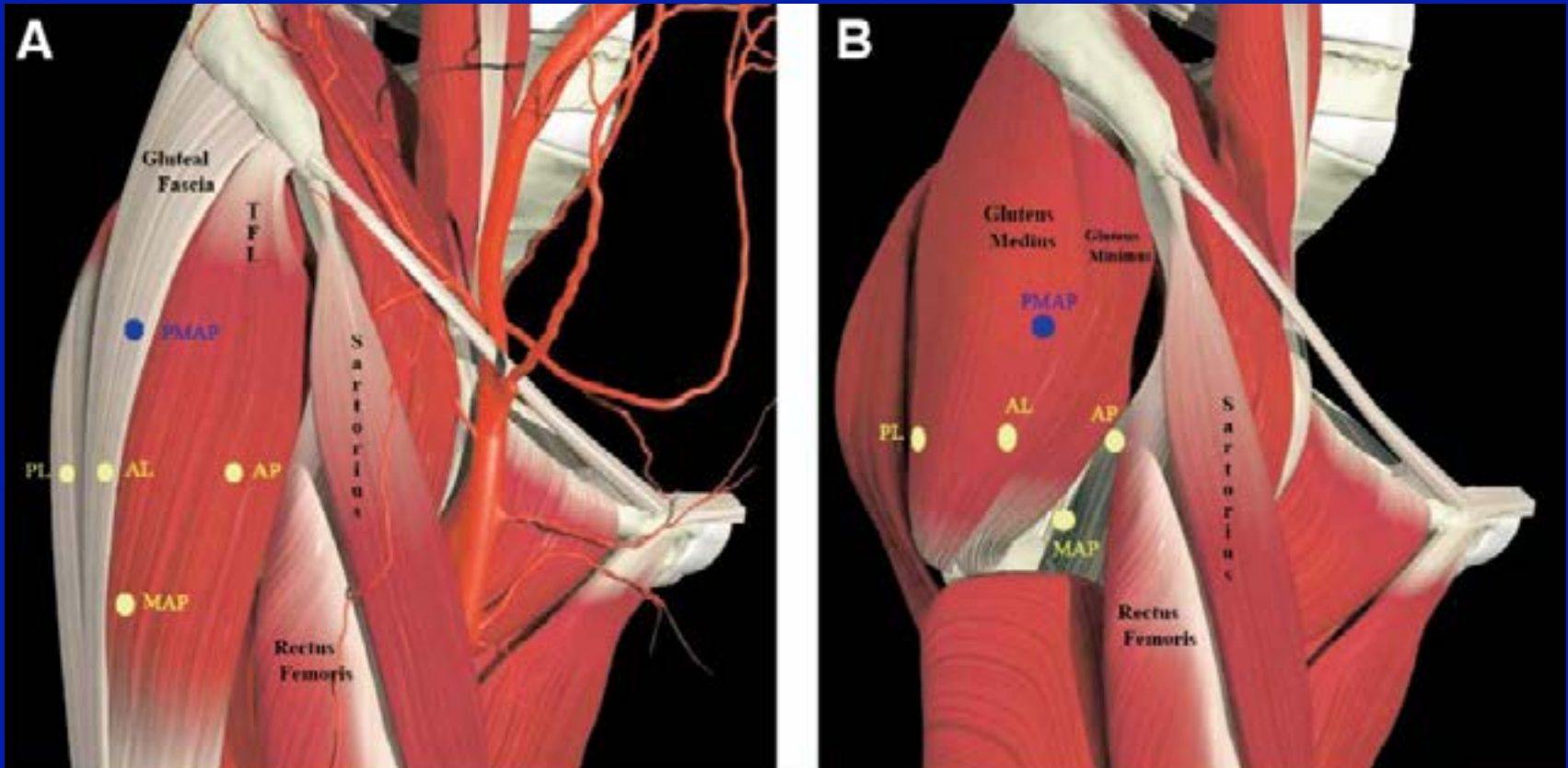
Robertson, Kelly, 2008



PORTALI ARTROSCOPICI

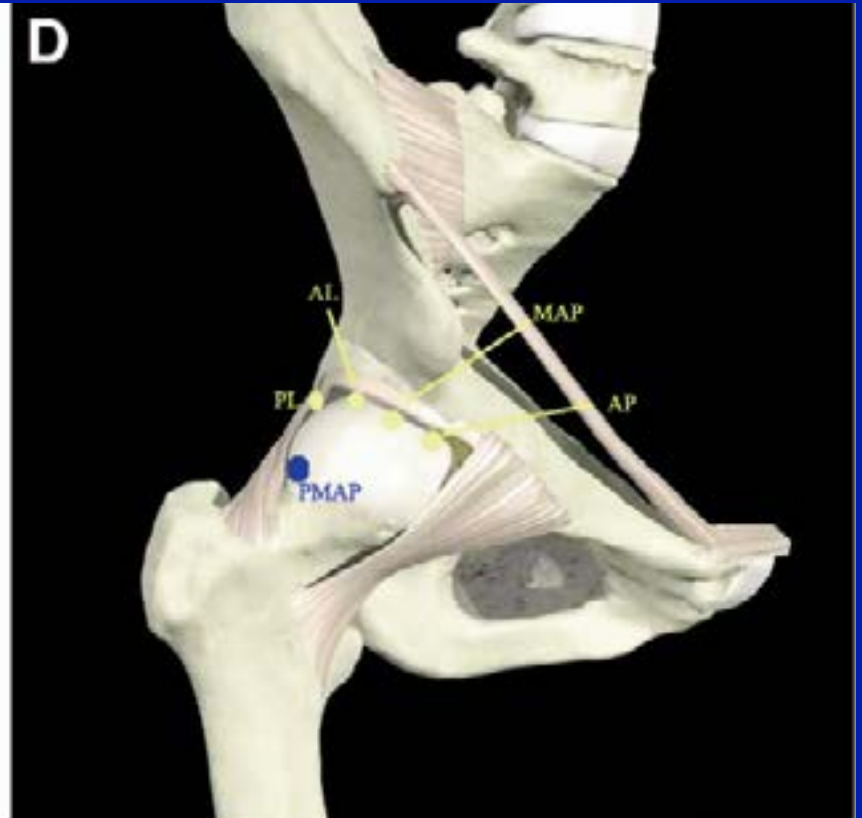
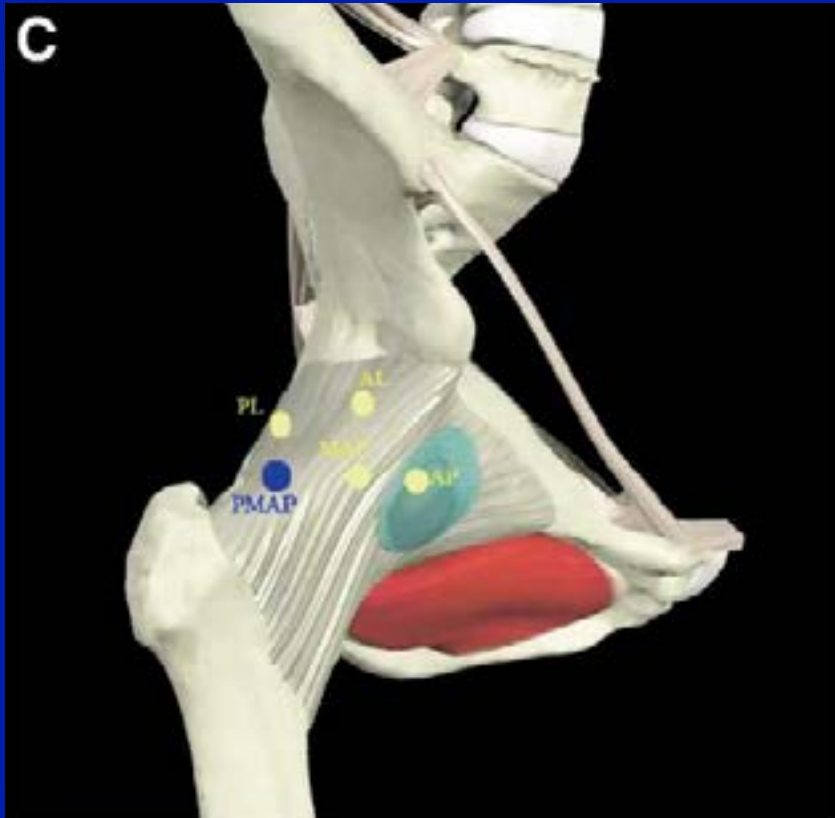


PORTALI ARTROSCOPICI



Robertson, Kelly, 2008

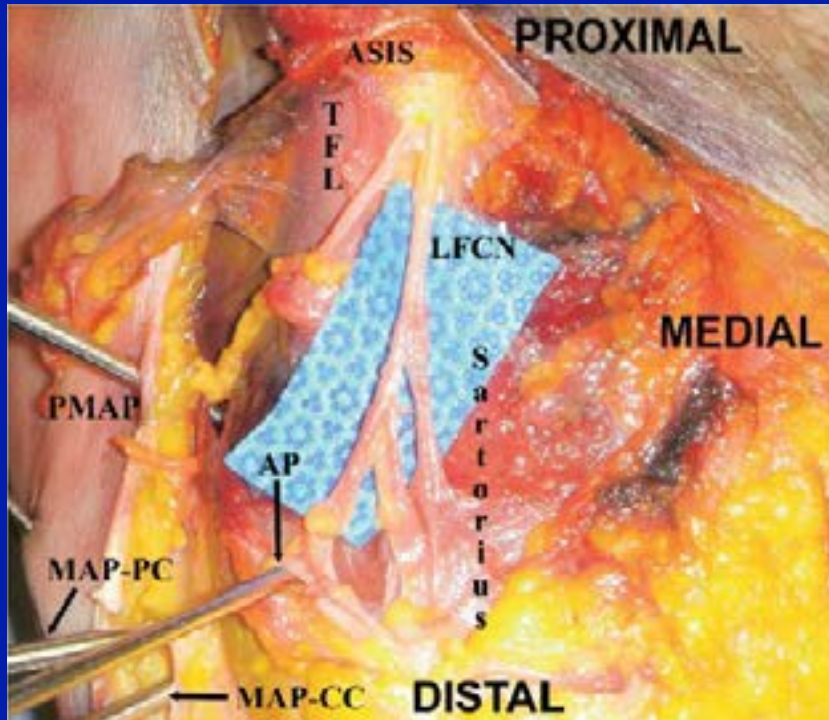
PORTALI ARTROSCOPICI



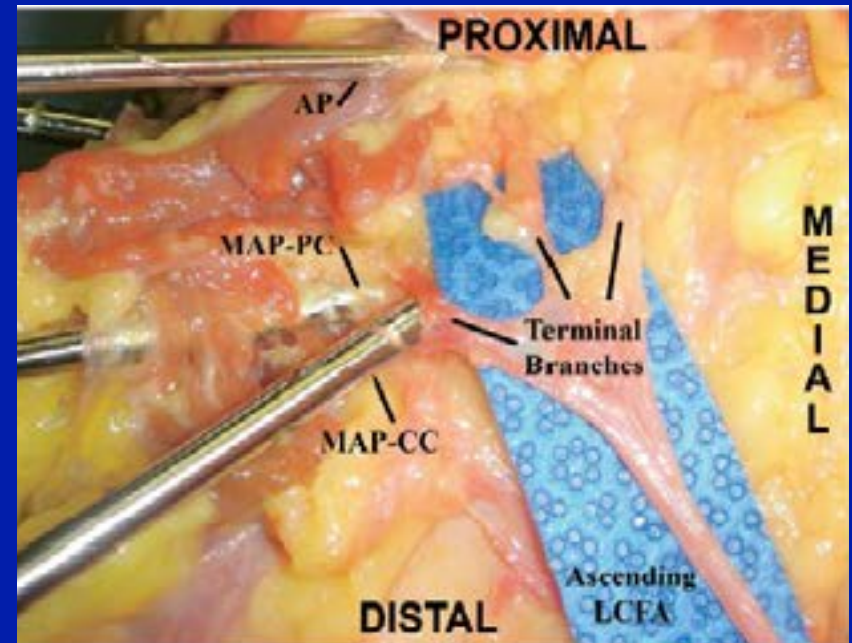
Robertson, Kelly, 2008

PORTALI ARTROSCOPICI

Anca DX



Anca DX



TFL = m. tensore fascia lata
LFCN = n. femoro-cutaneo laterale
LCFA = a. circonflexa laterale femore

Robertson, Kelly, 2008

PORTALI ARTROSCOPICI

TABLE 1. Results of Central and Peripheral Compartment Portals

Portal	Approximate Portal Insertion Angle	Anatomic Structure	Distance (mm)		
			Mean	SD	Range
Central compartment					
AP	35° Cephalad, 35° posterior	LFCN	15.4	9.7	1-28
		Femoral nerve at sartorius	54.3	10.5	40-73
		Femoral nerve at rectus femoris	45.4	11.7	34-71
		Femoral nerve at capsule	35.4	10.2	18-52
		Ascending LCFA	31.0	13.1	13-53
		Terminal branch of ascending LCFA	14.7	11.1	2-33
AL	15° Cephalad, 15° posterior	Superior gluteal nerve	64.1	13.1	39-81
		Sciatic nerve	40.2	8.0	31-51
MAP	35° Cephalad, 25° posterior	LFCN	25.2	9.3	9-38
		Femoral nerve at sartorius	63.8	13.8	46-87
		Femoral nerve at rectus femoris	53.0	15.1	35-85
		Femoral nerve at capsule	39.9	9.2	26-54
		Ascending LCFA	19.2	11.2	5-42
		Terminal branch of ascending LCFA	10.1	8.2	1-23
PL	5° Cephalad, 5° anterior	Sciatic nerve	21.8	8.9	11-38
Peripheral compartment					
AL	15° Caudad, 5° posterior	Superior gluteal nerve	69.4	11.0	52-85
		Sciatic nerve	57.7	12.2	38-66
MAP	15° Cephalad, 20° posterior	LFCN	30.2	11.1	7-47
		Femoral nerve at sartorius	70.0	14.3	51-93
		Femoral nerve at rectus femoris	57.0	15.8	35-85
		Femoral nerve at capsule	39.4	11.5	18-57
		Ascending LCFA	21.0	12.3	5-41
		Terminal branch of ascending LCFA	14.7	10.8	1-30
PMAP	40° Caudad, 25° posterior	Superior gluteal nerve	50.3	7.4	35-59
		Sciatic nerve	58.4	9.3	49-83
PL	25° Caudad, 15° anterior	Sciatic nerve	33.6	9.7	17-50

PORTALI ARTROSCOPICI

The Risk of Vascular Injury to the Femoral Head When Using the Posterolateral Arthroscopy Portal: Cadaveric Investigation

Patrick S. Sussmann, M.D., Matthias Zumstein, M.D., Frederik Hahn, M.D.,
and Claudio Dora, M.D.

2007



Accesso P.L.



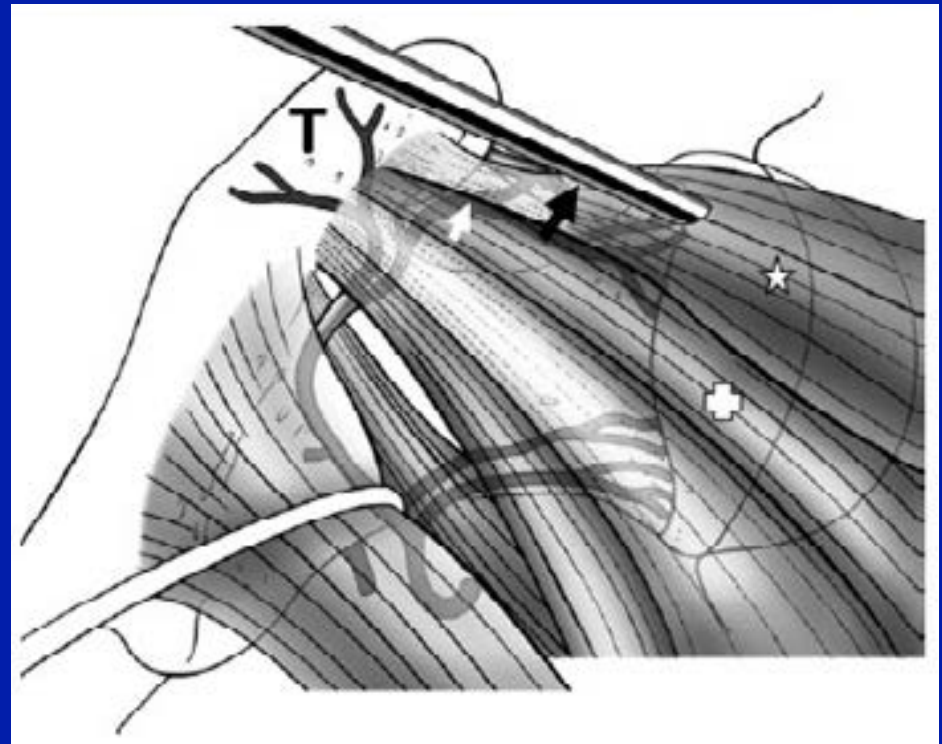
Branca profonda MFCA



M.M. Gemelli



M. Piriforme



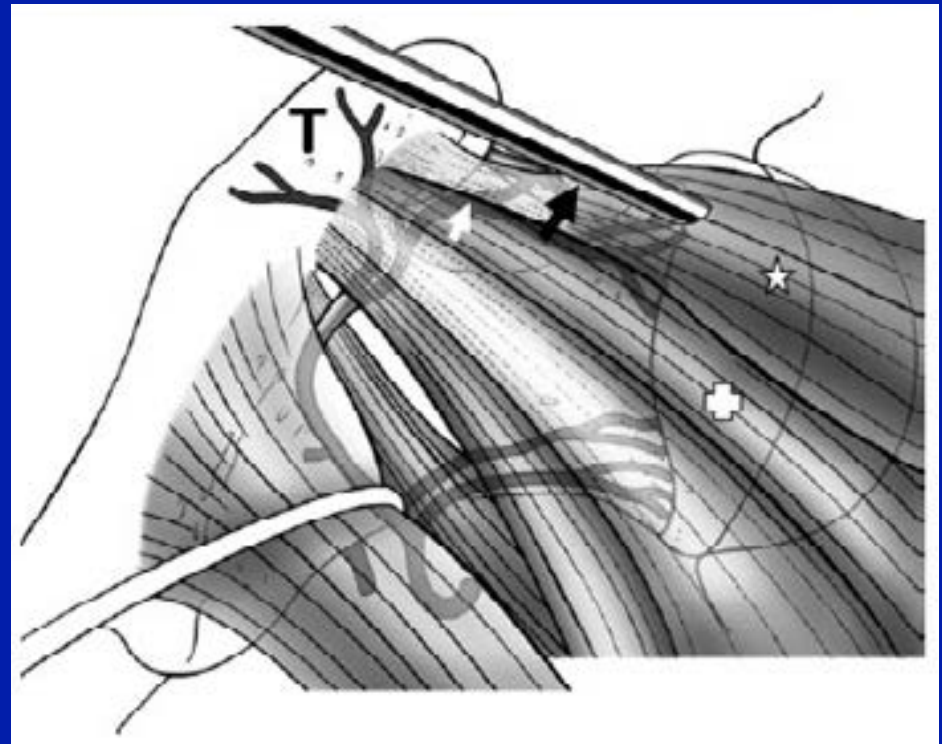
PORTALI ARTROSCOPICI

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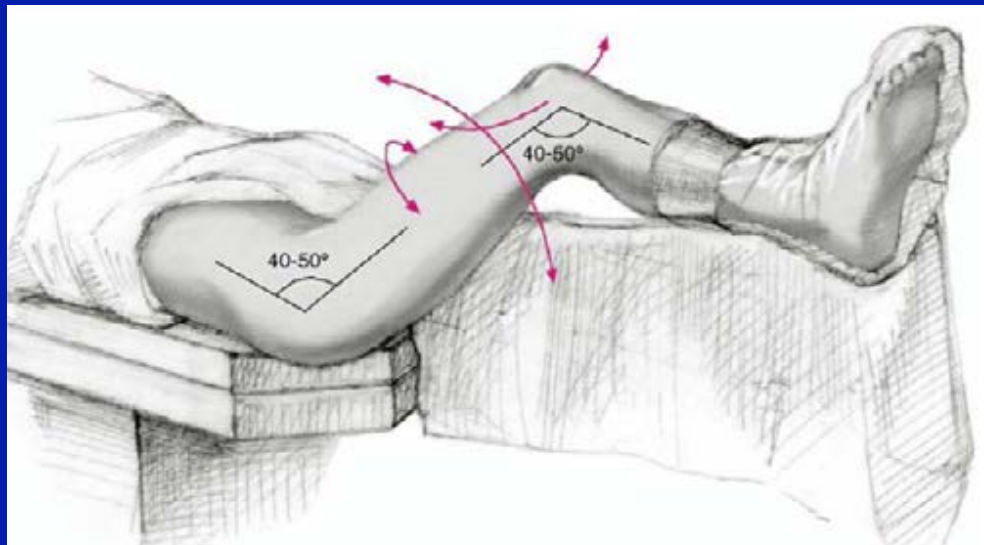
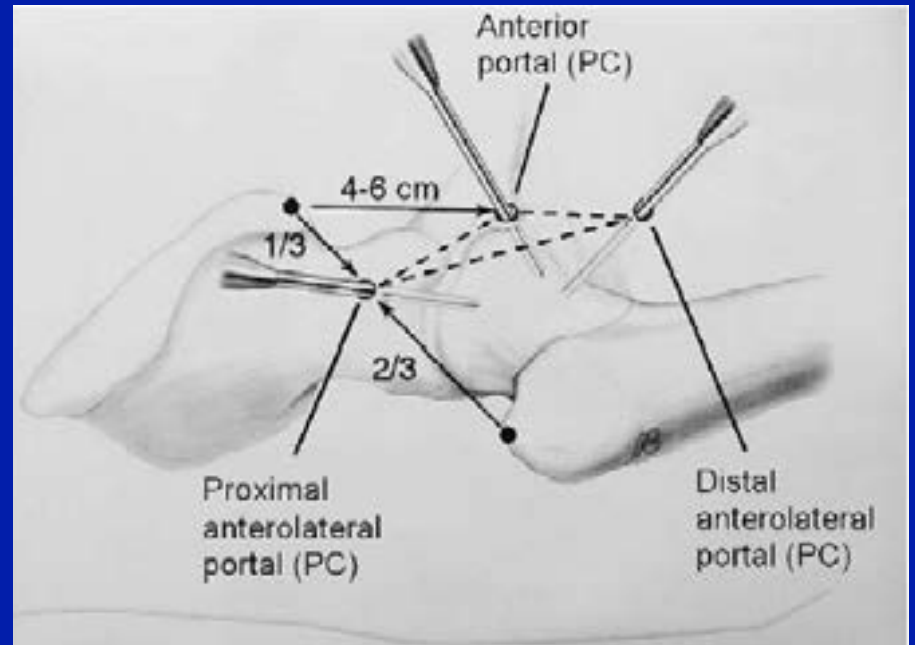
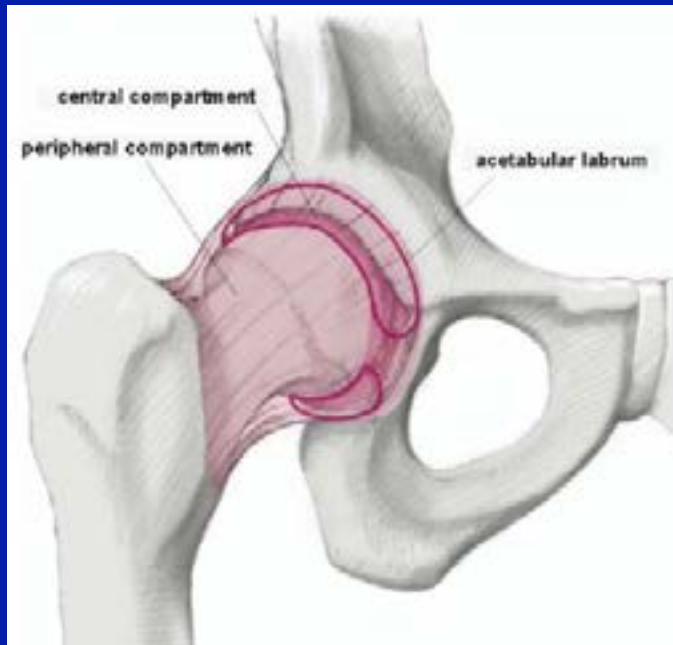
Patrick S. Sussmann, M.D., Matthias Zumstein, M.D., Frederik Hahn, M.D.,
and Claudio Dora, M.D.

2007

- Distanza media 10.1 mm
(range 3 - 15 mm)
(deviazione standard 4.4 mm)
- Protezione gran trocantere
(se l'accesso è tangente)
- Distanza n. sciatico 3 cm.

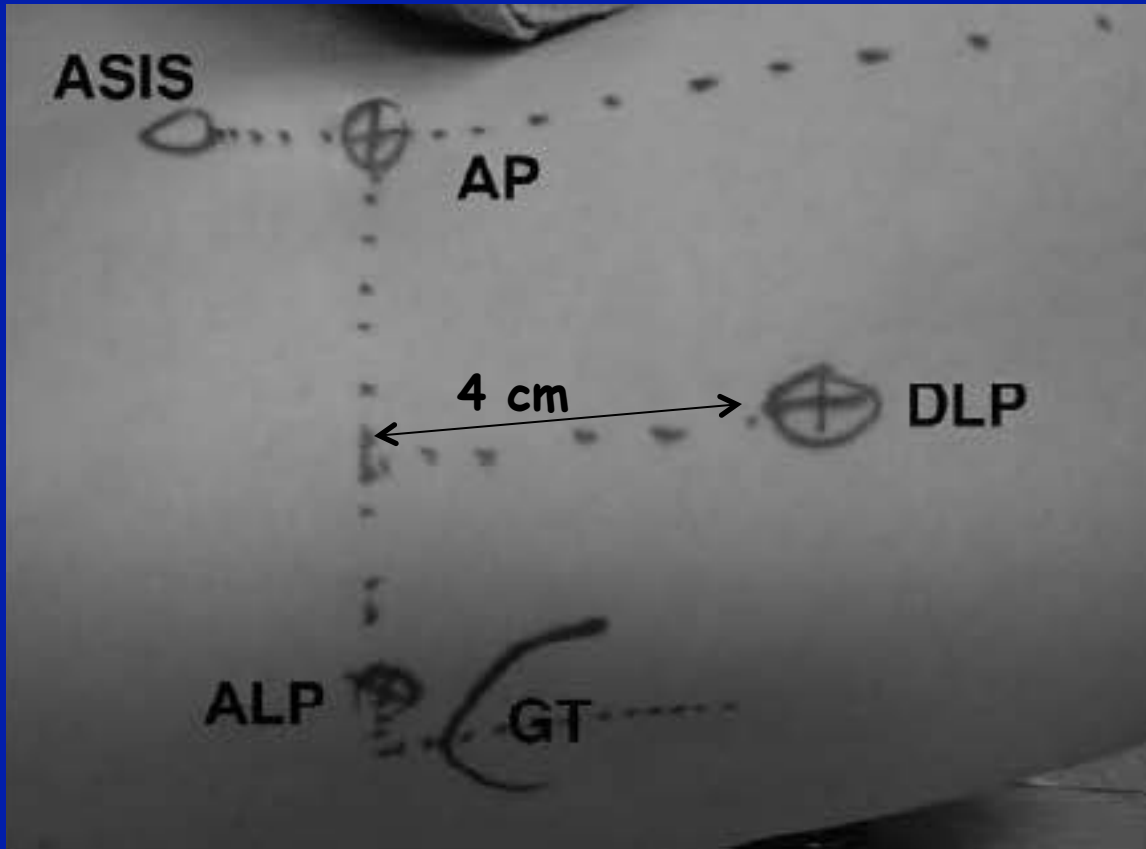


PORTALI ARTROSCOPICI (comparto periferico)



Wettstein, Dienst, 2005

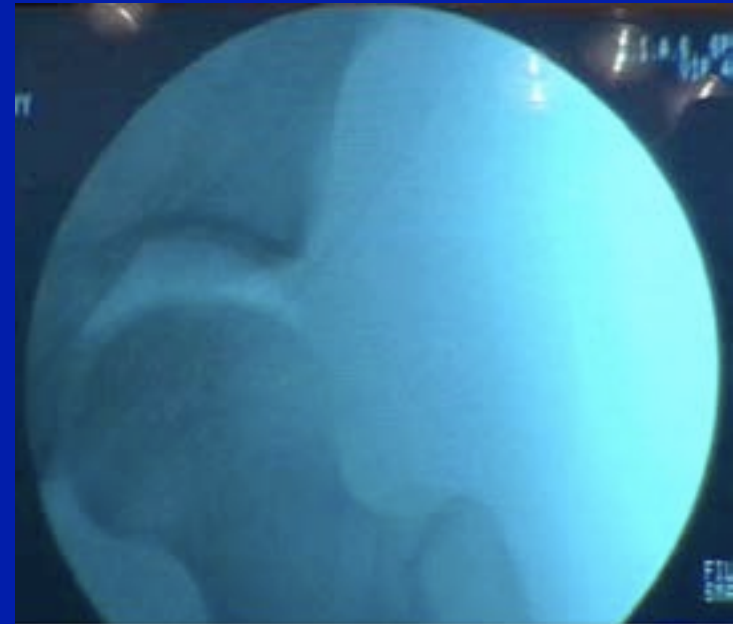
PORTALI ARTROSCOPICI (sutura del labbro)



Kelly et al. 2005

PORTALI ARTROSCOPICI

Effetto Halo



Technical Note

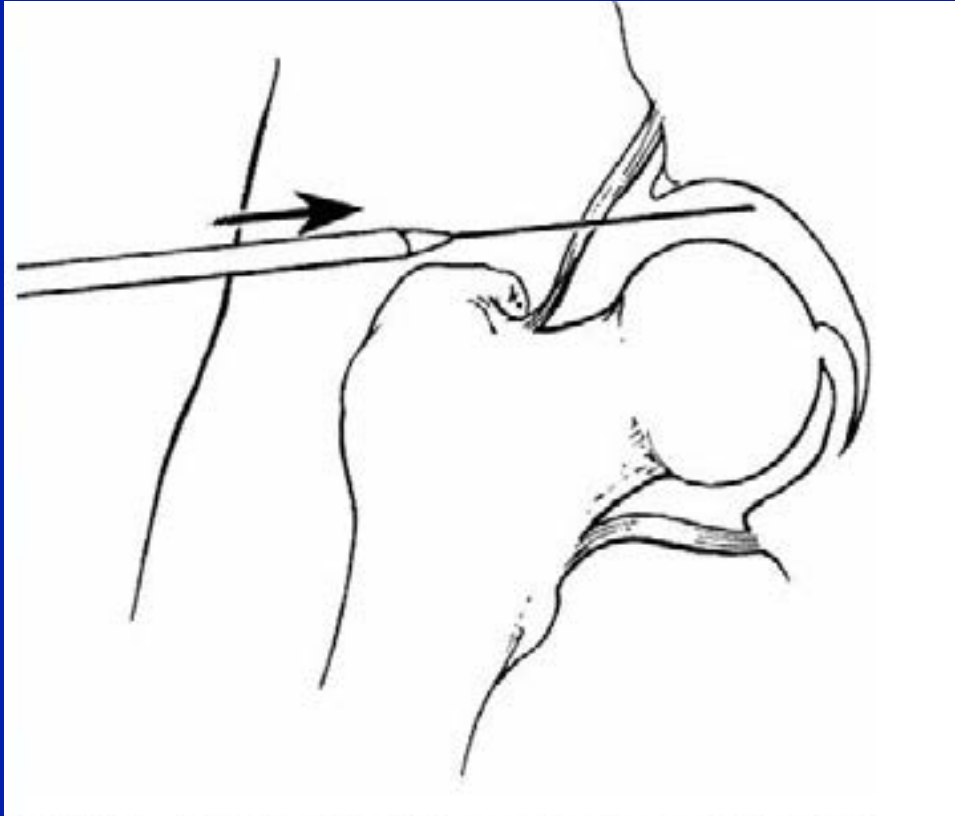
Avoiding the Labrum in Hip Arthroscopy

J. W. Thomas Byrd, M.D.

2000

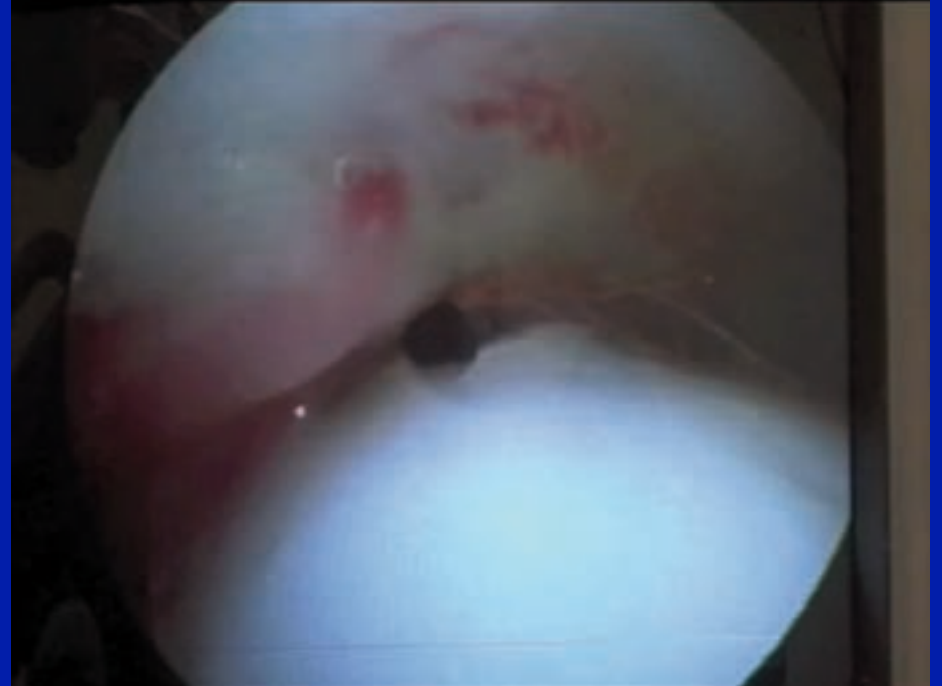
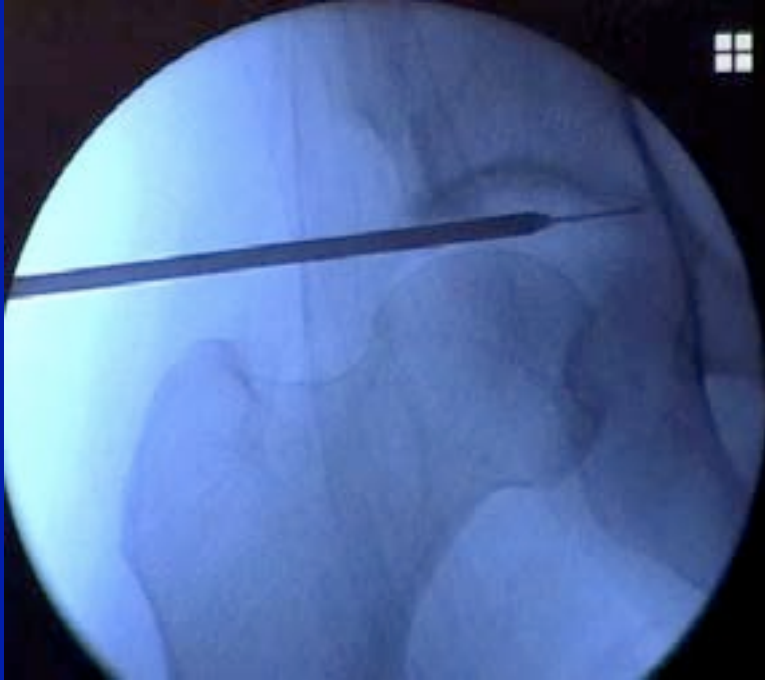
Summary: Iatrogenic joint damage is a potential complication of any arthroscopic procedure. The anatomic constraints of the hip cause particular concern. The greatest risks are perforation of the acetabular labrum and scuffing of the articular surface. Careful attention to the details of the technique described can reduce the likelihood of this problem. With current technology, some occasional damage is unavoidable. However, all steps should be taken to minimize the likelihood and magnitude of such occurrences. **Key Words:** Hip Arthroscopy—Complications—Acetabular labrum—Articular cartilage.

Lesioni iatrogene intra-articolari



Byrd, 2000

Lesioni iatrogene intra-articolari



CONCLUSIONI

- Posizionamento supino → più confortevole per il paziente
 - preferito dall'Anestesista
 - più agevoli le manovre dinamiche
 - più semplice il controllo RX
- Imbottiture
- Anestesia (rilassamento muscolare)
- Portali Antero-Laterale e Anteriore Medio (Postero-Laterale)
- Adrenalina nelle sacche di infusione
- Capsulectomia anteriore parziale nella chirurgia del FAI
- Lesioni iatrogene

GRAZIE