# Role Of Diagnostic Imaging in Evaluation Of Total Hip Arthroplasty

Essay
Submitted for Partial Fulfillment of
Master degree in Radiodiagnosis

#### By Hatem Mohamed Taha M.B.,B.Ch.

# Supervised By Prof. Dr. Marwa Ibrahim Fahmy

Professor of Radiodiagnosis
Faculty of Medicine
Ain Shams University

#### Dr. Remon Zaher Elia

Lecturer of Radiodiagnosis
Faculty of Medicine
Ain Shams University

Radiodiagnosis Department Faculty of Medicine Ain Shams University 2014



First and foremost, thanks to Allah, to whom I relate any success in achieving any work in my life. I wish to express my deepest thanks, gratitude and appreciation to Prof. Dr. Marwa Ibrahim Fahmy, Professor of Radiodiagnosis, Faculty of medecin -Ain Shams University for her sincere encouragement, constant advice and valuable guidance throughout the performance of this work. I owe special gratitude to Dr. Remon Zaher Elia, Lecturer of Radiodiagnosis, Faculty of medecin — Ain Shams University for his close supervision and continuous advice which gave me the best guide during different stages of this work. I would like to thank my professors, my family, my friends and my colleagues for their support and moral encouragement.

Hatem Mohamed Taha

#### **Abstract**

Total hip arthroplasty is a common and effective operation with a high success rate. The purpose of this essay is to review the appearance of normal successful hip arthroplasty and accepted post-operative changes as well as the appearance of complications such as osteolysis, infection, aseptic loosening as well as periprosthetic and component fracture. Knowledge of the potential complications and their imaging appearances will help in the diagnostic evaluation of the patient with a total hip arthroplasty. Moreover highlight the accepted post-operative changes will be beneficial not to be overestimated as a complication.

#### **Key Words:**

Total hip arthroplasty – post operative evaluation – successful - complicated

# **LIST OF CONTENTS**

➤ LIST OF ABBREVIATIONS	III
LIST OF FIGURES	${f V}$
LIST OF TABLES	XIII
> INTRODUCTION	1
> AIM OF WORK	4
ANATOMY OF THE HIP JOINT	
Anatomical considerations	5
<ul> <li>Vascular supply and lymphatic drainage</li> </ul>	14
Biomechanics of the hip joint	16
RADIOLOGICAL ANATOMY OF THE HIP JOINT	18
SURGICAL CONSIDERATIONS OF THE TOTAL HIP	24
ARTHROPLASTY	
➤ PATHOLOGY OF COMPLICATED TOTAL HIP	32
ARTHROPLASTY	
➤ IMAGING TECHNIQUES OF TOTAL HIP	
ARTHROPLASTY	
<ul> <li>Conventional Radiography Technique</li> </ul>	42
<ul> <li>Ultrasound Technique</li> </ul>	<b>45</b>
<ul> <li>MDCT imaging technique</li> </ul>	48
<ul> <li>Positron emission tomography</li> </ul>	57
<ul> <li>MRI imaging technique</li> </ul>	<b>58</b>
Radionuclide scan	68
• SPECT CT	<b>71</b>
Radionuclide Arthrography	73
➤ IMAGING OF SUCCESSFUL TOTAL HIP	77
ARTHROPLASTY	
➤ IMAGING OF COMPLICATED TOTAL HIP	
ARTHROPLASTY	
<ul> <li>Osteolysis (small-particle disease)</li> </ul>	86
Aseptic loosening	94

## List of content

<ul><li>Infection</li></ul>	101
• Prosthetic fracture	112
<ul> <li>Pseudotumors and Metal-On-Metal Resurfacing Arthroplast</li> </ul>	115
<ul> <li>Heterotopic ossification</li> </ul>	119
• Thromboembolic disease	122
• Bursitis	124
<ul> <li>Abductor muscle avulsion</li> </ul>	127
SUMMARY AND CONCLUSION	129
> REFERENCES	133

#### **LIST OF ABBREVIATIONS**

CT: Computed tomography

FDG: F-fluorodeoxyglucose

FOV: Field of vision

FSE: Fast spin echo

FSEIR: Fast spin echo inversion recovery

HO: Heteropic ossification

KVP: Kilo voltage peak

MARS: Metal artifact reduction sequence

mAs Milliamperes

MAVRIC: Multi-acquisition variable resonance

image contribution

MDCT: Multi detector computed tomography

MDP: Methyl diphosphonate

MRI: Magnetic resonance image

NEX: Number of excitations

NSA: Neck shaft angle

PE: Pulmonary embolus

PET: Positron emission tomography

#### List of abbreviations

PMMA: Polymethylmethacrylate

RBW: Recieved band width

SEMAC : Slice encoding for metal artifact correction

SPECT: Single positron emission computed tomography

STIR: Short time inversion recovery

Tc- 99m HMPAO: Technetium- 99m Hydroxy methyl

propylene amine oxime

TE: Time to echo

THA: Total hip replacement

TI: Time to inversion

TR: Time to repeat

VTE: Venous thromboembolism

# **LIST OF FIGURES**

Figure 1	The acetabulum and the hip bone.	6
Figure 2	The bony skeleton of the hip.	8
Figure 3	Diagram of hip joint (internally).	9
Figure 4	Muscular relation of the hip joint.	10
Figure 5	Hip Joint front view, Capsular ligament has been largely	11
	removed.	
Figure 6	Ligaments of the hip joint.	13
Figure 7	Blood supply of head and neck of femur.	14
Figure 8	Innervations of the hip joint & lower limb.	15
Figure 9	Biomechanics of the hip joint.	17
	(A) Q angle measurement.	
	(B) The neck shaft angle.	
Figure 10	Radiograph the hip joint.	18
J	(A) Lines of the hip joint.	
	(B) Fat pads.	
Figure 11	Normal axial CT section of the left hip.	19
Figure 12	MDCT reconstructed image of the anteversion angle.	20
Figure 13	Femoral neck angles, angle of inclination and angle of rotation.	21
Figure 14	Coronal reformat image of the hip joint.	22
Figure 15	T1-weighted SE image of both hip joints.	22
Figure 16	Coronal T1-weighted MR image of the left hip joint.	23
Figure 17	MR imaging of the hip, axial proton density images showing	23
J	the muscles about the hip joint.	
Figure 18	Surgical approach of total hip replacement.	27
J	(A) Line of skin incision.	
	(B) Exposure of joint after reflection of tensor fasciae latae	
	and gluteal muscles.	
Figure 19	Composition of total hip arthrolplasty prosthesis.	28
Figure 20	Acetabular and femoral component designed for cement	30
	fixation.	
Figure 21	(A) Hybrid total hip replacement.	31
_	(B) Bone ingrowth arthroplasty.	
Figure 22	AP view radiograph of right total hip arthroplasty.	43
Figure 23	Lateral view radiograph of left total hip replacement.	44
Figure 24	Obturator view radiograph of right total hip replacement.	44

Figure 25		47
	(A) transducer position (B) corresponding ultracound image	
Figure 26	(B) corresponding ultrasound image	48
Figure 26	Longitudinal sonogram shows increased amount of intra- articular fluid.	48
Figure 27	Axial CT of a cementless femoral stem tip with spline and flute	49
O	modification.	
Figure 28	Coronal MDCT reformatted image shows the femoral (ceramic	49
	head).	
Figure 29	Corresponding CT scan shows greater streak artifact from the	51
	more dense cobalt-chrome component than from the less dense	
	titanium component.	
Figure 30	Transverse reformats of two MDCT acquisitions of a key with	52
	different acquisition parameters:	
	(A) 120 kV and 135 mAs	
	(B) 140 kV and 270 mAs.	
Figure 31	Unipolar hemiprosthesis fixed with cement.	53
Figure 32	Bipolar hemiprosthesis fixed without cement and with the	53
	stem in varus position.	
Figure 33	Transverse reformats of two MDCT acquisitions of a key with	54
	different acquisition parameters:	
	(A) Nominal slice thickness of 2.7mm and pitch value of 0.7.	
T1 04	(B) Nominal slice thickness of 0.5mm and pitch value of 1.5.	
Figure 34	Coronal volume rendered 3D CT images:	56
	(A) Rendered to show right hip prosthesis.	
	(B) Rendered to show relationship of prosthesis screws to	
	skeleton adjacent iliac arteries.	
	(C) Rendered to show relationship of prosthesis screws to	
T. 45	skeleton and right ureter.	
Figure 35	Prominent susceptibility artifact is seen about the spherical	60
	cobalt-chrome femoral head component of left hip arthroplasty	
F: 26	on a fast spin-echo T1-weighted coronal image	<i>(</i> 2
Figure 36	Coronal T1 MRI (left) and plain radiograph (right) of a	63
E' 25	successful total hip arthroplasty.	<i>C</i> 1
Figure 37	Axial T1-weighted image through the pelvis in a patient with	64
E' - 20	bilateral metal-on-metal hip arthroplasties.	<u> </u>
Figure 38		65
	collections (arrows) associated with bilateral resurfacing	
	prostheses.	

	Coronal STIR image which showing large non infective collections (arrows) associated with bilateral resurfacing	
Figure 39	prostheses.  (A) The FSE pulse sequence of right hip arthroplasty shows marked susceptibility artifact (white arrows heads) arising from the cobalt chromium implants.	65
	(B) Coronal MAVRIC sequence shows marked reduction in	
T: 40	suscitbitiblity artefact.	
Figure 40	Normal post-operative finding of a small seroma in the line of	66
Figure 41	the post surgical scar.	67
Figure 41	A and B are sagittal T2-weighted MRI images of a revision THR with collections due to infection adjacent to the femur at	07
	multiple sites.	
Figure 42	MRI T1 weighted image showing right intertrochanteric	67
1150110 12	proximal femoral fracture via low signal line.	0,
Figure 43	Anterior planar image from a Tc 99m bone scintigram	69
8	revealing abnormal increased tracer uptake around the distal	
	aspect of the femoral portion of a long stem hip prosthesis.	
Figure 44	Normal periprosthetic lucency.	72
O	(A) Anteroposterior radiograph of a normal cemented	
	prosthesis.	
	(B) Axial CT and	
	(C) Fused SPECT-CT images in the same patient.	
Figure 45	(A) Radiographic arthrographic image after 10 ml of contrast	75
	agent showing leakage around at both acetabular and	
	femoral components	
	(B)Anterior bone scan showing moderately increased uptake	
	around the acetabulum, in the inter-trochanteric region and	
	at the tip of the prosthesis.	
	(C) Indium-111 colloid image with region of interest shown.	
	(D) Indium-111 region projected on the bone scan: leakage to	
Figure 16	the tip of the femoral component.  Measurement of lateral acetabular inclination.	78
Figure 46 Figure 47	Different anteversion of the acetabular cup.	79
Figure 47	Measurement of cup anteversion angle.	80
Figure 49	Reproducible assessment of periprosthetic lucency is aided by	81
I Iguit 4)	reference to standardized zones first proposed by Gruen (zones	01
	1–7) for the femur and DeLee, Charnley (zones I–III) for the	
	acetabulum.	

Figure 50	LEFT: Normal cement-metal interface (straight arrow). However loosening at cement-bone interface (curved arrow).	82
	RIGHT: At follow up also loosening at cement-metal interface.	
Figure 51	A radiolucent line of less than 1 mm in the femur is observed in	83
	(A) Zone 1 (arrow) after 6 months and did not change (B) after	
	18 years.	
Figure 52	Manipulated image showing normal reactions to the some of	84
S	the uncemented hip prostheses.	
Figure 53	Normal lucent zone, parallel to prosthesis and with a sclerotic	85
	demarcation zone.	
Figure 54	Progressive calcar resorption during follow up.	85
Figure 55	Eccentric position of femoral head within cup consistent with	87
	polyethylene wear.	
Figure 56	Coronal reformatted CT of the pelvis without contrast in bone	88
	algorithm shows complete osteolysis of the right acetabulum	
	with the space replaced by soft-tissue density and multiple foci	
	of metallic debris, suggestive of advanced metallosis. The right	
	femur is superiorly subluxated.	
Figure 57	(A) Axial contrast medium-enhanced CT image through the left	89
	hip and pelvis demonstrates a peripherally enhancing lobulated	
	mass of soft-tissue attenuation.	
	(B) Axial T2-weighted MRI image at a similar level through	
	the left hip demonstrates a lobulated mass that has irregular low	
Figure 50	signal margins and high signal centres.	90
Figure 58	Fast spin echo T1-weighted images demonstrate particle disease that markedly expands and destroys the medial	90
	acetabular wall on (A) coronal and (B) axial views.	
Figure 59	(A) Weighted coronal and (B) proton density-weighted sagittal	91
Figure 37	images demonstrate intermediate signal intensity osteolysis.	71
Figure 60	Axial proton density image through the acetabulum of a patient	91
rigure oo	with a total hip replacement shows dephasing artifact due to	71
	the acetabular cup.	
Figure 61	Wear debris granuloma formation in two different patients	92
8	after THA.	
Figure 62	Antero-posterior radiograph and Coronal CT image of the	93
G	same patient of a right THR demonstrating pelvic	
	discontinuity.	
Figure 63	Femoral stem loosening. AP radiograph shows a cemented	95
_	stem with irregular and focally wide radiolucency around the	

The case shows migration of the acetabular cup, which is

Radiographic arthrographic image after 10 ml of contrast

agent showing leakage around the acetabular component and

better appreciated if a reference point is used.

thinning of the cortex.

Figure 64

Figure 65

entire cement mantle, but particularly medially with marked

	in the lateral, distal segment of the femoral component	
	indicating loosening of both components.	
Figure 66	(A) Coronal slices, anterior view of the left hip showing pattern 1; no increased uptake of FDG in the prosthesis tissue interface (no loosening).	99
	<b>(B)</b> Coronal slices, anterior view of both hips showing pattern 2; increased uptake of FDG in the area of the femoral neck (no loosening).	
	(C) Coronal slices, anterior view of right hip, showing pattern 3a; increased uptake of FDG in the area of the femoral neck and in parts of the prosthesis-bone interface of the acetabular cup without covering the whole cup (no	
	loosening).  ( <b>D</b> ) Coronal slices, anterior view of left hip, pattern 4a; increased uptake of FDG in the area of the femoral neck and in the whole prosthesis-bone interface of the acetabular cup (loosening of the cup).	
	(E) Coronal slices, anterior view of right hip, pattern 4b; increased uptake of FDG in the area of the femoral neck and in wide parts of the prosthesis-bone interface of the stem (loosening of the stem); left hip, pattern 3a, increased uptake of FDG in the area of the femoral neck and in parts of the prosthesis-bone interface of the acetabular cup without covering the whole cup (no loosening)	100
	<b>(F)</b> Coronal slices, anterior view of both hips, pattern 5; Uptake of FDG in the periprosthetic soft tissue (infection and loosening of the right acetabular component)	
Figure 67	Manipulated image showing the typical radiographic changes in Loosening (left) - Particle disease (middle) - Infection (right).	101
Figure 68	The typical radiographic findings of infection with irregular bone destruction and periosteal reaction.	102

96

97

Figure 69	Longitudinal sonogram shows infected total hip prosthesis with increased amount of intraarticular fluid.	103
Figure 70	Infected hip arthroplasty	104
riguite 70	(A) Longitudinal sonographic image of the prosthetic hip joint shows a large joint effusion around the prosthetic head (H) and neck (N).	104
	(B) Oblique sonographic image shows the effusion	
	communicating with a large peritrochanteric collection.	
Figure 71	Coronal reformatted CT of the right hip demonstrating osteolysis at the bone cement interface.	105
Figure 72	50-year-old man with extensive metallosis. Non-contrast CT of the right hip, at the level of the inferior pubic ramus, shows	105
	several round, fluid-density collections with high-density peripheral rims.	
Figure 73	CT scan with soft-tissue reconstruction shows joint distention and focal areas of low attenuation in the muscle. Extension into the subcutaneous tissues to the skin was confirmed as an	106
	abscess.	
Figure 74	(A) Axial STIR image of an infected collection of the posterior aspect of the hip. There is oedema of the overlying soft	107
	tissues.	
	(B) Axial T1 post gadolinium imaging demonstrates rim enhancement of the collection.	
Figure 75	Sagittal T2-weighted MRI images of a revision THR with collections due to infection adjacent to the femur at multiple	107
	sites.	
Figure 76	Axial T2 weighted image of a sinus tract communicating with	108
C	the posterior aspect of the joint.	
Figure 77	Infected hip arthroplasty.	
	(A) Coronal T2-weighted inversion recovery image shows a peritrochanteric collection, with communication to the	109
	skin.	
	(B) Coronal T1-weighted image after intravenous contrast shows the peritrochanteric abscess and the superficial	
<b>T</b> . <b>T</b> 0	draining abscess.	110
Figure78	(A) Anterior planar image from a Tc 99m bone scintigram revealing abnormal increased tracer uptake around the distal aspect of the femoral portion of a long stem hip prosthesis. This	110
	could represent aseptic or septic loosening.	

	(B) Anterior planar image from a WBC scan in the same	
	patient showing increased uptake at distal end of the femoral	
	stem suggesting infection.	
	(C) Corresponding anterior planar image from a Tc99m	
	labelled nano-colloid scan revealing a matching area of	
	increased uptake at the distal aspect of the femoral prosthesis	
	indicating the presence of ectopic haematopoietic marrow at	
	this point and not infection.	
Figure 79	Anterior bone image (left) shows intense uptake around a right	111
O	total hip replacement, but an anterior gallium image (right) is	
	normal.	
Figure 80	Marked superior migration of the head of a Charnley femoral	113
S	prosthesis the polyethylene erosion has compromised the	
	structural viability of the cup which has fractured.	
Figure 81	Fractured femoral prosthesis in a distally fixed stem with	114
O	proximal loosening.	
Figure 82	T2-weighted MARS MRI image demonstrating a fracture of	115
C	the medial calcar with fluid / haemorrhage tracking between	
	the medial calcar and the adjacent intact cement mantle.	
Figure 83	(A) Normal conventional radiograph of a patient with	116
O	symptoms of recurrent hip pain 2 years after a right metal-on-	
	metal hip arthroplasty.	
	(B and C) Axial T1-weighted and T2-weighted MARS MRI images within 1 month of the radiograph demonstrates a large	
	fluid collection with a low signal T2-weighted rim surrounding	
	the neck of the prosthesis and the right greater trochanter. The	
	gluteal tendons, which should be visible at this level, have been	
	avulsed.	
Figure 84	An inversion-recovery coronal image in 45 year old female 3	117
	years following metal on metal hip arthroplasty reveals a large	
	fluid collection compatible with pseudotumor along the	
	posterolateral aspect of the hip.	
Figure 85	Despite extensive metal artifact in this patient 1.5 years	118
	following placement of a Depuy ASR metal-on-metal hip	
	resurfacing implant, a pseudotumor at the posterolateral aspect	
	of the greater trochanter is readily apparent on the fast spin-	
	echo proton density-weighted coronal view.	
Figure 86	Communication with the joint and the surrounding low signal	119
	intensity rim are demonstrated on the corresponding fast spin-	
	echo T2-weighted axial image.	

Figure 87	Classification of heterotopic ossification according to Brooker.	120
Figure 88	Various degrees of heterotopic ossification.	121
Figure 89	(A) Transverse image with color Doppler indicating the	123
O	biphasic flow in a proven profunda femoris pseudoaneurysm	
	encountered following hip arthroplasty.	
	(B) Corresponding CT angiogram of the profunda femoris	
	pseudoaneurysm, which was first identified on sonograph.	
Figure 90	A Transverse image with color Doppler indicating the biphasic	124
8	flow in a proven profunda femoris pseudoaneurysm	
	encountered following hip arthroplasty.	
Figure 91	Trochanteric bursitis. Axial MR image of a hip arthroplasty	125
8	shows distension of the greater trochanteric bursa.	
Figure 92	Coronal proton density MR image shows atrophy of the gluteus	125
8	medius muscle. There are also areas of high signal intensity	
	acetabular and femoral osteolysis and a resultant fracture of the	
	greater trochanter.	
Figure 93		126
O	during a cortisone injection shows a spinal needle positioned	
	with its tip deep to the iliopsoas tendon. The iliopsoas bursa (B)	
	is distended by the injectate. The metal acetabular component.	
Figure 94	(A) Coronal T1weighted image shows bilateral metal artifact	127
O	at site of prostheses with intact abductors on right and avulsed,	
	retracted abductors on left.	
	(B) Coronal shows healthy abductors on right, with fluid over	
	left greater trochanter at site of abductor avulsion.	
Figure 95	Suspected algorithm for evaluation of the total hip arthoplasty.	128