



AOA
AUSTRALIAN
ORTHOPAEDIC
ASSOCIATION

Australian Orthopaedic Association National Joint Replacement Registry

Lay Summary

Hip, Knee & Shoulder Replacement



ANNUAL
REPORT
2020

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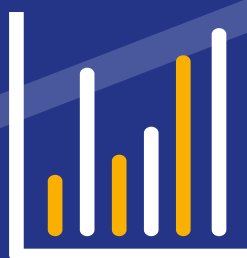
Australian Orthopaedic Association National Joint Replacement Registry

2020 Lay Summary

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AOANJRR Data Snapshot 2019



1,603,846

Total number of joint replacement procedures reported in the Registry at the end of 2019

Joint Replacement Procedures Reported in 2019

51,163

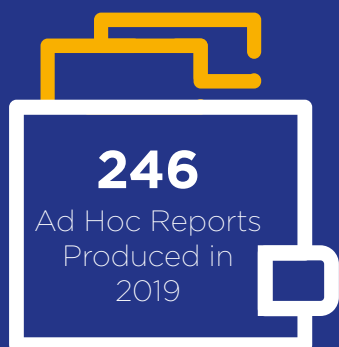
Hips Reported

66,729

Knees Reported

7,735

Shoulders Reported



26
Journal Articles Published in 2019



1,374
CPD Certificates Produced in 2019



924
Individual Surgeon Reports



70
Conference Presentations

Accessing Data from the AOANJRR

Publicly available documents on the website:

- Annual Report
- Supplementary Reports
- Prosthesis Investigations

<http://aoanjrr.sahmri.com>

Ad Hoc Reports by request

Annual individual surgeon reports via the surgeon portal

Stakeholder specific web portals

The online Automated Industry Report System (AIRS)

AOANJRR Update 2019

Patient Reported Outcome Measures (PROMs)

The AOANJRR has developed an automated platform for integrated data capture known as RAPID with dashboard facilities for the delivery of real-time data including trial recruitment, PROMs and outcome data.

The PROMs pilot is now completed and has shown that RAPID is a very effective data collection and reporting platform.

The final report of the pilot study is available on the AOANJRR website

<https://aoanjrr.sahmri.com/proms-pilot-report>

RAPID

When patients are registered and consented in RAPID, 97.8% complete pre-op data entry and 79% complete data entry 6 months after their joint replacement surgery.

Registry Nested Clinical Trials (RNCTs)

The AOANJRR has designed and developed a clinical trials platform which has been purpose-built in parallel with, and complements, the PROMs and AOANJRR data linkage programs. By developing the clinical trials platform simultaneously with the PROMs program, the infrastructure has been established to undertake large, efficient, cost effective registry-nested trials within Australia.

Other Registries within the AOANJRR

The Knee Osteotomy Registry is currently being rolled out nationally and is now in 59 hospitals and 528 procedures have been collected.

Work to deliver a Temporomandibular Joint Registry (TMJ) across Australia and New Zealand is well underway.

Introduction

This summary is an explanation of the major findings of the Australian Orthopaedic Association National Joint Replacement Registry 2020 Annual Report for Hip, Knee and Shoulder Arthroplasty (replacement). This is the major clinical report produced by the Registry each year.

The Lay Summary is provided to ensure that a clear, concise, and easily understood explanation of the published findings are available to all those who may be interested.

The Australian Orthopaedic Association (AOA) believes this is especially important because of the high level of community interest in the Registry and the need to ensure that reports are accessible to all.

The full version of the 2020 Annual Report on Hip, Knee and Shoulder Arthroplasty is available in the 'Publications' section of the Registry website.

This year's report involved the analysis of 1,603,846 primary and revision procedures (694,730 hips, 849,329 knees and 59,787 shoulders). This is the total number of hip, knee and shoulder replacement operations recorded by the Registry with a procedure date up to and including 31 December 2019. This is 125,627 additional hip, knee and shoulder procedures compared to the 2019 Annual Report.

In addition to the Annual Report and this Lay Summary, there are a further 12 supplementary reports published by the Registry on the website: <https://aoanjrr.sahmri.com/annual-reports-2020/supplementary>.

A Brief History of the Registry Origins

The AOA commenced the National Joint Replacement Registry in 1999. It was initially for hip and knee replacement only. This was a complex system to set up and therefore it took almost 3 years to fully implement the Registry across Australia. The Registry receives information from over 300 hospitals. Since mid-2002, the Registry has received information on almost all hip and knee replacements undertaken in Australia.

In November 2007, the Registry commenced national data collection on a number of additional types of joint replacement. This included shoulder joint replacement procedures, the analysis of which is presented along with hip and knee replacement in the main report. The other additional types of joint replacement that the Registry collects information on include elbow, wrist, ankle, and spinal disc replacement. The analysis of these procedures is presented in the supplementary reports available on the Registry website.

The Purpose of the Registry

The AOA started the Registry to improve the results of joint replacement surgery in Australia. Generally, this type of surgery is very successful, but as with all areas of healthcare, there is always room for improvement. Since the Registry commenced data collection and reporting of that data, the results of joint replacement surgery has got much better.

One of the most serious consequences of a less than successful operation is the need to have a revision (redo) operation. The Registry provides information to assist surgeons to keep the number of these operations to a minimum. It does this by identifying those things that work best and highlighting what can be improved.

Prior to establishing the Registry, Australian orthopaedic surgeons felt they had a lack of detailed information on the results of the many different procedures and types of joint replacement available. In particular, the surgeons required information to compare the impact of the many different factors known to influence the results for their patients.

Surgeons have a large choice of different types of artificial joints that they can use to replace damaged and painful joints. There are also different techniques, which can be used to put these artificial joints in place. Surgeons know that there is variation in the results depending on the patient, the nature of the patient's problem, which joint is being replaced, the way the operation is performed, and the type of artificial joint replacement used.

The Registry publishes data in addition to that included in the Annual Report, in the following Supplementary Reports:

- 1. Partial Hip Arthroplasty**
With the aim of streamlining the Annual Report detailed information on Partial Hip Replacement has been moved to this supplementary report
- 2. Partial Knee Arthroplasty**
With the aim of streamlining the Annual Report detailed information on Partial Hip Replacement has been moved to this supplementary report
- 3. Demographics of Hip, Knee and Shoulder Arthroplasty**
This report details the age and gender profile of people receiving hip, knee or shoulder replacement and includes information on the reasons for undergoing replacement surgery.
- 4. Cement in Hip and Knee Arthroplasty**
This report details the use of the different types of cement in hip and knee replacement surgery.
- 5. Mortality of Hip and Knee Arthroplasty**
This report details the risk of dying following the different types of hip and knee replacement surgery.
- 6. Revision of Hip and Knee Arthroplasty**
This report details the outcome of revisions of hip and knee replacements.
- 7. Prosthesis Types No Longer Used**
This report details the outcomes of classes of hip and knee replacement that are no longer used and therefore do not appear in the main report.

8. Metal on Metal Bearing Surface in Total Conventional Hip Arthroplasty

This report details the outcome of metal on metal bearings when used with large (greater than 32mm) femoral heads.

9. Demographics and Outcomes of Elbow and Wrist Arthroplasty

This report details the age and gender profile of people receiving elbow and wrist surgery. It includes reasons for undergoing these different types of joint replacement as well as some early information on the outcome of these operations.

10. Demographics and Outcomes of Ankle Arthroplasty

This report details the age and gender profile of people receiving ankle joint replacement and reasons for undergoing ankle replacement as well as some early information on the outcome of this operation.

11. Demographics of Spinal Disc Arthroplasty

This report details the age and gender profile of people receiving spinal disc replacement and reasons for undergoing this operation.

12. Analysis of State and Territory Health Data – All Arthroplasty 1993/1994 – 2018/2019

Investigations of Prostheses with Higher than Anticipated Rates of Revision

Each year the Registry identifies prostheses that have a higher than anticipated rate of revision. This is a series of reports providing detailed information on each of the prostheses identified in the 2020 Annual Report.

The Registry is able to compare all of these different factors simultaneously. In doing so, it provides information to assist surgeons to decide the best type of artificial joint replacement to use in any particular situation. The Registry is able to detail the results for different classes (or categories) of artificial joints and different individual types of artificial joints in each of the classes. It can also determine if patient age, gender, weight, general health, and/or the reason a joint replacement is performed, affects the result.

It is important to emphasise that this is not the only information that is used to determine what the best approach should be. When providing advice to patients, surgeons will also rely on their training and experience as well as information from medical journals, other registries elsewhere in the world, conferences and courses they may attend, as well as learning from other surgeons.

The Registry provides information to assist in deciding the best type of artificial joint replacement to use in any particular situation.

When surgeons interpret information from the Registry, they use their knowledge and experience to put that information into context. The Registry does not decide or recommend the best joint replacement for a particular patient. This can only ever be decided by the surgeon in consultation with the patient. In this way, all factors can be carefully taken into consideration.

How the Registry Works

The Registry collects a small amount of confidential information on each joint replacement operation undertaken in Australia, with the exception of those people who choose not to have their information collected by the Registry. The information collected includes details of the patient including age, gender, weight, height, general health the reason for the surgery, the joint that was replaced, and whether it was on the right or left side. Information on the type of artificial joint replacement and the individual components used in the operation are also collected.

Currently the Registry monitors and has information on over 1.6 million joint replacement operations.

As previously mentioned, if a problem occurs following a joint replacement one of the possible outcomes is that the operation is redone. This is referred to as a revision procedure. The Registry is notified about the revision, records this information and links it to the first (or primary) operation. By doing this it is able to determine how many initial primary procedures have been revised, the reason for the revision, how long after the original surgery, and which of the components (if any) were replaced is also recorded.

Who Funds the Registry?

The Commonwealth Government, through the Department of Health, funds the Registry. The Government and the Department have been very supportive of the Registry. They provided the initial funding to establish the Registry and have maintained its core funding since the Registry commenced.

The Format of the 2020 Hip, Knee & Shoulder Arthroplasty Annual Report

When the Registry prepares the Annual Report each year it updates important information that it has reported previously. This is done in the routine chapters. In addition to the updates of information in these chapters, there is often new information presented. The reason that this new information is included is because it is an area of interest that has not previously been covered or because the Registry has sufficient new data to present.

The Annual Report also includes one or more new chapters that are on topics of importance that have either not previously been reported in any detail or have not been reported for some time. The usual focus is on factors that affect the results of primary joint replacement. A primary replacement is the first joint replacement done for each of the joints. This year it was decided that the new chapter should focus on the outcome of revision (redo) hip and knee replacement operations. Each year we provide some information on these revision operations in one of the Registries supplementary reports. This year's analysis, which is included in the main report is a much more in-depth look. The purpose is to provide information on how the results of revision operations vary depending on the type of revision operation and the reason why the revision was done.

The remainder of this year's Annual Report includes the routine chapters. They contain an additional year of information on the results that the Registry has previously reported as well as some new information as previously mentioned. As was mentioned last year, as the size of the main report continues to get bigger, each year decisions are made to remove some of the information that has previously been reported. However, the information is never lost as it is updated and moved to a supplementary report that is accessible from the AOANJRR website.

As with previous reports, there is a section on the outcome of those devices that have reached 10 and 15 year outcomes, as well as sections on primary hip replacement, primary knee replacement, primary shoulder replacement the Registry provides a summary of prostheses that have been identified as having a higher than anticipated rate of revision. Detailed information on all of these devices is also available online in the publications section titled "Prostheses Investigations".

How the Registry Presents the Results

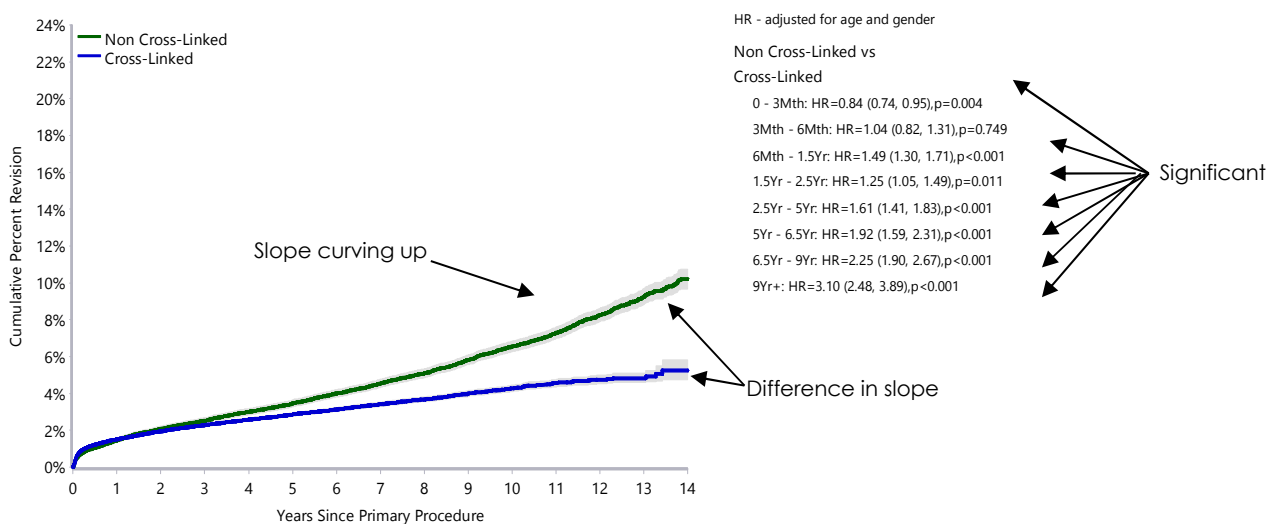
The fact that the Registry is a national database means it reports on the results of a very large number of operations, which improves the value of the information. Currently, the Registry monitors and has information on over 1.6 million joint replacement operations.

The Registry presents the results in different ways. The clearest and most important way is by graphs and tables. We know the time until the redo (revision) operation and so we can calculate the percent of procedures that have been revised at 1, 2, and 3 years after the original procedure. This is known as the cumulative percent revision. There are many things that can affect this i.e. make it lower or higher. The aim is to identify what things make the cumulative revision rate lower, which means that there is less chance of having to have the operation again. This is done by comparing results in when the surgery is undertaken in different types of patients, (young vs older, male vs female, heavy vs normal weight etc) different types of joint replacement prostheses and different techniques for implanting the device. Examples of different techniques include the use of different types of instruments, or robotic surgery or the operative approach. By comparing these different groups, we are not only able to understand better what works better in certain situations but also what does not work so well.

GRAPHS

To assist in the interpretation of any difference we often graph the results. Figure L1 is a typical example of a cumulative percent revision graph which is comparing two different types of plastic used in hip replacement. The cumulative percent revision which gets progressively greater as time progresses is plotted for each group at specific times since the original surgery. The time period scale is usually in years since the first operation.

Figure L1 Example of a graph with Cumulative Percent Revision which compares the results of two different types of plastic commonly used in joint replacement surgery (cross-linked and non-cross-linked polyethylene).



The lines on the graph represent the results for the factors being compared. The more the lines slope upwards the greater the number of revision (redo) operations that have been done. In general, the greater the difference in the slope of the lines the more important the difference. This graph shows that there are more revisions when non cross-linked polyethylene (the green line) is used compared to cross-linked polyethylene (the blue line).

The information on the right-hand side of each of these graphs is important. This gives a measure of the amount of difference, how this is changing with time, and how confident you can be that the

difference is real. The most important information is the HR (hazard ratio) and the p (probability) value. These are explained a little further down.

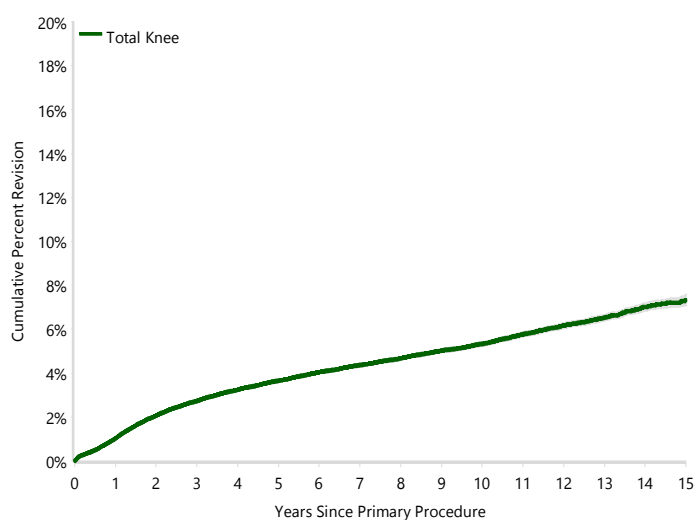
TABLES

The Registry also reports data in cumulative percent revision tables which accompany these graphs. These tables give the number of revisions as a percentage of the number of operations at particular times i.e. 1 year, 3 years, etc. The numbers are simply the values on the graph at these specific time points and are listed to provide the actual number for each year so that the number does not need to be guessed at by looking at the graph.

Figure L2 Example of a table and corresponding graph

Figure KT12 Cumulative Percent Revision of Primary Total Knee Replacement (Primary Diagnosis OA) from the 2017 Registry Annual Report

Knee Class	N Revised	N Total	1 Yr	3 Yrs	5 Yrs	7 Yrs	10 Yrs	15 Yrs
Total Knee	17213	482373	1.0 (1.0, 1.1)	2.7 (2.7, 2.8)	3.6 (3.6, 3.7)	4.4 (4.3, 4.4)	5.3 (5.2, 5.4)	7.3 (7.1, 7.6)
TOTAL	17213	482373						



This table also shows some values in brackets after the main number i.e. at ten years the main number is 5.3%, which means that at ten years if you are still alive you have a 5.3% chance of having a revision. The reason that there are numbers in brackets afterwards (in this case 5.2 and 5.4) is because 5.3% is not an exact number, it is an estimate based on the analysis of all the data. The numbers in the brackets represent the 95% confidence interval. This means that the estimate is 5.3% and there is 95% confidence that the actual or real number is somewhere between 5.2% and 5.4%. This is a small confidence interval which is usual when the number of operations is large. When the confidence interval is small the estimate is likely to be accurate.

On occasion, the Registry provides only cumulative percent revision tables and does not provide the graphs. This is usually when the results of a large number of different replacements in one category are being presented. The reason the graphs are not provided for each of the different replacements is simply a space issue. It would make the report too large.

When examining the tables, it can be seen that there is variation in the outcome of the different prostheses that are listed. It is important to understand that just because a prosthesis combination has a higher cumulative percent revision than other prosthesis combinations, it does not necessarily mean that the combination is not as good. It is possible that this difference in the number of revisions between the prostheses has occurred by chance rather than being a true difference. In reality, most but not all prostheses have equally good results.

HAZARD RATIOS

Hazard Ratios (HR) are used to compare 2 different factors such as non-cross linked poly (non-XLPE) compared to cross linked poly (XLPE). The HR is an indication of the difference in the risk of revision for non XLPE compared to XLPE. For example, if the HR=3, this means that there is a three times greater risk of being revised. If the HR=1, then this means that there is no difference. If the HR=0.5 then this means that that risk of revision is half.

The p value is a measure of the likelihood that a difference observed between groups being compared is real, rather than occurring by chance. In statistical terms, this is called significance. The difference is regarded as significant (in other words likely to be true) if a p value is smaller than 0.05. A p value of 0.05 means that there is a 1 in 20 chance that the difference is not true. A p value of 0.001 means that there is only a 1 in 1,000 chance that the difference is not true. In other words, it is more certain that the difference is real.

Figure L3 Example of a hazard ratio from a Registry graph

HR adjusted for age and gender	
Non Cross-Linked vs Cross-Linked Polyethylene	
0-3Mth:	HR=0.84 (0.74, 0.95), p=0.004
3Mth-6Mth:	HR=1.04 (0.82, 1.31), p=0.749
6Mth-1.5Yr:	HR=1.49 (1.30, 1.71), p<0.001
1.5Yr-2.5Yr:	HR=1.25 (1.05, 1.49), p=0.011
2.5Yr - 5Yr:	HR=1.61 (1.41, 1.83), p<0.001
5Yr - 6.5Yr:	HR=1.92 (1.59, 2.31), p<0.001
6.5Yr - 9Yr:	HR=2.25 (1.90, 2.67), p<0.001
9Yr+:	HR=3.10 (2.48, 3.89), p<0.001

Quite often different hazard ratios (HRs) are listed for different time periods as above. The time period is the number that is on the left. The values in the brackets after the HR number are the possible lower and upper limits of the HR. The reason that these numbers are given is because the HR number is an estimate just like the revision estimate and the numbers in the brackets indicate that there is a 95% degree of certainty that the actual HR falls within this range. Again, in the same manner as the revision estimate. For instance, the first entry in Table LS2 above referring to the 0-3 month period has a lower limit of 0.74 and an upper limit of 0.95. The HR value of 0.84 is the arithmetic mean (average) value of the upper and lower limit but because this is an estimate there is a possibility that the actual HR is not this figure but there is a 95% likelihood that it falls within the range identified by the numbers in the brackets.

When the Registry compares two different factors, such as non cross-linked to cross-linked polyethylene, to see if there is a difference, it also tests whether that difference changes with time. That is why all the different time periods are listed. With this particular comparison, it can be clearly seen that the difference between the two different polyethylenes is increasing as the time after the original operation increases i.e. the HR is increasing with time after surgery.

The length of time after the initial operation when differences become evident is an important piece of information in helping to determine why there is a difference. Using Figure LS2 as an example, the HRs have been divided into eight time periods, the time from the joint replacement to three months after the surgery, then three months following the surgery to six months, and so on. There are many reasons why some things may differ soon after surgery and these reasons often change as the time after surgery increases. What can also happen as is the case in the example provided is that the extent of difference can vary with time; sometimes the difference is greatest early, and other times the difference may increase as time progresses which is what has occurred with this example. In some graphs, the difference does not change with time but is the same from start to finish. When this occurs then instead of having a list of different time periods, only one HR will be given, and it will state that the HR is over the entire period.

Revision Joint Replacement

Introduction

In this new chapter for 2020, the Registry reports on the outcome of revision (or redo) operations for both hip and knee replacement. Shoulder revision replacements have not been reported this year because the Registry commenced collection of shoulder data much later than hip and knee replacement and there are fewer shoulder replacements done. The consequence of both this, is that we do not have as much information on the shoulders that have been revised and the follow-up time is not as long as the other types of joint replacement. It is anticipated that we will begin to provide some information on shoulder revision outcomes in the next few years.

It is important to understand the approach that was used to look at this information. A first revision is a redo of the initial (primary) operation. We assess the result of the initial operation by the cumulative percent revision. A second revision is a redo of the first revision. We assess the result of the first revision by the cumulative percent 2nd revision. When considering the outcome of the first revision we have only considered revisions that have been undertaken for reasons other than infection. Assessing the outcome of revisions for infection is more complex and we have left this for a later time.

Revision of Total Conventional Hip Replacement

Many factors affect the outcome of the first revision of a primary total hip replacement. One important factor is the reason that the first revision was undertaken. The most common reason for a patient needing a revision of their initial operation is that one or both, of the acetabular and femoral components have come loose in the bone. Other common reasons for a revision of a primary hip replacement are dislocation (i.e. the hip has come out of joint) and fracture of the bone around the joint replacement, most commonly a fracture of the femur. Of the 4 most common reasons for revision other than infection the least common is lysis. This is when holes develop in the bone around the device used. It usually occurs because there has been wear of the articulating surface that has caused an inflammatory response in one area of the bone because of little particles of material that have accumulated in the bone secondary to the wear.

If a primary hip replacement needs to be revised, then the risk of having a further revision is about 4-5 times higher compared to the revision risk of a primary total hip replacement. The risk of a second revision is highest early after the first revision with about 8% of patients needing a redo in the first 12 months. The risk of revision after that time increases but at a much slower rate. Just under 20% of patients have required a second revision by 10 years. The most common reason for requiring a second revision is dislocation.

The age of patients at the time of surgery does not seem to have a major effect on the risk of revision although women less than 65 years have a slightly higher risk of a redo compared to older women. The age of men does not affect the risk of revision. The ASA Score (a measure of how sick a patient is at the time of their first revision operation) does not affect the risk of having a second revision. However, being very overweight does increase the likelihood of a second revision.

Revisions are classified as either minor or major. A minor revision is when only the femoral head and/or the insert which makes up the socket inside the acetabular component are revised. In a minor revision, the femoral and acetabular components are not revised. In a major revision one or both of the femoral or acetabular components are revised. The risk of having a second revision is higher when the first revision is a minor revision.

A big factor affecting the risk of a second revision, is the reason that the first revision was done. When the first revision is for dislocation, this is the hardest to get right as it has the highest chance of requiring a second revision. The risk of a second revision is more than 50% higher than when the first revision is undertaken for any other reasons. When comparing the other main reasons for revision (excluding revision for infection) the results of the revision are very similar for each of the reasons.

The risk of dying after a revision operation also varies depending on the reason for the revision. The reason for the revision that has the highest mortality risk is fracture. At 5 years after the first revision about 30% of patients having that first revision for a fracture have died.

One final analysis that was done on the outcome of first revision hip replacement was to compare the results of first revision surgery over time. This was done to determine if the results of these operations are changing. This analysis showed that the results are getting better with the best outcomes for this surgery occurring in more recent years.

Revision of Total Resurfacing Hip Replacement

When resurfacing was first introduced over 20 years ago, one of the arguments used in support of this device was that it was a conservative operation and that when it was revised, the outcomes of that revision would be better than a conventional total hip replacement. The results of revising a resurfacing hip replacement do show that early on, the risk of a second revision is slightly less than when a primary conventional hip replacement is first revised. However, this small benefit is lost after two years and from then on, the risk of a second revision is the same for both types of primary hip replacement. The outcome of revising a resurfacing hip replacement is not affected by patient age, health, or the reason for the first revision. Mortality following revision is low, but this is almost certainly because patients undergoing a revision of a resurfacing hip are much younger and healthier than those having a revision of a primary conventional total hip replacement.

Revision of Total Knee Replacement

The most common reason for a patient needing a revision of their initial primary total knee replacement is loosening of one or both of the femoral and tibial components. Other common reasons for a revision of a primary total knee replacement are problems with patella, instability of the knee replacement, pain and arthrofibrosis.

If a primary knee replacement needs to be revised, then the risk of having a further revision is very similar to a primary hip being revised and that is 4-5 times higher compared to the revision risk of a primary hip or knee operation. The risk of a second revision is about 5% of patients needing a redo in the first 12 months. Just over 20% of patients require a second revision by 10 years. The most common reason for a second revision is loosening, this accounts for about a third of all second knee revisions.

Age at the time of surgery has a major effect on the risk of a second revision. Younger patients (aged less than 65 years) have a much higher rate of second revision. This is true for both men and women. Men have a higher risk of needing a second revision irrespective of their age compared to women. Patients with the lowest ASA Score (i.e. the healthiest patients) have the highest risk of a second revision. However, being very overweight does increase the likelihood of a second revision largely because of an increased risk of infection.

Revisions are classified as either minor or major. A minor revision is when only the tibial insert is replaced, or a patella is revised or resurfaced. A major revision is when either one (partial major) or both (total major) femoral or tibial components are revised. The risk of having a second revision is higher when a major partial revision is undertaken. There is no difference in the outcome when minor and major total revisions are compared

There is some variation in the rate of second revision depending on the reason for the first revision. The lowest 10 year cumulative percent 2nd revision is 17.3% for malalignment and the highest is 23.7% for arthrofibrosis.

The risk of dying after a revision operation also varies depending on the reason for the revision. The reason that has the highest mortality risk is fracture. At 5 years after the first revision just under 25% of patients who had the first revision for a fracture have died.

One final analysis that was done on the outcome of first revision knee replacement, compared the results of first revision surgery over time. This was done to determine if the results of these operations are changing. This analysis showed that the results are getting better with the best outcomes for this surgery occurring in more recent years.

Ten and Fifteen Year Prosthesis Outcomes

This chapter provides information on hip and knee prostheses that have the longest follow-up in the Registry. This year, the Registry is reporting on the outcome of 99 different hip prostheses (combinations of femoral and acetabular prostheses with at least 10 years of follow-up). Prostheses with 10 years of follow-up data, account for 68.5% of all primary total conventional hip procedures being undertaken in Australia. The cumulative percent revision of primary total hip procedures that have 10 years of follow-up data varies from 1.6% to 46.3%. In this analysis two groups of devices have been identified that have performed to a high standard i.e. they are revised less often than other devices. There are prostheses with what is referred to as a 'superior benchmark' and then a second group which have been identified as having a 'non-inferior benchmark'. All of these devices have proven low revision rates at 10 years. The superior benchmark devices have either a slightly lower revision rate than the non-inferior benchmark devices or the certainty of the lower revision rate is higher. Both of these groups have what is regarded as low revision rates at 10 years. The Registry identified 16 hips with a superior benchmark and an additional 18 hips with a non-inferior benchmark. In other words, of the 99 different hip prosthesis combinations 34 (34.3%) are identified as having low revision rates at 10 years. This is regarded as a very good result for these 34 different hip replacements.

A similar analysis was undertaken for primary total knee replacement. The Registry identified 71 total knee replacement combinations with data for 10 years or more. This group accounts for 86.9% of all the total knee procedures reported to the Registry. The percentage of knee replacement procedures that have 10 years of follow-up data and have been revised varies from 2.1% to 13.3%. The Registry identified 9 knee prostheses with a superior benchmark and an additional 22 prostheses with a non-inferior benchmark. In other words, of the 71 different knee prostheses combinations, 31 (43.7%) are regarded as having a very good result.

The Registry also has prostheses (58 hips and 43 knees) with information that extends out to 15 years. Many of the devices have performed well. The percentage of hip procedures that have 15 years of follow-up data and have been revised varies between 2.6% and 20.9%. Seventeen of the hip prostheses have a 15 year revision rate that is less than 6.5%, and 6 have a revision rate that is less than 5.0%. For knee replacements, the percentage of procedures that have 15 years of data and have been revised varies between 4.0% to 15.6%. Eight of these knee prostheses have a percent revision of less than 6.5% and 3 with less than 5%.

Hip Replacement

The Registry considers three different categories of hip replacement. These are primary partial, primary total and revision hip replacement. Each of these categories is divided into a number of different classes. These are described in the Annual Report at the start of the section on hip replacement.

There were 51,163 hip replacements reported to the Registry in 2019. This is an increase of 1.9 % compared to the number undertaken in 2018. Primary partial hips account for 14.6% of all hip replacements reported to the Registry since it commenced data collection. Primary total hips account for 74.6% and revision hips 10.8%.

Due to the staged introduction of the Registry, the first year that the Registry recorded complete national data was 2003. Since that time, the number of hip replacements reported to the Registry has increased each year. The number of hip replacements undertaken in 2019 was 89.3% more than undertaken in 2003.

However, there are differences in the rate of increase depending on the category of hip replacement. The number of primary partial hip replacements, which are almost always done for fractured neck of femur (broken hip), has increased by 29.1% since 2003. The number of primary total hips, which are most often done due to severe arthritis, has increased by 116.1% during the same time. The increase in revision hip replacement was the lowest of all categories and comparing 2003 to 2018 the number of revision hip procedures increased by 23.0%.

The proportion of hip replacement procedures that are undertaken each year that are revision operations is called the revision burden. The aim of any intervention to improve the outcome of joint replacement is to reduce the revision burden. The revision burden has declined since 2003 with the exception of 2011. In that year, the Registry reported an increase in the revision burden. This was largely due to the high revision rate of large head metal on metal hip replacements and in particular the ASR XL prostheses. In 2012, the revision burden again declined and has continued to decrease since that time. In 2011, the revision burden was 12.6%, in 2012 it was 11.9%, in 2013 it was 10.7%, and in 2019 it had decreased to 8.4%. This is the lowest revision burden for hip replacement ever reported by the Registry.

The Registry data continues to show that in general, Australian surgeons have increasingly used approaches to hip replacement and hip replacement prostheses that the Registry has identified as being associated with an improved result. This is particularly evident in recent years with the increased use of prostheses known to have excellent outcomes over a long period and the decreased use of those that are known to have a less satisfactory result. It is anticipated that the effect of these changes will have a progressively beneficial impact on the revision burden in coming years.

Primary Partial Hip Replacement

Most partial hip replacements are used to treat broken hips. In particular, elderly patients with a broken hip involving a complete fracture at the base of the femoral head (ball of the hip joint) which is significantly displaced (moved out of position). This is commonly referred to as a sub-capital fractured neck of femur.

The Registry has previously reported that the risk of further revision surgery following the treatment of broken hips with primary partial hip replacement is dependent on a number of factors. These include the age at the time of surgery, class of partial hip replacement, method of fixation, and the type of prosthesis used.

There are three main classes of partial hip replacement: unipolar monoblock prostheses, unipolar modular prostheses, and bipolar prostheses. Each has their place in the management of broken hips.

When the Registry first started collecting data over twenty years ago, unipolar monoblock prostheses were the most common type of partial hip prostheses used. Of the three types of partial hip replacement, this has the highest rate of revision. The use of these devices has continuously declined over the years and it is now rarely used.

Unipolar modular and bipolar replacement have a lower risk of revision in the 'younger' elderly population (below 85 years). Bipolar prostheses are revised less frequently than unipolar modular prostheses when individuals are less than 75 years of age.

The use of cement fixation reduces the risk of revision by approximately half, regardless of the class of partial hip replacement. Consequently, in recent years there has been a dramatic increase in the use of cement fixation when partial hips are used. However, the vast majority of partial hip replacements will do well, whether they are cemented or not. The information on the use of fixation is available in the supplementary report on partial hips.

Primary Total Hip Replacement

There are two main classes of primary total hip replacement. The first and most common is total conventional hip replacement, which involves replacing the femoral head (ball of the hip joint) as well as the acetabulum (socket of the hip joint). The second, is a total resurfacing hip replacement. Although the socket is replaced in a similar way to a conventional hip, it differs in that only the surface of the femoral head is replaced rather than the whole head.

Overall, resurfacing hip replacement has a higher rate of revision compared to primary total conventional hip replacement. In recent years, the use of total resurfacing hip replacement has continued to decline. In 2019, it was used in only 1.0% of all hip replacements performed.

Factors that affect the outcome of primary total resurfacing hip replacement include the type of prostheses used, as well as the gender, age, and size of the patient. Women have a significantly higher rate of revision this difference has resulted in this procedure now being done almost exclusively in males. Men have an age-related rate of revision. Males over the age of 65 years have a much higher rate of revision in the first 6 months after surgery and consequently, this surgery is almost never done in patients above this age.

It appears that there are a number of reasons for the difference in outcomes related to gender. The first relates to the size of the patient. Smaller femoral head sizes do not do as well in a resurfacing procedure and women on average have smaller femoral head sizes. It also appears that women still have a higher rate of revision following a resurfacing hip replacement when a larger head size is used, but the reason for this is not clear. Males with a smaller femoral head size also have an increased risk of revision when compared to males with larger femoral head sizes. The use of this type of hip replacement is now largely confined to men younger than 65 years who have larger femoral heads.

The Registry has identified many factors that affect the outcome of primary total conventional hip replacement. These can be divided into patient and prosthesis factors.

Patients with osteoarthritis have better outcomes compared to patients having a total hip replacement for a different reason. Generally, it can be said that women have a slightly lower risk of revision compared to men. In the long term, the rate of revision decreases as the age at the time of the initial surgery increases. This is more apparent in women than in men.

The Registry is again reporting on the impact of ASA score and BMI for all patients. The impact of ASA score and BMI is only reported for the first few years after surgery as the Registry only commenced collection of ASA data in 2012 and BMI data in 2015. The ASA score is a measure of general health. The score increases with the number of health problems. The higher the ASA score, the higher the risk of revision, this is due in part to an increased risk of revision for infection. This is because the general health of patients with a higher ASA score at the time of surgery is not as good. There are six

categories of BMI which include underweight, normal, pre-obese and then obese 1, 2, and 3. The revision rate is increased in patients with a BMI that is categorised as obese 1, 2, or 3. The most common reason for the increased rate of revision is infection.

The Registry is again reporting on the effect of surgical approach. The Registry only commenced collecting data on approach in 2015 so this analysis is only relevant to early outcomes. There are three main operative approaches used for hip replacement. They are posterior, lateral and anterior. As was reported last year, there is no difference in the risk of a revision when the three approaches are compared. However, there are differences in the reasons why a revision is undertaken. The anterior approach has a higher rate of revision for fracture in the first 3 months and loosening but a lower rate of revision for dislocation and infection. When the anterior approach is used, the patients tend to be younger, healthier and less overweight. When these factors are taken into account the anterior approach currently has a slightly higher rate of early revision

As has been done in previous years, important prosthesis characteristics that influence outcomes have been highlighted in this year's report. These include the method of fixation, the type of bearing surface of the artificial hip joint and some special design features of both the femoral and acetabular prostheses.

Primary total conventional hip replacements vary in the method used to fix the prosthesis to bone. There are three main types of fixation, cemented, cementless and hybrid fixation. Cemented fixation is when the femoral and acetabular prostheses are fixed to bone using a hard setting plastic called methyl methacrylate (bone cement). Cementless fixation is when the femoral and acetabular prostheses are fixed directly to bone without using cement. Initially the fixation is achieved by fitting the device tightly into the bone. This tight fit then allows bone to grow into specially designed roughened surfaces on both the femoral and acetabular components to permanently fix the device in place. Prostheses are designed to be specifically used with cemented or cementless fixation. The other main approach to fixation is hybrid fixation. This involves cementing the femoral component and using a cementless acetabular component.

For many years, the Registry has reported that age has a major influence on the outcome of the different types of fixation. In general, older patients do better with hybrid or cement fixation and younger patients do better with hybrid or cementless fixation. The likely reason for this is that cementless fixation particularly of the femoral component does better when the quality of a patient's bone is good. It is known that bone quality declines as we get older.

This year, the Registry is again reporting on the outcomes related to the use of different bearing surfaces. The bearing surface is the articulating surface i.e. the artificial ball and socket of the hip joint. It varies depending on the material used to make the femoral head and the acetabular socket. The socket may be plastic, ceramic, or metal. The type of plastic used is called polyethylene, it may be non cross-linked (non XLPE) or cross-linked (XLPE). XLPE means that an additional manufacturing process has been used that increases the bonding of the molecules within the polyethylene. It has been shown in laboratory testing that increasing the cross-linking, reduces the wear of this material as the hip replacement moves. The femoral head (ball) may be made of metal, ceramic, or a third option called ceramicised metal, which is available mainly from one company. The bearing surface is made up of the combination of materials used to make both the ball and the socket. Consequently, there are a number of possible combinations that make up the different bearing surfaces. These include metal on polyethylene (non XLPE and XLPE), ceramic on polyethylene (non XLPE and XLPE) and ceramic on ceramic. Ceramicised metal femoral heads are only used with polyethylene (XLPE and non-XLPE). Metal on metal bearings were used in the past but this bearing is now largely confined to resurfacing hip replacements. The reason that metal on metal is not used in other types of hip replacements, is because it does not work as well as other available artificial joint surfaces.

In recent years the type of polyethylene used has been almost entirely XLPE. The use of this material has been associated with a significant reduction in the rate of revision in primary total conventional hip replacement for dislocation, loosening, and lysis. The reduced rate of revision for dislocation is due to an increased use of larger head sizes (32mm or greater) in XLPE procedures. It is possible to use

these larger head sizes because this type of polyethylene is more resistant to wear. When a larger head size is used, the hip replacement is more stable and so there is a lower rate of revision for dislocation. The reduced rate of revision for loosening and lysis is thought to be due to the reduced wear rate. Loosening and lysis are most often due to an inflammatory reaction, that occurs following the production of small wear particles. Theoretically, a reduced wear rate means fewer particles and therefore less inflammation.

The lower rate of revision for XLPE compared to non XLPE occurs, regardless of whether a metal, ceramic or ceramicised metal femoral head is used. No matter what type of femoral head is combined with an XLPE socket the results are very similar.

The Registry has undertaken a detailed analysis of ceramic on ceramic bearings. Although the Registry has information on three different ceramics, only one of these ceramics (mixed ceramic) is in current use. It is the best of the three ceramics. The revision rate of mixed ceramic varies slightly with femoral head sizes less than 32mm having a slightly higher rate of revision. Compared to the different femoral heads used with XLPE the results are very much the same. On occasion in the main report, you may see that the Registry has referred to modern bearings, these include ceramic on ceramic bearings as well as metal, ceramic and ceramicised metal femoral heads combined with XLPE.

The Registry also reports the results of a number of different types of hip replacements that have special features. These include exchangeable neck femoral components, mini femoral stems, as well as constrained and dual mobility acetabular components. The Registry is reporting on the results of these devices again this year.

Exchangeable neck femoral stems have a neck that is modular and includes different lengths and angles that can be fitted into the femoral stem. This differs from most other femoral stems where the neck and the stem are attached. The purpose of exchangeable necks was to give the surgeon greater choice to replicate the desired anatomy and the optimum position of the femoral component. Unfortunately, these devices generally don't work as well as fixed neck stems and they have largely been abandoned. Mini stems are very short cementless femoral stems, where fixation to the bone is over a smaller area entirely in the top of the femur. This contrasts with the standard femoral stem that usually extends almost halfway down the length of the inside of the femur. Currently, mini femoral stems remain a relatively new technology and are not commonly used. They represent only 1.5% of all total conventional hip procedures. This analysis does not identify any difference in the overall revision rate compared to standard femoral stems. There is a difference in the reasons for revision, with the mini stems requiring revision because they were more likely to become loose at 10 years compared to the standard stem. The rate of revision also varies depending on the type of mini stem used.

A constrained acetabular prosthesis is a special prosthesis. Unlike normal acetabular prostheses, it has a mechanism to lock the femoral head inside the acetabular socket so that there is a reduced chance of dislocation but at the same time allowing almost normal movement of the hip joint. It is not surprising to find they are used in different types of clinical situations to usual acetabular prostheses. In particular, they have been used more commonly in situations known to have a higher risk of dislocation. They do seem to have some beneficial effect because there is no difference in the rate of revision when a constrained acetabular prosthesis is used, when it would be expected that the risk of revision would be increased in the patient that it has been used in. However, younger patients (aged 70 years or less) do not do as well compared to older patients when a constrained cup is used, they have over three times the rate of revision. Most commonly total hip replacement is used to treat osteoarthritis. In recent years it is also being used to treat some hip fractures. Total hip has a higher rate of dislocation when it is used to treat hip fractures. In this situation, if a constrained acetabular prosthesis is used this reduces the risk of revision for dislocation.

Another type of special acetabular prosthesis is the dual mobility acetabular prosthesis. The reason it is called dual mobility is because the femoral head articulates with a polyethylene liner, but unlike the common situation where the polyethylene liner is fixed to the acetabular shell, in the dual mobility the liner is designed to move or articulate with the metal shell (i.e. there is dual mobility). The purpose of

the dual mobility design is similar to the constrained acetabular prosthesis, in that it is designed to reduce the risk of dislocation. Similar to constrained acetabular prostheses the proportion of dual mobility acetabular prostheses used for unusual reasons is high compared to standard acetabular prostheses. At 5 years, there is no difference in the revision rate of dual mobility acetabular prostheses compared to standard acetabular prostheses when the patient is being treated for either osteoarthritis or fractured neck of femur.

Knee Replacement

As with hips, the Registry considers three different categories of knee replacement: primary partial, primary total, and revision knee replacement. Each of these categories is further divided into a number of different classes. These are described in the Annual Report at the start of the section on knee replacement.

There were 66,729 knee replacements undertaken and reported to the Registry in 2019. This is an increase of 1.3% compared to the number reported in 2018.

Primary partial knee replacement accounts for 7.7% of all knee replacements reported to the Registry since it commenced data collection. Primary total knees account for 84.3% and revision knees 8.1%.

Since 2003 (which as previously mentioned was the first year that the Registry collected full national data), the number of knee replacements undertaken each year has increased. In 2019, there was a 133.1% increase in the number of knee replacements compared to 2003. However, the rate of change differs depending on the category of knee replacement. Primary total knee replacement has increased by 160.9% since 2003 and revision knees by 129.3%. However, primary partial knees have decreased by 6.0%. Almost all primary knee replacements, whether they are partial or total, are undertaken for osteoarthritis.

The proportion of knee procedures that are revision procedures, has been decreasing since the Registry was implemented. The percentage of knee replacements that are revisions decreased from 8.8% in 2004 to 8.0% in 2019.

Primary Partial Knee Replacement

A partial knee replacement is a replacement that only replaces part of the knee joint. The Registry identifies five classes of primary partial knee replacement. Most are used in small numbers and two are no longer used in Australia. The main report provides information on unicompartmental knee replacements and other partial knee replacements still being used are reported in the Partial Knee Arthroplasty Supplementary Report. The results of the two classes of partial knee replacement that are no longer used are available in the supplementary report on the AOANJRR website called Prosthesis Types No Longer Used.

The most used partial knee replacement is the unicompartmental knee. This replaces the femoral and tibial joint surfaces on either the inner or outer side of the knee (most commonly the inner side of the knee), its use accounts for 92.8% of all primary partial knees. Primary unicompartmental knee replacement has a higher rate of revision than primary total knee replacement. Age is a major factor affecting the outcome of unicompartmental knee replacement. The younger the patient, the more likely it is that the procedure will be revised early. At 19 years following a unicompartmental knee replacement, 29.5% have been revised. Almost 45.1% of patients less than 55 years of age at the time of their surgery have been revised within 19 years.

Unicompartmental knee replacement may be undertaken on the medial (inner), or lateral (outer) side of the knee. Medial unicompartmental knee replacement is much more common and accounts for 95.8% of all unicompartmental knee replacements. There is no difference in the revision rate when medial and lateral unicompartmental knee replacements are compared. The revision rate of unicompartmental knee replacement varies depending on the type of prosthesis used. The Registry has been following and reporting on the outcomes of unicompartment knee replacement that is placed in position using robotic surgery. Most commonly this is used with one device. The early results of this type of surgery appear to be satisfactory.

Primary Total Knee Replacement

A primary total knee involves the removal and replacement of the joint surface of the femur and the tibia on both the medial (inner) and lateral (outer) sides. A single femoral prosthesis and a single tibial prosthesis are used. The tibial prosthesis may be one component, but it is more commonly two that are put together at the time of surgery. Usually, a metal tray fits over the cut surface of the tibia with a plastic insert (tibial insert) that fits inside the tray to make the tibial prosthesis. This then articulates with the single femoral replacement. A primary total knee replacement may or may not have the under-surface of the patella replaced.

Primary total knee replacement has the lowest rate of revision compared to all other types of primary knee replacement. Men have a slightly higher rate of revision compared to women. The most important patient factor identified by the Registry that influences the rate of revision, is age at the time of surgery, the younger the patient the higher the subsequent rate of revision. Patients less than 55 years of age at the time of surgery have a 19.0% chance of being revised at 19 years. The rate of revision however is less for older patients.

There is only a small variation in the outcome of knee replacement related to the type of fixation used to hold the tibial and femoral components tightly to bone. Hybrid fixation has the lowest rate of revision, but the difference is not major. Cemented fixation has a lower rate of revision compared to cementless fixation, but this varies depending on whether the total knee replacement is minimally or posterior stabilised. Minimally stabilised knees do best if at the very least the tibial component is cemented. Posterior stabilised knees do best when both the tibial and femoral components are cemented to the bone.

An important difference between hip and knee replacement is what keeps the artificial joint surfaces from moving out of position. This is referred to as the stability of the joint. An unstable joint has additional unnatural movements between the joint articulating surfaces. The very extreme example of this is when the articulating surfaces come apart. This is referred to as dislocation which unlike hip replacement is very rare following knee replacement. There can also be lesser degrees of unnatural movement that can cause problems with the function of an artificial joint without the joint actually dislocating. In general, the stability of the joint is dependent on the shape of the joint as well as the soft tissues (muscles and ligaments) around the joint. If everything is working correctly, the combination of these factors allows normal movement and prevents unnatural movements (sideways or back and forward) between the joint surfaces. As the hip is a ball inside a socket joint, there is a lot of stability simply because of the shape. This is not the case with knee replacement, where two relatively flat surfaces articulate with each other. The stability of the knee joint is much more dependent on surrounding soft tissues and in particular ligaments that hold these joint surfaces in place and in the correct alignment. Quite often in patients receiving a knee replacement, one or more of these ligaments may already be damaged. In order to address this issue, primary total knee replacement can vary depending on the additional built in stability that may be required. In certain circumstances, it is necessary to use a replacement that is designed to substitute for one or more of the damaged ligaments.

Most knee replacements used do not require any additional stabilising, other than substituting for the anterior cruciate ligament. These are referred to as minimally stabilised knee replacements. The next most common group is posterior stabilised. These have additional stability built into the knee replacement so that the prosthesis substitutes for both the posterior and anterior cruciate ligaments. The vast majority of knee replacements used are either minimally or posterior stabilised prostheses. Minimally stabilised prostheses have a slightly better outcome than posterior stabilised prostheses. However, there is some difficulty in being too definite about this, as posterior stabilised prostheses may be used more often in difficult cases. If a case is more difficult, it has more potential to be revised.

Other important ligaments around the knee are the medial and lateral collateral ligaments. These can also be substituted by what is often referred to as constrained knee replacements. These are not often required in primary operations. There is one final group of knee replacement when considering stability and these are hinged knees. These are used mostly when there is absolutely no ligament stability left in the knee. Their use is very rare for primary knee replacement.

Another general difference in the design of primary total knee replacement, is the way the tibial insert is designed to move on the surface of the tibial tray. It may either be fixed to the tray (fixed insert) or designed to move slightly in one or more specific directions (mobile insert). Mobile inserts either rotate, slide or do both. For a number of years, the Registry has reported that in general, fixed inserts have a lower rate of revision.

Unlike hip replacements, knee replacements only have two main types of bearings. They are a metal femoral component combined with polyethylene, either XLPE or non-XLPE. Comparing the outcome of XLPE to non-XLPE across all knee replacements, there appears to be a benefit when XLPE is used. There is a lot of variation between the type of prostheses and the type of polyethylene used. As a consequence, any difference seen when comparing the overall result of XLPE to non-XLPE may be in part due to the type of prosthesis, rather than the type of polyethylene. To try and overcome this problem, the Registry has undertaken analyses of specific designs of total knee replacement that have used both XLPE and non-XLPE. There does not appear to be any situation where XLPE performs worse than non-XLPE. Sometimes it is better and sometimes it is the same.

The registry has also carefully monitored the use and outcomes of computer navigation in primary total knee replacement. Computer navigation is computer-assisted surgery, which was first used over 20 years ago. It involves the use of intraoperative computer monitoring in an attempt to more accurately place the knee prosthesis. It is known that accurate positioning of the prosthesis is a very important factor in determining the result of the operation. The current information from the Registry suggests that there may be a small advantage, particularly in younger patients, as there is a small reduction in the rate of revision for loosening in this group.

There is another technique, which surgeons are using in an attempt to improve the positioning of knee prostheses. This is known as Image Derived Instrumentation (IDI). This technique involves obtaining accurate images of the knee joint preoperatively so that the instruments used to achieve the alignment can be specifically made for that patient. The Registry has looked at the 12 different total knee prostheses where either the standard approach or IDI was used to determine the correct position of the knee prosthesis. For 10 of these prostheses, there was no difference in the subsequent revision rates when these two techniques were compared. For 2 of the prostheses, the revision rate was increased when IDI was used.

Shoulder Replacement

Shoulder replacement is also grouped into three different categories: primary partial, primary total, and revision shoulder replacement. Each of these categories is divided into a number of different classes. These are described in the Annual Report at the start of the section on shoulder replacement.

There were 7,735 shoulder replacements reported to the Registry in 2019. This is an increase of 4.9% compared to the number undertaken in 2018.

Primary total shoulders account for 78.5% of all shoulder replacements reported to the Registry since it commenced data collection. Primary partial shoulders account for 11.8% and revision shoulders 9.7%.

Due to the staged introduction of the Registry, the first year that the Registry recorded complete national shoulder data was 2007. Since that time, the number of shoulder replacements reported to the Registry has increased each year. The number of shoulder replacements undertaken in 2019 was 186.6% more than undertaken in 2008.

However, there are differences in the rate of increase depending on the category of shoulder replacement. The number of primary partial shoulder replacements has decreased by 69.5% since 2008. The number of primary total shoulders has increased by 338.0% and revision shoulder replacement has increased by 148.6% during the same time.

The proportion of shoulder procedures that are undertaken each year that are revision operations is called the revision burden. The aim of any intervention to improve the outcome of joint replacement is to reduce the revision burden. In 2008, the revision burden was 9.8%. This increased and peaked at 10.9% in 2012 and 2015. In 2019, the revision burden has declined and is lowest at 8.5%.

Primary Partial Shoulders

The Registry subcategorises primary partial shoulder replacement into four main classes. These are defined by the type of prostheses used. The main report provides information on the two main classes of partial shoulder replacement.

The most used shoulder replacement is hemi stemmed. This replaces the humeral head and humeral stem prosthesis. Hemi stemmed accounts for 72.6% of all primary partial shoulder replacements.

The second most used partial shoulder replacement is hemi resurfacing that uses a humeral prosthesis to replace the humeral articular surface only, without replacing the humeral head. Hemi resurfacing accounts for 23.7% of all primary partial shoulder replacements.

Partial resurfacing involves the use of one or more button prostheses to replace part of the natural articulating surface on one or both sides of the shoulder joint. Partial resurfacing accounts for 2.7% of all primary partial procedures. Hemi mid head is the least used type of primary partial shoulder replacement, accounting for 0.9%. It involves the resection of the humeral head and replacement with a humeral head and a humeral stem prosthesis. A humeral stem prosthesis may have metaphyseal or diaphyseal fixation.

Primary Total Shoulders

There are four types of primary total shoulder replacement: total reverse, total stemmed, total mid head, and total resurfacing.

Total reverse accounts for 64.6% of all primary total shoulder replacements. It involves glenoid replacement with a glenosphere prosthesis combined with resection of the humeral head and replacement with humeral cup and humeral stem prostheses. A humeral stem prosthesis may have metaphyseal or diaphyseal fixation.

After 3 months, total reverse shoulder replacement has a lower rate of revision compared to total stemmed shoulder replacement.

Total stemmed is the second most used type of primary total shoulder replacement, accounting for 30.3%. This procedure involves glenoid replacement combined with resection of the humeral head and replacement with humeral head and humeral stem prostheses. A humeral stem prosthesis may have metaphyseal or diaphyseal fixation. Cement fixation of the glenoid component in total stemmed shoulder replacement has a lower rate of revision.

Total mid head is less frequently used accounting for 4.5% of all primary total shoulder replacements. This procedure involves glenoid replacement combined with resection of part of the humeral head and replacement with a humeral head and an epiphyseal fixation prosthesis.

Total resurfacing shoulder replacement is the least used type of primary total shoulder replacement accounting for 0.5%. This procedure involves glenoid replacement and the use of a humeral prosthesis that replaces the humeral articular surface without resecting the head.

Hip, Knee and Shoulder Prostheses with a Higher than Anticipated Rate of Revision

The Registry reports on the results of individual prostheses in the different classes. There is variation in the revision rates for different types of prostheses in each class. Many of these differences are not statistically significant.

The Registry, however, does identify individual prostheses that have a statistically significant higher rate of revision. The threshold for that identification is that the revision rate is more than twice that of all other prostheses in the same class and the difference is statistically significant. In other words, the revision rate of these devices lies outside the expected norm. They are often referred to as outliers. These outliers are identified in the final chapter of the 2020 Annual Report.

This information highlights to surgeons, orthopaedic companies, and regulatory bodies worldwide, that something unexpected is happening with respect to the outcome of these prostheses. It enables consideration to be given as to the possible reasons for this difference and whether it is worthwhile or appropriate to continue to use these prostheses.

It is important to emphasise that there may be many reasons why the revision rate is twice that of other prostheses. Some of these may not necessarily be related or specific to the identified prostheses. The data related to each of these prostheses have been carefully considered by an expert group of orthopaedic surgeons who have recommended these prostheses be identified and therefore be considered further as to whether or not they should continue to be used. When they undertake that consideration, all available data is reviewed and any subsequent investigation that they may request is undertaken and provided. The consequence of this process is that not all outliers are recommended for identification. One of the main reasons that an outlier is not identified is because it is a non-standard prosthesis that is used in unusual or complex clinical situations associated with a higher risk of revision. In this situation, it is not fair to compare the results of these special devices to that of standard prostheses used in standard clinical situations.

This year, the Registry has identified 145 prostheses, or prosthesis combinations (84 hip, 54 knee and 7 shoulder).

The identified prostheses are listed in one of three groups. There are those that have a higher rate of revision that are being identified for the first time and are still in use in Australia. The second group includes prostheses that are being re-identified but are also still used. This list identifies that the prosthesis continues to have a higher than anticipated rate of revision and it provides updated information on its continued use. Most prostheses that are identified for the first time or re-identified prostheses decline in use with time. This is usually evident only after the first year because almost a full year of use has occurred prior to the identification in a previous Annual Report.

The third group are prostheses that are identified but are no longer used in Australia. Most of these have been previously identified. However, occasionally there is a prosthesis in this group that is identified for the first time. These are prostheses that are no longer available for use in Australia, and that as time progresses the Registry is able to identify that this device has a revision rate that is subsequently identified to be higher than anticipated.

The Registry identification of prostheses with a higher than anticipated rate of revision has resulted in many of these prostheses being withdrawn from national and international markets. Only summary information is provided in the Annual Report. However, the full detailed analysis for each of these prostheses is available from the Registry website (Investigations of Prostheses with Higher than Anticipated Rates of Revision).

Conclusion

The purpose of the AOANJRR is to provide high-quality independent data on the results of joint replacement in Australia.

The Registry provides this information to surgeons, and all other stakeholders to assist them to make informed judgments on the best approach to joint replacement surgery.

It is hoped that the information presented in this report is useful to people who are seeking additional information on joint replacement surgery, particularly those that are considering or have already undergone the operation. Registry information can be very complicated, as many factors interact to influence the outcome of the surgery. The intention of making this information available to everybody is to assist in promoting informed discussion about the outcome of joint replacement surgery, particularly between patients and their treating surgeons.