Evaluation of the Epidemiological Profile and Physiotherapeutic Conducts in Patients Undergoing Hip Arthroplasty

Avaliação do Perfil Epidemiológico e das Condutas Fisioterapêuticas em Pacientes Submetidos à Artroplastia de Quadril
Evaluación del Perfil Epidemiológico y Conductas Fisioterapéuticas en Pacientes Sometidos a Artroplastia de Cadera

RESUMO
Objetivo: Traçar e analisar o perfil epidemiológico dos pacientes submetidos à artroplastia de quadril, as condutas fisioterapêuticas realizadas e impactos na qualidade de vida, para minimizar e prevenir deficits funcionais melhorando as intervenções fisioterapêuticas. **Método:** pesquisa realizada no banco de dados PubMed, e análise dos prontuários nos últimos quatro anos no Hospital Universitário de Londrina. **Resultados:** Principalmente mulheres, idade média de 60 anos com osteoartrite de quadril, sobrepeso e hipertensão arterial sistêmica. A artroplastia não cimentada com a via posterolateral foi a mais realizada, havendo poucas complicações e óbitos. As condutas fisioterapêuticas foram principalmente na modalidade ativa. A hospitalização durou em média três dias e o apoio total no membro acometido em torno de 60 dias. **Conclusão:** A análise deste perfil epidemiológico e de como este paciente é atendido pela fisioterapia é de extrema importância para traçar novos protocolos de atuação.
DESCRITORES: Epidemiologia; Artroplastia de Quadril; Fisioterapia

ABSTRACT
Objective: To outline and analyze the epidemiological profile of patients undergoing hip arthroplasty, the physiotherapy procedures performed, and their impact on quality of life, aiming to minimize and prevent functional deficits by improving physiotherapy interventions. **Method:** Research conducted in the PubMed database, and analysis of medical records from the last four years at the University Hospital of Londrina. **Results:** Mainly women, mean age 60 years, with hip osteoarthritis, overweight, and systemic arterial hypertension. Uncemented arthroplasty with the posterolateral approach was the most frequently performed, with few complications and deaths. Physiotherapy procedures were primarily active. Hospitalization lasted an average of three days, and full weight-bearing on the affected limb lasted approximately 60 days. **Conclusion:** Analyzing this epidemiological profile and how these patients are treated by physiotherapy is extremely important for developing new protocols.
DESCRIPTORS: Epidemiology; Hip Arthroplasty; Physical Therapy Specialty

RESUMEN
Objetivo: Delinear y analizar el perfil epidemiológico de los pacientes sometidos a artroplastia de cadera, los procedimientos de fisioterapia realizados y su impacto en la calidad de vida, con el objetivo de minimizar y prevenir déficits funcionales mediante la mejora de las intervenciones de fisioterapia. **Método:** Investigación realizada en la base de datos PubMed, y análisis de registros médicos de los últimos cuatro años en el Hospital Universitario de Londrina. **Resultados:** Principalmente mujeres, edad promedio de 60 años, con osteoartritis de cadera, sobrepeso e hipertensión arterial sistémica. La artroplastia no cementada con el abordaje posterolateral fue la realizada con mayor frecuencia, con pocas complicaciones y muertes. Los procedimientos de fisioterapia fueron principalmente activos. La hospitalización duró un promedio de tres días y la carga completa de peso en la extremidad afectada duró aproximadamente 60 días. **Conclusión:** Analizar este perfil epidemiológico y cómo estos pacientes son tratados por fisioterapia es extremadamente importante para el desarrollo de nuevos protocolos.
DESCRIPTORES: Epidemiología; Artroplastia de Cadera; Fisioterapia

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INTRODUCTION

Hip arthroplasty (HA) is a surgical procedure that involves total or partial replacement of the hip joint (coxofemoral) with the aim of relieving pain, improving function, and returning to activities of daily living (ADLs) as soon as possible [1] for patients, most of whom are women between the ages of 60 and 69 [2].

The type of prosthesis for each patient varies according to the material and the replacement performed, and may be total hip arthroplasty (when the entire joint is replaced) or partial hip arthroplasty (when only the femoral head is replaced). As for the material, it can be cemented, non-cemented, ceramic, and hybrid (when one of the prosthesis components is cemented and the other is not).

Physical therapy begins in the preoperative period, enabling patients to perform activities of daily living as quickly as possible. To this end, it focuses on strengthening, metabolic exercises, sitting, early weight bearing, and ambulation, reducing hospitalization time and preventing thromboembolic events and pulmonary complications [3].

The objective of this study was to describe and analyze the epidemiological profile and physiotherapy procedures performed on patients undergoing hip arthroplasty at the University Hospital of Londrina, identify conditions and factors that may characterize this population and impact their quality of life, minimize or prevent such deficits, and enable improvement in physiotherapy interventions for QoL.

METHOD

A retrospective observational study was conducted in the PubMed database using the descriptors ((Epidemiology) AND (Arthroplasty, Replacement, Hip)) NOT (arthroscopy)) NOT (Medical Oncology)) NOT (Low Back Pain) and ((Arthroplasty, Replacement, Hip) AND (exercise)) in the last five years in Portuguese and English, free full texts, and epidemiological data from the National Institute of Traumatology and Orthopedics (INTO). This research was conducted in accordance with Resolution 466/2012 of the National Health Council and approved by the Ethics Committee for Research Involving Human Subjects (CEP) of UEL under opinion number: 5,477,998. The request for the medical records of patients who underwent total hip arthroplasty at the University Hospital of Londrina was made to the Medical Records and Statistics Department of the hospital itself with ICDs 180138 and 180134, from January 2021 to June 2024. A form (APPENDIX 1) was developed to collect epidemiological data on patients who underwent hip arthroplasty. Demographic data, medical history, details of the surgery, recovery, and physiotherapy procedures were collected and analyzed descriptively.

RESULTS

A total of 199 surgeries were per-

formed with ICDs 180138 and 180134 for hip arthroplasty from January 2021 to June 2024. One medical record was excluded because it had the wrong ICD. Of the 199 patients, 102 were female (51%) and 97 were male (49%), with a mean age of 61 years (3 were excluded because their age was not described in the medical record).

With the collection of weight and height data, it was possible to calculate the BMI of 159 patients (80%), as 40 patients did not have this data in their medical records. Of these 159, 62 (39%) were overweight, 55 (34%) were of normal weight, 28 (17%) were grade 1 obese, 6 (4%) were underweight, 5 (3.5%) were grade 2 obese, and 3 (2.5%) were grade 3 obese.

Of the 196 patients (98%) who had the diagnosis presented in the medical records, the majority, 123 patients, had osteoarthritis (63%), 55 (28%) had fractures, 17 (8%) had a diagnosis of aseptic necrosis, and 1 (1%) had a diagnosis of osteoporosis. Regarding the type of fracture: 53 (96%) were femoral neck fractures, 1 (2%) was a femoral head fracture, and 1 (2%) was a proximal femur fracture.

Of the 199 patients, 157 had comorbidities, which were as follows: 98 (62%) patients with hypertension, 33 (21%) with diabetes mellitus, 28 (18%) with dyslipidemia, 18 (11%) smokers and 17 (10%) former smokers, 17 (10%) heart disease, 15 (9%) with hypothyroidism, 13 with depression (8%), 9 (6%) had cancer (2 (22%) of the intestine, 2 (22%) of the breast, 1 (11%) of the cerebellum, 1 (11%) of the rectum, and 1 (11%) of the skin), 8 (5%) previous strokes, 7 (4%) with labyrinthitis, 7 (4%) with osteoporosis, 7 (4%) with systemic lupus erythematosus, 6 (3%) acute myocardial infarctions, 6 (3%) with chronic obstructive pulmonary disease, 5 (3.1%) patients with asthma, 5 (3.1%) with fibromyalgia, 4 (2.5%) with epilepsy, 4 (2.5%) with hypercholesterolemia, 3 (1.9%) with panic syndrome, 3 (1.9%) with anxiety, 3 (1.9%) with hepatitis, 3 (1.9%) with benign hyperplasia, 3 (1.9) with knee osteoarthritis, 2 (1.2%) with deep vein thrombosis, 2 (1.2%) with leprosy, 2 (1.2%) with gastritis, 2 (1.2%) with glaucoma, 2 (1.2%) had COVID-19, 2 (1.2%) with schizophrenia, 2 (1.2%) with osteopenia, 2 (1.2%) with psoriasis, 2 (1.2%) with AIDS, 2 (1.2%) with bipolar affective disorder, 1 (0.6%) with varicose veins, 1 (0.6%) with dementia, 1 (0.6%) with Alzheimer's disease, 1 (0.6%) with pituitary macroadenoma, 1 (0.6%) with trigeminal neuralgia, 1 (0.6%) with recurrent urinary tract infection, 1 (0.6%) kidney cyst, 1 (0.6%) with LECOA, 1 (0.6%) with nephrolithotripsy, 1 (0.6%) thyroid cyst, 1 (0.6%) sickle cell anemia, 1 (0.6%) with gastroesophageal reflux disease, 1 (0.6%) with colitis and diverticulitis, 1 (0.6%) lipomatosis, 1 (0.6%) with severe esophagitis, 1 (0.6%) with Raynaud's phenomenon, 1 (0.6%) meningitis, 1 (0.6%) seizure, 1 (0.6%) with bilateral posterior tibial neuropathy, 1 (0.6%) with rheumatoid arthritis, 1 (0.6%) with Sjögren's syndrome, 1 (0.6%) with neurotoxoplasmosis, 1 (0.6%) with hip dysplasia, 1 (0.6%) aneurysm, 1 (0.6%) Legg-Calvé-Perthes disease, 1 (0.6%) tuberculosis, 1 (0.6%) with hyperuricemia, 1 (0.6%) femoroacetabular impingement, 1 (0.6%) with nephrolithiasis, and 1 (0.6%) chronic venous insufficiency.

The average length of stay was three days, during which it was possible to analyze the complications that patients had. A total of 7 (3.5%) general complications were observed. Upon analyzing these complications, it can be observed that 2 were pulmonary (28%), 2 were renal (29%), 2 (29%) were osteomyelitis, and 1 (14%) was due to previous breast cancer. Of the patients studied, 2 (1%) died (1 due to a renal complication and the other due to previous breast cancer). For patients who had laboratory test results, it was possible to calculate the pre- and post-surgery averages. 119 had a pre-surgery white blood cell count average (8,743) and 88 had a post-surgery white blood cell count average (10,787), while the average of the 121 who had a pre-surgery red blood cell count (4.39) and 89 had a post-operative mean (3.25). Also, 121 people had a pre-operative platelet count mean (238,826) and 90 had a post-operative mean (233,288). The pre-operative CRP mean for 58 people was (42.2), and the post-operative mean for 70 was (104.08).

Of 111 patients (55%), the surgical incision was described in the medical records. The most commonly used access route in 101 patients was the posterolateral approach (90%), followed by the posterior approach in 4 patients (4%), anterior in 3 (3%), posterior superior in 1 (1%), anterolateral in 1 (1%), and posterior medial in 1 (1%). Of the 199 medical records evaluated, 14 (7%) did not have information about the type of prosthesis, totaling 185 medical records with complete data. Of these, the cementless prosthesis was the most commonly used, totaling 116 (63%), followed by 5 (3%) patients with cemented prostheses, then two (1%) hybrid prostheses, and finally 2 (1%) partial prostheses, while the material was not specified in 60 (32%) cases. After the patients were discharged, 49 of them (25%) had an average total weight-bearing release in the affected limb of 60 days, the rest were not described in the medical records, or had not yet been released, or, for other reasons, these patients were no longer ambulatory before surgery.

The physical therapy procedures performed during the hospitalization period of these patients were also analyzed. Eleven patients did not receive treatment due to severe pain or refusal of care. Thus, of the 188 individuals, 9 (5%) received passive mobilization of the operated lower limb, 142 (75%) were able to perform active mobilization, and only 1 (0.5%) was able to perform resistance exercise of the operated lower limb. Bedside sitting was performed in 160 patients (85%), 117 (62%) were able to stand upright, in 98 (58%) it was possible to develop gait training, and

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100 (53%) required the use of walking aids such as crutches and walkers.

DISCUSSION

According to the study, it can be observed that the highest hospitalization rate occurs among females with an average age of 69 to 79 years[4]. The indication for this surgical procedure is the result of diseases and other conditions that cause the patient pain and functional disability, mainly due to osteoarthritis, femoral neck fracture, and aseptic necrosis[4-6].

Few studies address the comorbidities found in patients undergoing hip arthroplasty and whether they increase the risk of complications during or after surgery. Studies indicate that an increase or decrease in BMI does not interfere with the need for hip replacement, just as obesity does not increase the risk of complications from deep vein thrombosis and pulmonary embolism when compared to patients with a normal BMI[7-8].

According to research, metabolic syndrome (MS) does not negatively influence joint replacement surgery or increase the risk of revision [9], unlike diabetes, which, regardless of whether it is controlled or not, increases the chances of hospital readmission and postoperative complications, including mechanical complications, pneumonia, and infections [10]. Similarly, patients with human immunodeficiency virus (HIV) and kidney disease due to diabetes are more susceptible to complications after surgery [11-12].

A search on gender differences in complications after hip arthroplasty concluded that women had higher complication rates during surgery, but men had a significantly higher risk of complications within 30 days after surgery, including infection, dislocation, and revisions. Studies suggest several factors that increase the risk of complications and death, such as age over 75, being female, femoral neck fracture, intensive care unit (ICU) admissions, and hospitalization longer than 2 to 3 days after surgery [4, 14-15].

Authors investigated QA materials and concluded that cementless prostheses are a safe procedure and do not increase the risk of surgical complications, and that cemented prostheses present better results in relation to prosthesis loosening and periprosthetic fractures [16-17]. Positive points are also applied to partial and total prostheses, while partial prostheses reduce surgery time and blood loss, total prostheses reduce hospitalization time [18-19].

The access routes used to perform the surgical procedure also present positive factors or possible complications. Researchers have found the direct anterior approach to be safe and efficient, in addition to causing less blood loss, providing greater visualization of the acetabulum, causing less heterotopic ossification, resulting in faster recovery time, and saving medical resources [20-21]. However, a study published in 2024, in addition to presenting positive points such as lower rates of infection and dislocation related to the posterior approach, showed a significantly higher rate of revision due to loosening of the femoral component [22].

A 2020 study on a rehabilitation protocol for post-ATQ patients aimed at reducing hospital stay included 104,745 patients, who underwent rehabilitation without range of motion limitations (not specified in the article) or weight bearing and early ambulation within 24 hours of the procedure. The average length of stay was 2 to 3 days, achieving the goal of significantly reducing hospital stay.

Another study in 2022 compared inpatient physical therapy approaches in elderly patients after TKA to observe functionality and quality of life. Patients were divided into two groups in the postoperative period. Group A adopted orthostatic exercises and walking with an assistive device (walker), and the entire body weight was placed evenly on the entire foot, with the distance depending on the patient's condition at the time. Group B performed bedside exercises and attempted orthostasis with assistive devices. The procedures involved active hip flexion, active dorsal and plantar flexion of the ankle, and isometric exercises of the quadriceps femoris and gluteus muscles to increase hip, knee, and ankle strength. Each exercise was performed 10 times in 5 sets. This author concluded that elderly patients undergoing ATQ in group A had better hip function and quality of life, in addition to reducing the incidence of deep vein thrombosis (DVT) compared to group B [24].

A 2021 analysis related to routine postoperative laboratory tests in hip hemiarthroplasty for femoral neck fractures in the elderly indicated that in most of the patients involved in this study, abnormal laboratory tests were less frequent [25].

Thus, it was possible to evaluate and compare the various factors that form the epidemiological profile of patients exposed to hip arthroplasty surgery, in addition to showing the importance of studying intra-hospital physiotherapeutic approaches for better rehabilitation of these individuals.

CONCLUSION

It can be concluded that the epidemiological profile of patients undergoing hip arthroplasty at the University Hospital of Londrina is mostly composed of elderly women who are overweight, have SAH (main comorbidity), and osteoarthritis. This profile leads to pain and physical disability, which impacts the quality of life of these patients, a fact that further highlights the importance of physical therapy in this treatment. The analysis of this epidemiological profile and how these patients are treated by physical therapy is extremely important for developing new protocols for action.

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APPENDIX 1 - FORM

QUADRIL em Foco
FISIOTERAPIA HU/UEL

Data da cirurgia (Dia/mês/ano): / /

Data de alta, transferência ou óbito (Dia/mês/ano): / /

Questionário

Sexo

( ) - Feminino

( ) - Masculino

Idade na data do procedimento _____

IMC;

Peso: Altura:

Diagnóstico clínico;

( ) - Osteoartrite

( ) - Fratura

( ) - Displasia

( ) - Necrose asséptica

( ) - Outras _____

Tipo de fratura _____

Comorbidades antes da cirurgia _____

Data de internação (Dia/mês/ano): / /

Via de acesso da cirurgia

( ) Anterior

( ) Anterolateral

( ) Lateral

( ) Posterolateral

( ) Posterior

Exames Laboratoriais pré-operatório

- Leucócitos:
- Parte vermelha:
- Plaquetas:
- PCR:

Complicação da cirurgia

( ) - sim / ( ) Cardiovascular ( ) Pulmonar

Outras _____

( ) - Não

Condutas realizadas:

( ) Mobilização passiva do membro acometido;

( ) Mobilização ativa do membro acometido;

( ) Mobilização resistida do membro acometido;

( ) Sedestação beira leito;

( ) Ortostatismo;

( ) Treino de marcha;

Outros: _____

Dispositivo auxiliar de marcha sim ( ) não ( ) qual _____

Quanto tempo liberado carga total _____

Tipo de prótese;

( ) Artroplastia total de quadril

( ) Artroplastia parcial de quadril

( ) Artroplastia total de quadril híbrida

( ) Resurfacing

( ) Cimentada ( ) Não cimentada

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