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## Research article

### FUNCTIONAL OUTCOME WITH BIPOLAR HEMIARTHROPLASTY AS AGAINST TOTAL HIP ARTHROPLASTY IN INTRACAPSULAR FRACTURE NECK FEMUR

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## ABSTRACT

**Rationale:** Internal fixation is considered a reliable method for an undisplaced intracapsular fracture and also for displaced intracapsular fractures in young patients. A unipolar or bipolar hemiarthroplasty is preferred for these fractures in elderly patients with low functional demands. However, controversy exists regarding the choice of prosthesis in patients with displaced intracapsular femoral neck fractures in relatively young and active adults.

**Design:** 45 patients with displaced intracapsular femur neck were randomized to undergo a Total hip arthroplasty or a Bipolar hemiarthroplasty. The outcome was assessed with the use of the Harris hip score and the Mobility score of Parker and Palmer. **Results:** The mean age of the patients was 63.54 years. The mean blood loss was higher in Group 2 (THA) [545.24 ± 134.07 ml] as against Group 1 (BH) [443.75 ± 88.84 ml] (p= 0.004). The mean duration of surgery in Group 2 [121.90 ± 20.40 mins] was significantly higher as compared to that in Group 1 (BH) [87.50 ± 10.52 mins]. No significant difference was observed in the mean postoperative Mobility Score at the end of 6 months amongst the 2 groups. The Harris Hip Score at the end of 6 months was Excellent for 9 patients, Good for 27 patients, Fair for 6 patients and Poor for 2 patients. 40 patients were able to do their daily activities and 4 were unable to do so owing to their general medical condition. **Conclusion:** Total Hip Arthroplasty offers better functional outcome in early follow-up and can be used for treating for these fractures in this age group.

**Key words:** Bipolar Hemiarthroplasty, Total Hip Arthroplasty, Fracture Neck Femur, Proximal Femoral Fracture.

## INTRODUCTION

Proximal femoral fractures are common orthopaedic injuries in older patients; typically occurring in the neck, the intertrochanteric and sub trochanteric regions. They impair mobility, cause excessive morbidity, mortality, loss of independence and also account for more than two-thirds of all hospital days due to fracture. <sup>1</sup>Displaced, unstable fractures of the femoral neck generally represent an indication for early surgical intervention. The surgical treatment for

displaced intracapsular femoral neck fractures in relatively young and active has always been controversial.<sup>2,3</sup> Established treatment options include internal fixation, hemiarthroplasty, where the head of the femur is replaced with a prosthetic implant or total hip replacement, which essentially includes, replacing the femoral head as well as the acetabulum with a prosthetic implant.

The proponents of arthroplasty suggest that replacing the femoral head eliminates the risk of revision surgery due to serious complications such as head necrosis or nonunion.<sup>4</sup> There appears to be a consensus that unipolar or bipolar hemiarthroplasty is the preferred treatment for displaced intracapsular fractures in elderly patients with low functional demands. However, the choice of prosthesis for the joint replacement in patients with displaced intracapsular femoral neck fractures, especially in relatively young and active adults have been a matter of debate.<sup>5</sup>

Well recognized goals of surgical treatment are immediate pain relief, early mobilization and maintenance of independent living. In addition to these prerequisites, the ideal implant must be associated with a low risk of surgical complications and subsequent revision. At best, patients should not be hampered by the treated hip during their remaining lifetime.<sup>6,7</sup>

The aim of this study was to compare the clinical outcome in elderly patients undergoing Primary Total Hip Arthroplasty as against Bipolar Hemiarthroplasty in intracapsular fracture neck femur. The primary outcome measured was Functional outcome. The revision rate of surgery, mortality and complication rate were secondary outcomes.

## MATERIAL AND METHODS

The study was carried out in a tertiary institution with well established Orthopaedic and Anesthesia set up. The Institutional Ethics Committee approval and written informed consent were obtained for all the participants in the study.

Forty five patients with displaced intracapsular femur neck undergoing replacement arthroplasty were randomized to receive either a bipolar hemiarthroplasty or a Total Hip Arthroplasty and were followed up at a period of 1 month from the day of discharge, monthly for the first 3 months and every 3 monthly, then onwards till the end of the study.

### Inclusion Criteria:

a) Patients above the age of 50 years with a displaced intracapsular fracture neck of Femur.

### Exclusion Criteria:

a) Suspected pathological fracture or metastatic disease

b) Bedridden, barely mobile patients or one with significant dementia.

c) A patient who refused surgery.

Each patient was evaluated preoperatively and scored on their mobility prior to the injury based on the Mobility Score of Parker and Palmer. All patients were given Buck's skin traction<sup>8</sup>. The average duration between the occurrence of fracture and day of operation was noted preoperatively. All patients were operated under Regional combined spinal – epidural anesthesia and were operated using the posterior approach to the hip. Prophylactic antibiotics were administered intravenously one hour prior to surgery.

Intraoperative parameters measured were:

a) Total duration of surgery,

b) Amount of blood loss

c) Units of blood transfused intraoperatively.

d) Any intraoperative complications, including neurovascular injury, hemorrhage, fractures and complications of cementing

e) Complications due to morbid conditions or death were noted.

All patients were started on static quadriceps exercises and foot and ankle mobilization exercises on the 2nd post operative day and were made to sit by edge of the bed and dynamic knee mobilization was started by 3<sup>rd</sup> day post operative. The patients were made to walk with the help of walker starting 3<sup>rd</sup> day post operatively depending on the pain relief and comfort of the patient. Postoperative complication namely infection, bedsore, thromboembolism, dislocation, urinary tract infection, implant failure or loosening, septicemia or any complication due to associated morbid condition were treated accordingly before discharging the patients from the hospital and the total duration of hospitalization was noted.

The patients were followed up every month for the first 3 months and then every 3 months from then on. During each visit, the patient was assessed clinical by noting:(a) pain relief – complete /partial /no relief, (b) shortening in cm, (c)standing – unable /partial weight bearing /full weight bearing, (d) walking – unable to walk/ with walker/ with cane, unaided: inside house /outside house /go shopping, visit relative, (e) distance walked – unlimited /inside house /bed and chair, (f) climbing stairs – without using railing /using railing /unable to climb, (g) wear footwear – ease /difficulty /unable to wear, (h) sitting on a chair – comfortable /not possible, (i) range of movement, (j) deformity (k) able to do routine work

– yes /no, (I) Overall satisfaction with surgery – completely satisfied /partially satisfied /not satisfied and radiological by obtaining an antero-posterior radiograph of Pelvis with both hips. Functional Outcome was measured at final follow up using HARRIS HIP SCORE<sup>9</sup> and Mobility Score of PARKER and PALMER.<sup>10</sup>

## RESULTS

**Statistical Analysis:** The parameters were tested for statistical significance depending on their distribution either by a Student's *t*-test or a Mann-Whitney U test. Dichotomous variables were analyzed using a chi-squared test or Fisher's exact test as appropriate. The paired T-test was used to assess the difference in preoperative and postoperative difference in the Mobility score of Parker and Plamer. A *p*-value < 0.05 considered statistically significant.

The study included 24 patients treated by Bipolar Hemiarthroplasty (Group 1) and 21 patients treated by a Total Hip arthroplasty (Group 2). The mean follow up for Group 1 (BH) was 10.17 months (6 – 21 months), for Group 2 (THA) was 9.7 months (6 – 22 months). No patient was lost to follow up.

**Table 1: Demographic and pre operative data**

Parameter	Bipolar (n=24)	THA (n=21)	P value
Mean age (range)	63.54 (50 – 84)	63.52 (50 – 82)	0.995 <sup>+</sup>
Sex - M:F	8 : 16	8 : 13	0.491 <sup>+</sup>
Side – right : left	12: 12	7 : 14	0.205 <sup>+</sup>
Type of injury			
Low velocity	24	21	-
High velocity	0	0	
ASA Grading	2.0±0.62	1.8±0.68	0.228 <sup>+</sup>
1	4	7	
2	15	11	
3	5	3	
Pre op Mobilty Score of Parker and Palmer ± S.D	7.1±1.57	6.9±2.03	0.693 <sup>+</sup>
Trauma – surgery interval ± S.D	2.0±1.12	1.8±0.85	0.734 <sup>+</sup>

+ = not significant \* = significant (*p*-value < 0.05)

All patients in the 2 groups were comparable to each other in terms of their mean age, sex ratio, the side of

the limb involved, Pre operative Mobility Score of Parker and Palmer and Trauma – Surgery interval.

**Table 2: Intraoperative data**

Parameter	Bipolar (n=24)	THA (n=21)	P value
Mean intraoperative time (minutes) ± S.D	87.50 ± 10.52	121.90 ± 20.401	<b>0.001*</b>
Mean blood loss (ml) ±S.D	443.75 ± 88.84	545.24 ±134.075	<b>0.004*</b>
Mean blood transfusion in ml ± S.D	481.25 ± 248.82	516.66 ± 210.55	0.611 <sup>+</sup>
Mean hospitalization time (days) ± S.D	17.33 ± 5.378	16.71 ± 4.326	0.670 <sup>+</sup>

+ = not significant \* = significant (*p*-value < 0.05)

The mean blood loss was higher in Group 2 (THA) [545.24 ±134.07 ml] as against Group 1 (BH) [443.75± 88.84 ml] (*p*= 0.004). The mean duration of surgery in Group 2 [121.90 ±20.40 mins] was significantly higher as compared to that in Group 1 (BH) [87.50 ±10.52 mins].

The total volume of blood transfused (in ml) and the total duration of hospital stay were comparable amongst the 2 groups. There were no intraoperative complications observed. 1 female patient died of pulmonary embolism on the 2<sup>nd</sup> postoperative day in Group 1 (BH) which could be attributed to cementing.

**Table 3: Complications**

Complications	Bipolar (n=24)	THA (n=21)	P value
A) EARLY			<b>0.407<sup>+</sup></b>
1. Bed sore	4(16.66%)	2(9.52)	0.48 <sup>+</sup>
2. UTI	1 (4.16%)	1 (4.76%)	0.97 <sup>+</sup>
3. Thrombophlebitis	1(4.16%)	0	0.32 <sup>+</sup>
4. Foot drop	1(4.16%)	0	0.32 <sup>+</sup>
5. Pulmonary embolism	2 ( 8.33%)	0	0.14 <sup>+</sup>
6. Septicemia	0	0	NA
7. Wound infection	1(4.16%)	0	0.32 <sup>+</sup>
B) LATE *			0.331 <sup>+</sup>
1. Hip dislocation	1 (4.16%)	3(14.28)	0.26 <sup>+</sup>
2. MORTALITY	1(4.16%)	0	0.32 <sup>+</sup>
3. IMPLANT LOOSENING (at final follow up)	1 (4.16%)	0	0.32 <sup>+</sup>
4. REOPERATION	0	1	0.467 <sup>+</sup>

\* late complications were considered after the death of 1 patients.

+ = not significant \* = significant (*p*-value < 0.05)

Among the early complications, 6 patients had bed sores (four in Group 1 and two in Group 2), 2 had urinary tract infections (one each in Group 1 and Group 2), one patient had thrombophlebitis (Group 1) and 1 patient had a superficial infection (Group 1). One patient from Group 1 developed a foot drop. All patients were treated for these complications using appropriate measures before discharge. The distribution of the above in the two groups was not found to be statistically significant [p value 0.407]

One patient in Group 1 (BH) and 3 patients in Group 2 (THA) suffered dislocation of the hip. All except one dislocation (one in Group 1 and two in Group 2) occurred within the first two weeks after surgery. The only dislocation in Group 1 (BH) and one dislocation in Group 2 (THA) occurred when the patient was being made to sit from a supine position from bed. One dislocation in Group 2 occurred while the patient was being shifted to the ward from the operating room. One dislocation occurred at 3 weeks post surgery when the patient was rising from the toilet chair. One dislocation in Group 2 occurred in the first week post surgery, which was closed reduced. The patient suffered another dislocation 3 weeks post surgery and was subsequently.

**Table 4: Functional assessment**

Parameter	Bipolar (n = 24)	THA (n = 21)	P value
Walks unaided FWB (weeks) ± S.D	6.3 ± 0.7	6.1 ± 0.8	0.193
<b>Pain (at 6 months) (%)</b>			
No	14 (60.9%)	16(76.19%)	0.376
Slight	5 (21.7%)	4 (19.0%)	
Mild	4 (17.4%)	1 (4.8%)	
Moderate	0	0	
Severe	0	0	
Mean Limb Length Discrepancy (cms) (at 6 months) ± S.D	0.47 ± 0.66	0.59 ± 0.64	0.557
<b>Able to do daily activities</b>			
Yes (%)	7 (70%)	12 (75%)	0.339
No (%)	3 (30%)	4 (25%)	
Post op Mobility Score by Parker and Palmer (at 6 months) ± S.D	5.96 ± 1.79	6.29 ± 1.64	0.531
<b>Harris Hip Score (at 6 months) (%)</b>			
Excellent	5 (21.7%)	4 (19.0%)	0.560
Good	13 (56.5%)	14(66.7%)	
Fair	(13%)	3 (14.3%)	
Poor	2 (8.7%)	0 (0.00)	

All the above p values are not significant  
The time to full weight bearing (FWB) was similar in both the groups. 31 out of 45 patients [68.2%] reported no pain at 6 months follow up. Of the 31

patients, 15 from Group 1 (BH) [60.9%] while 16 were from Group 2 (THA) [76.2%]. Nine patients [20.5%] reported slight pain at 6 months, 5 patients [21.7%] from Group 1 (BH) as compared to 4 patients [19%] in Group 2 (THA). 90.9% of the patients in the study group were able to do daily activities.

No significant difference was observed in the mean postoperative Mobility Score at the end of 6 months amongst the 2 groups. The mean postoperative Mobility score of Parker and Palmer at the end of 6 months decreased from the preoperative score in both the groups. [p< 0.001]

The Harris Hip Score at the end of 6 months was Excellent for 9 patients, Good for 27, Fair for 6 and Poor for 2 patients. 4 were unable to do their daily activities owing to their general medical condition.



**Fig 1. Total hip Arthroplasty A: Preoperative – Right Transcervical fracture neck femur, B: Immediate post operative C: Dislocation in first week, D: 6 month follow-up.**



**Fig 2: Bipolar Hemi arthroplasty. A & B: Preoperative – Left Transcervical fracture neck femur, C: Post operative, D: 3 month follow-up, E: 14 month follow-up.**

## DISCUSSION

As the elderly population increases, the occurrence of a femoral neck fracture is becoming more common, hence increasing their socioeconomic importance.

<sup>11</sup>These fractures can be devastating injuries that require medical and surgical treatment and consume considerable health care resources. The goal of treatment of these fractures is restoration of pre fracture function without associated morbidity. Satisfactory recovery of pre fracture ambulatory status correlates with younger age, co-morbid medical conditions, competent mental status, male gender, community support structure and pre fracture ambulatory status.<sup>12</sup>

Out of the 45 patients, 24 patients were operated by Bipolar Hemiarthroplasty and 21 by Total Hip Arthroplasty and were followed up for an average period of 10 months [Group 1 for  $10.17 \pm 4.58$  months and Group 2 for  $9.57 \pm 4.51$  months]. The duration of the study was 26 months. All the fractures occurred as a result of a low velocity trauma as a result of a fall at home. A cemented stem was used in 5 out of the 24 cases in Group 1 and in one patient belonging to Group 2. The choice of a particular type of stem was left to the discretion of the operating surgeon after discussing the cost factor with the patient. The un-cemented Total Hip arthroplasty was performed using a Ceramic head –on – ceramic acetabular lining whereas for the cemented Total Hip arthroplasty, a metal head on polyethylene acetabular lining was used.

The mean age of the study group was 63.53 years. Other baseline parameters such as the sex ratio, side involved and ASA grading were compared between the two groups. 30 patients were females – 16 in group 1 [BH] and 13 in Group 2 [THA] indicating a higher incidence of osteoporosis in elderly, post menopausal females [p value 0.491]. The mean blood loss in Group 1 (BH),  $443.75 \pm 88.84$  ml was lower than Group 2 (THA),  $545.23 \pm 134.075$  ml [p value 0.004]. The mean duration of surgery in the Group 2 (THA) [ $121.90$  mins  $\pm 20.40$ ] was much more than that in Group 1 (BH) [ $87.50$  mins  $\pm 10.52$ ] [p-value 0.002].

M.P. J. van den Beckerom et al<sup>13</sup>, in their study found the duration of surgery to be longer in THA group [28% > 1.5 hours versus 12% > 1.5 hours]. The intra-

operative blood loss was also found to be higher in the THA group (26% > 500ml versus 7% > 500ml).

Bloomfield et al<sup>14</sup> in their study showed that the mean blood loss in the THA group was 460 ml (100 to 1100 ml) and, in the bipolar group was 320 ml (50 to 850 ml) with the mean duration of surgery being 102 mins and 78 mins respectively, both were statistically significant. Hopley et al<sup>6</sup> in their analysis observed that a Total Hip Replacement lengthened the duration of surgery by 11 minutes on an average (4 to 19 minutes), which is similar to our study. The mean volume of blood transfused in Group 2 (THA) [ $516.66 \pm 210.55$ ] was more than Group 1 (BH) [ $481.25 \pm 248.82$ ], the difference was not significant [p value 0.611]. The higher volume of blood transfusion in comparison to blood loss is attributed to low preoperative haemoglobin in patients belonging to either group. Keating et al<sup>15</sup> in their study concluded that patients undergoing a total hip arthroplasty were more likely to receive a blood transfusion as compared to bipolar hemiarthroplasty which is similar to the present study. The mean duration of hospital stay was comparable in the two Groups and the difference was not significant.

Early complications among the study group were 24.44% [37.5% Group 1, 14.28% Group 2]. Bed sore was the most frequent in both the groups [16.66% in Group 1 & 9.52% in Group 2]. All the bedsores were superficial and responded well to local dressing and subsequently healed with patient mobilization. 4 out of the six bedsores occurred in females and all occurred in patients where the trauma- surgery interval [3.5 days] was increased as compared to the study group [ $1.96 \pm 0.99$ ] due to delay in obtaining fitness for surgery. Pulmonary embolism was the second most frequent [4.4% overall]. Both the patients were from Group 1 (BH) whereas no pulmonary embolism occurred in Group 2 (THA). Other early complications namely Urinary tract infection, Foot drop and wound infection [4.16% each], all of which occurred in Group 1 (BH).

Beckerom et al<sup>13</sup> reported early complication in 34 patients (25%) in the bipolar hemiarthroplasty group in comparison to 28 patients (24%) in the Total hip arthroplasty group (p = 0.93).

Hopley et al<sup>6</sup> observed the general complications to be slightly more often following Total Hip Arthroplasty than after Bipolar Hemiarthroplasty. In comparison, the present study found a high

occurrence of complications in the Bipolar Hemiarthroplasty group [37.5%].

Dislocation occurred in 4 patients [8.8%], one patient [4.16%] from Group 1 (BH) and three patients [14.28%] from Group 2 (THA). All patients were operated by the posterior approach<sup>16</sup>. Three dislocations [1 in Group 1 (BH) and 2 in Group 2 (THA)] occurred within the first two weeks after surgery and were attributed to inability to maintain limb abduction especially during moving out of bed. The only dislocation in Group 1 (BH) and one dislocation in Group 2 (THA) occurred when the patient was being made to sit from a supine position from bed. One dislocation in Group 2 (THA) occurred while the patient was being shifted to the ward from the operating room. They were treated by closed reduction using the Allis maneuver consisting of longitudinal traction along the femur followed by flexion of the affected hip for 90°. The reduction was completed by external rotation of the hip. An assistant stabilizes the pelvis throughout the procedure. Alternatively, the East Baltimore lift or Stimson's anti gravity method can be used.<sup>17, 18</sup> None suffered another episode of dislocation in the follow-up period. One dislocation occurred in the first week post surgery, which was closed reduced. The patient suffered another dislocation 3 weeks post surgery when the patient was rising from a chair. This surgery was subsequently revised using a larger size skirted head to increase the offset and soft tissue repair (Figure. 1). The patient did not suffer any subsequent dislocations and had a good hip function at 6 months follow-up.

The fracture patient is not accustomed to careful positioning of the affected hip, and hence may be more likely to move his hip into at-risk positions postoperatively, increasing his chance for dislocation.<sup>20, 21, 22</sup>

Dislocation occurred in 4.16 % in Group 1 and 14.28% in the Group 2 which is similar to the study by K. Karthik et al<sup>23</sup>, W. H. TAINÉ et al<sup>24</sup> and Tidermark et al<sup>25</sup> and have attributed the posterior approach as a reason for higher dislocation following prosthetic replacement.

Dorr et al<sup>26</sup> has attributed the increase rate of dislocation in the THA group due to the enhanced stability of the bipolar hemiarthroplasty owing to the large acetabular shell in this group. This has made the

orthopaedic surgeon hesitant to recommend it for active elderly patients.<sup>5</sup>

Late complications, including mortality occurred in 7 patients [15%], 19.04% of patients in Group 2 (THA) as compared to 12.5% of patients in Group 1 (BH). There was one mortality in the study population [2.2%], 4.16% in Group 1 (BH) as compared to no mortality in Group 2 which is lower than other studies.<sup>6, 15</sup> This may be due to a relatively younger sample size as compared to the other studies.

Implant loosening was observed in one patient in the study group [2.2%]. It occurred in Group 1 (BH) when the patient followed up 14 months post surgery (Figure. 2). The patient complained of minimal anterior thigh pain, however maintained good hip function. This is attributed to first generation cementing technique<sup>27</sup>. The patient was advised to follow up regularly and the need for operation in the future.

The mean weeks of unaided full weight bearing (FWB) in Group 1 (BH) [6.35 ± 0.71 weeks] and Group 2 (THA) [6.14 ± 0.85 weeks] were comparable. 31 patients [68.2%] reported no pain at 6 months follow-up; 15 were from Group 1 (BH) [60.9%] and 16 were from Group 2 (THA) [76.2%].

Nine patients [20.5%] reported slight pain at 6 months, 5 [21.7%] from Group 1 (BH) as compared to 4 [19%] from Group 2 (THA).

Mild pain was reported in 5 patients [11.4%] in the study group requiring infrequent analgesic use, 4 from Group 1 (BH) [17.4%] and 1 patient from group 2 (THA) [4.8%].

The mean limb length discrepancy (LLD) in centimeters was more in Group 2 (THA) [0.59 ± 0.64 cms] as compared to Group 1 (BH) [0.47 ± 0.66 cms] which is comparable to other studies.<sup>28, 29, 30</sup>

It is universally perceived when shortening exceeds 10 mm and lengthening 6 mm.<sup>30</sup> Two patients from the THA group and one patient from the Bipolar hemiarthroplasty group complained of perception of limb length discrepancy. They were subsequently managed with a shoe raise

At the end of 6 months, 90.9% patients were able to do daily activities, 20 patients [86.9%] from Group 1 (BH) as against 20 patients [95.23%] in Group 2 (THA). Two patients from Group 1 (BH) and one patient from Group 2 (THA) reported inability to do daily activities owing to their general medical condition and advanced age of the patients.

The mean preoperative mobility score of Parker and Palmer (Table. 4) (Chart. 10) was  $7.26 \pm 1.54$  in Group 1(BH) and  $6.95 \pm 2.03$  for Group 2 (THA). Post operative mobility scores of Parker and Palmer was  $5.96 \pm 1.79$  in Group 1 (BH) as against  $6.29 \pm 1.64$  in Group 2 (THA). The comparison of pre operative and post operative scores showed a statistically significant decrease in Group 1 (BH) [1.21] as compared to Group 2 (THA) [0.67] [p value 0.011].

9 patients [20.5%] had an excellent Harris Hip Score. (5 in the bipolar group [21.73%] and 4 in THA group [19.04%]), 27 patients [61.4%] had a good result (13 in the bipolar group [56.52%] and 14 in THA group [66.7%]), 6 patients had a fair result (3 each in Group 1 (BH) [13%] and THA group [14.3%]), and 2 patients [4.54%] had a poor result both of which were from the bipolar group. None of the patients had a poor result in the THA group.

The outcome was marginally better in patients going for Total hip Arthroplasty with 85.7% patients having either an excellent or good result as compared 78.26% of the patients in Group 1 (BH). These findings are similar to the study by Iorio et al<sup>31</sup> with superior outcome in patients following Total Hip Arthroplasty. Bloomfield et al<sup>14</sup> in their randomized study comparing bipolar hemiarthroplasty with total hip arthroplasty involving 120 patients reported similar results at 4 and 12 months follow-up. They attributed the poorer scores in the Bipolar Hemiarthroplasty group to early acetabular wear following prosthetic replacement.

Keating et al<sup>32</sup> concluded that the best clinical and functional outcomes in the study were observed after total hip arthroplasty.

In contrast, K Karthik George et al<sup>23</sup> reported better Harris Hip Score in the Bipolar Hemiarthroplasty group [86.93] in comparison to total hip arthroplasty [83.82]. The difference was however not statistically significant. Primary osteoarthritis of the hip is uncommon in the south Asian population.<sup>33</sup> They suggested in their findings that in a resource limited countries like India, Bipolar hemiarthroplasty would be the preferred treatment option in fracture neck femur. We agree with this opinion that, a Total Hip Arthroplasty would significantly increase the surgical costs borne by the health care system as well as increase surgical duration and increased blood loss, both of which may contribute to postoperative

morbidity. All of the following have the potential to increase the overall treatment expense.

The Early conversion of a Bipolar to Unipolar Device and subsequent acetabular wear may contribute to poor functional outcome post surgery.<sup>34, 35</sup> Total hip arthroplasty may eliminate the possibility of acetabular cartilage erosion, which may cause pain and lead to inferior clinical result.<sup>6</sup>

The findings in the present study of early follow up suggests that even though, the mean blood loss and the mean duration of surgery were significantly more, the functional results following total hip arthroplasty were superior to hemiarthroplasty for the treatment of independent, and active patients suffering from displaced intra capsular fracture neck femur.

Both groups experienced functional deterioration postoperatively as compared with the preoperative scores as per the mobility score of Parker and Palmer; however, patients in the total hip arthroplasty group had less deterioration.

## CONCLUSION

In a resource-poor country like India with low life expectancy of 66.4 years as compared to the western countries (80 years)<sup>36</sup> and where primary osteoarthritis of the hip is uncommon, the bipolar hemiarthroplasty provides functional results comparable with the Total Hip Arthroplasty with lower surgical duration, relatively easy procedure and lower complication rates. The surgeon may take into account the patients' level of activity and independence, and quality of bone and joint while choosing between the two options; Total Hip Arthroplasty been reserved for patients with pre-existing acetabular disease, younger, and more active patients who are likely to tolerate the vigor of an extensive surgery and benefit more from Total Hip Arthroplasty than older, less active patients. However, long term outcome following the two surgeries, especially in the South Asian population is a topic for additional investigation. The limitation of this study was, the sample size and the short follow up period.

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**Conflict of Interest:** Nil

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