Accuracy of Radiographic Assesment of acetabular component anteversion and inclination after THA in Comparison to CT based Measurement

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Abstract

Introduction: Malposition of the acetabular component after total hip arthroplasty (THA) is related to dislocation of the prosthetic femoral head, increased polyethylene liner wear, and limited range of motion. 1, 2, 3, 4, 5 The orientation of the acetabular component comprises inclination and anteversion. Although the inclination of the acetabular component can be easily measured on plain radiographs, calculation of the anteversion is difficult. There are several radiological methods for measuring the anteversion of the acetabular component after THA, and a single standardized method has not been established.

Objectives

- To assess the accuracy of measurement of acetabular cup anteversion and inclination after THA using plain radiographs vs computed tomography-based measurements.
- To determine if plain radiograph is reliable method for determining acetabular cup anteversion and inclination.

Methodology: The present descriptive observational study was carried out at Department of Orthopaedics, Sanjay Gandhi Institute of trauma and Orthopaedics, Bangalore during the period of November 2019 to October 2020 including 40 patients admitted for THA at Department of Orthopaedics, Sanjay Gandhi Institute of trauma and Orthopaedics, Bangalore with the objective to assess the accuracy of measurement of acetabular cup anteversion and inclination after THA using plain radiographs vs computed tomography based measurements and to determine if plain radiograph is reliable method for determining acetabular cup anteversion and inclination.

Results: The angle of anteversion assessed on X ray and on CT, the difference was not statistically significant. It means though the anteversion angle on CT was slightly higher, but it was not significantly higher compared with X ray angle. (p>0.05). The angle of inclination assessed on X ray and on CT, the difference was not statistically significant. It means though the inclination angle on CT was slightly higher, but it was not significantly higher compared with X ray angle. (p>0.05).

Conclusion: Accuracy of measurement of acetabular cup anteversion and inclination after THA using plain radiographs is almost equal with computed tomography-based measurements.

Keywords: Anteversion, inclination, retroversion

1. Introduction

Total hip arthroplasty (THA) has become one of the most successful and cost-effective interventions in the history of medicine. Over time patient demands have increased significantly, with a greater focus on range of motion and function as well as pain relief. Malposition of the acetabular component after total hip arthroplasty (THA) is related to dislocation of the prosthetic femoral head, increased polyethylene liner wear, and limited range of motion. 1, 2, 3, 4, 5 The orientation of the acetabular component comprises inclination and anteversion. Although the inclination of the acetabular component can be easily measured on plain radiographs, calculation of the anteversion is difficult’ Orientations of inclination and anteversion are currently defined in 3 different measurement systems: the radiographic, anatomical and operative orientations; with conversion equations 21 allowing comparison between different manufacturers and literature guidelines. Lewinnick's22 definition of a 40° lateral opening angle and 15° anteversion with a safety zone
of ± 10° appears to be the most widely accepted as the desired orientation for the acetabular cup and adherence to these guidelines has been shown to reduce the chance of dislocation.

**Materials and Methods**

**Study setting:** Department of Orthopaedics, Sanjay Gandhi Institute of trauma and Orthopaedics, Bangalore

**Study population:** All the patients admitted for THA at Department of Orthopaedics, Sanjay Gandhi Institute of trauma and Orthopaedics, Bangalore

**Study period:** November 2019 to October 2020

**Study design:** Descriptive observational study

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**Formula for sample size calculation**


\[
n = \frac{Z^2 \cdot \sigma^2}{d^2}
\]

Variable considered for calculation of sample size: Mean anteverision is considered here for calculation of sample size


<table>
<thead>
<tr>
<th>M</th>
<th>Your guess of Population M</th>
<th>19.40</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Standard deviation of M</td>
<td>6.80</td>
</tr>
<tr>
<td>1-α</td>
<td>Set level of confidence (value &lt; 1.0)</td>
<td>0.95</td>
</tr>
<tr>
<td>Z</td>
<td>Z value associated with confidence</td>
<td>1.96</td>
</tr>
<tr>
<td>d</td>
<td>Absolute precision (value &lt; M)</td>
<td>2.1</td>
</tr>
<tr>
<td>n</td>
<td>Minimum sample size</td>
<td>40</td>
</tr>
</tbody>
</table>

So, the minimum sample size was 40.

**Sampling technique:** Simple random sampling

**Inclusion criteria:**

- Patients with the age of more than 30 years and less than 80
- Patients with osteoarthritis of hip (primary and secondary) indicated for total hip replacement
- Both the genders- male and female
- Patient willing for total hip replacement surgery and giving informed written consent

**Exclusion criteria:**

- Patients under going complex primary THA in protrusion acetabuli, dysplastic acetabulum, acetabular fractures
- Patients with septic arthritis
- Patients with neuropathic joints with neurological deficit around hip (paralyzed abductors)
- Patients who are unfit for surgery due to associated medical problems
- Presence of active foci of infection in the body
- Patients not willing for surgery

**Variables used in study:** Age, gender, anteversion angle on radiography

**Methods of data collection**

After obtaining institutional ethics committee clearance, written informed consent (Annexure 1), inpatients of Department of Orthopaedics fulfilling the inclusion and exclusion criteria will be enrolled in the study. Each patient will be given unique identity number, demographic data, history, clinical examination, physical examination including recording of vital signs and details of investigations and details of implant used by treating doctor, interventions will be recorded in the study proforma and radiological assessment as mentioned in (Annexure 2) will be done after THA in the post-operative period.

**Measurement of the anteverision of the acetabular component on AP plain radiographs**

The method of Liaw et al²⁸ (fig 1)

Version \( \frac{1}{2} \sin_1 \tan β \) where β angle is the angle between the long axis of the component (AB in Fig. 1a) and the line connecting the end of AB with the end-point of the ellipse (Fig. 1).

**Measurement of the anteverision of the acetabular component on CT scan (fig 1a)**

- The largest section of acetabular component selected in CT axial view
- First line connecting centres of two hips
- Second line perpendicular to first
- Third line from most anterior point of component to its most posterior point

The angle between second- and third-line measures version which is reference standard.

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**Fig 1:** Measurement of the anteverision of the acetabular component on AP plain radiographs

**Fig 1a:** Measurement of the anteverision of the acetabular component on CT scan
Measurement of the inclination of the acetabular component on AP plain radiographs (fig 2)
Inclination is the angle between transischial tuberosity line and the acetabular axis projected on to the coronal plane.

Measurement of the inclination of the acetabular component on CT scan (fig 2a)
Inclination is the angle between trans pubic tubercal line and the acetabular axis projected on to the coronal plane.

Statistical analysis
Data was collected by using a structure proforma. Data thus was entered in MS excel sheet and analysed by using SPSS 24.0 version IBM USA.
Qualitative data was expressed in terms of percentages and proportions Quantitative data was expressed in terms of Mean and Standard deviation Association between two qualitative variables was seen by using Chi square/ Fischer’s exact test
Comparison of mean and SD between two groups will be done by using unpaired t test to assess whether the mean difference between groups is significant or not
Descriptive statistics of each variable was presented in terms of Mean, standard deviation, standard error of mean.
A p value of <0.05 was considered as statistically significant whereas a p value <0.001 was considered as highly significant.

Results

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aseptic loosening of right amp</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Bilateral AVN hip</td>
<td>8</td>
<td>20.0</td>
</tr>
<tr>
<td>Bilateral osteoarthritis hip</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Left AVN hip</td>
<td>9</td>
<td>22.5</td>
</tr>
<tr>
<td>Left hip arthritis secondary to AS</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Left neck of femur fracture</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Left OA hip</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Right osteoarthritis hip</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Right AVN hip</td>
<td>12</td>
<td>30.0</td>
</tr>
<tr>
<td>Right osteoarthritis hip</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Majority of the patients i.e., 12(30%) had right AVN hip, 9(22.5%) had left AVN hip, 8(20%) had bilateral AVN hip and 4(10%) had right osteoarthritis hip.
Table 2: Distribution according to type of surgery

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left Thr</td>
<td>17</td>
<td>42.5</td>
</tr>
<tr>
<td>Right Thr</td>
<td>23</td>
<td>57.5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Out of 40 patients, majority were operated for right sided THR i.e. 23(57.5%) and remaining 17(42.5%) for left sided THR.

Table 3: Comparison of anteversion angle on X ray and on CT

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>t</th>
<th>p</th>
<th>Inference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anteversion On X ray</td>
<td>40</td>
<td>18.78</td>
<td>3.90</td>
<td>-0.33</td>
<td>0.743</td>
<td>Not significant</td>
</tr>
<tr>
<td>Anteversion On CT</td>
<td>40</td>
<td>18.85</td>
<td>4.28</td>
<td>(&gt;0.05)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Angle of anteversion assessed on X ray was 18.78±3.9 degree and on CT it was 18.85±4.28 degrees. When we compared the angle of anteversion assessed on X ray and on CT, the difference was not statistically significant. It means though the anteversion angle on CT was slightly higher, but it was not significantly higher compared with X ray angle. (p>0.05)
Angle of inclination assessed on X ray was 39.83±2.45 degree and on CT it was 40.10±2.23 degrees. When we compared the angle of inclination assessed on X ray and on CT, the difference was not statistically significant. It means though the inclination angle on CT was slightly higher, but it was not significantly higher compared with X ray angle (p>0.05).

So we can use X ray for assessment of anteversion angle in our study.

Angle of inclination assessed on X ray was 39.83±2.45 degree and on CT it was 40.10±2.23 degrees. When we compared the angle of inclination assessed on X ray and on CT, the difference was not statistically significant. It means though the inclination angle on CT was slightly higher, but it was not significantly higher compared with X ray angle (p>0.05). So we can use X ray for assessment of anteversion angle in our study.

The plain radiograph remains the mainstream tool for evaluation of the cup orientation intra- or postoperatively.

**Conclusion**

Accuracy of measurement of acetabular cup anteversion and inclination after THA using plain radiographs is almost equal with computed tomography-based measurements. So we can use plain radiograph for determining acetabular cup anteversion and inclination. This will be easy and cost-effective approach. Measurement of the orientation of acetabular components on plain AP radiographs is reliable and accurate compared with measurement on CT.
References