Radiological comparison of acetabular anteversion on roentgenograms and computed tomograms & functional outcomes in total hip arthroplasty

Ayush Sharma, Mukand Lal, Sandeep Kashyap and Anupam Jhobta

DOI: https://doi.org/10.22271/ortho.2021.v7.i4l.2972

Abstract

Introduction: Orientation and Alignment of prosthetic components are vitally important for the stability of total hip arthroplasty. Poor acetabular positioning is one of the many issues implicated with persistent pain due to impingement, dislocation, edge loading and liner fracture, which may be lead to patient dissatisfaction after total hip arthroplasty.

Material and methods: Post-operative radiological analysis of the version of acetabulum through X-ray images and CT images was performed. Pre & post-operative scoring according to Modified Harris Hip Score (HHS), Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) and Oxford Hip Score (OHS) was documented.

Results: A total of 55 patients were included in the study. The mean anteversion angle calculated on anteroposterior (AP) radiographs by Lewinnek’s method was 23.48° (Range 11 – 39°) and on cross-table lateral radiograph by Woo and Morrey’s method was 22.41° (Range16 – 56°), compared to CT Scans measured was 28.64° (Range 11.10 – 50.10°).

Conclusion: Majority 69.09% of patients had excellent functional outcomes in a range of 11.1 – 36° of anteversion compared to Lewinnek’s safe zone. It suggests that there is flexibility in positioning the acetabular component than previously believed. If one has to err, it should be towards more anteversion. In fact to avoid dislocation, more anteversion is required to guard against unwarranted activities on part of the patient.

Keywords: Roentgenograms, computed tomograms, total hip arthroplasty

Introduction

Total hip arthroplasty (THA) is one of the most common procedures performed in Orthopaedic Surgery and is considered to be one of the best medical innovations of our generation [1]. Arthroplasty depends upon ideal placement of both acetabular and femoral components. Accurate biomechanical reconstruction of the joint is essential to achieve function and longevity with acetabular positioning being a key factor, the consequences of malposition include instability, increased wear, impaired muscle function, reduced range of motion (ROM), impingement, bearing-related noise generation, poor functional outcomes,1 limb length discrepancy, and loosening and cup failure [2,3,4]. Dislocation is one of the most frequent complications after THA with an incidence of 0.6% to 11% in the early postoperative period; between 13% and 30% of dislocations reportedly are caused by implant malpositioning [3]. It is found that even in normal subjects there is a great variation in acetabular morphology. However, the range of normal acetabular & femoral variation may differ between races [6]. At age 13 to 14, the mostly ossified bones of the ilium, ischium, and pubis unite at the acetabulum, forming Y-shaped triradiate cartilage that proceeds to fusion by age 15 to 16. The other secondary centers unite and fuse between the ages of 20 and 22. The acetabular surface is orientated approximately 45 degrees caudally and 15 degrees anteriorly. The average anteversion of the native acetabulum measures 16 to 21 degrees with an average inclination of 48 degrees. Men tend to have less anteversion than females. Angular position includes the anteversion and inclination (abduction angle) of the cup. The most commonly quoted study is by Lewinnek et al. He found an increased dislocation rate in cups placed outside anteversion angles of 5°–25° and 30°–50° of inclination.
Inclination and anteversion can thus be operative, radiologic, or anatomic [7]. Operative and radiographic angles are the most relevant surgically in the lateral position of the patient. During surgery in the lateral position, operative anteversion is assessed by looking down, to project the insertion angle onto the sagittal plane, and measuring against the longitudinal axis. The most commonly used method for radiographic analysis is the one proposed by Woo and Morrey [8] namely the “angle formed by a line drawn tangential to the face of the acetabulum and a line perpendicular to the horizontal plane, as seen on a lateral view of the pelvis”. In comparison, McCollum and Gray [9] suggested a position of 40° ± 10° abduction and 30° ± 10° flexion to prevent impingement and dislocation. Harris recommends a position of 30° abduction and 20° anteversion; however, the Harris angles are referenced using a mechanical guide and the trunk of the patient [10]. During the implantation process, surgeons use different techniques to judge the positioning of the acetabular component. The purpose of the present study was aimed at the morphometric evaluation of the acetabular version radiologically using well-defined parameters of acetabular positioning in primary total hip replacements on patient satisfaction and functional outcomes at a tertiary center which will further help in planning, execution, and evaluation of total hip arthroplasty (THA). However, most of the studies have been done on western populations with limited follow-up period & to the best of our knowledge, only limited studies have been done in the Indian populations. The present study was undertaken to study the effects of acetabular component position well as acetabular position relative to bony anatomy on patient-reported functional outcomes and further to compare results whether accurately positioned acetabular component in Lewinnek’s safe zone using freehand technique as wide variability has been reported in cup orientation, also how accurately operating surgeon can achieve desired anteversion using factors such as visual cues and side of the operating table. To determine whether acetabular component positioned assessed by cross table radiographs and anteroposterior radiographs and computed tomography could provide measure of acetabular version and compare their reliability and accuracy of methods.

Material and methods
This present study was conducted in tertiary care institution between the periods of 2017 to 2019, a total of 55 patients were included in the study. In this study, males were 58.2% compared to 41.8% females. The mean age of study population was 49.65 years with range from 17-75 years. The most common indication for surgery in our study was idiopathic osteoarthritis in 43.64% patients followed by postsurgical osteonecrosis of femoral head in 21.82%.The mean follow-up was 19.83 months.

Inclusion criteria
- All age group patients, who need THA for painful disabling hip were included in the study.

Exclusion criteria
- Revision surgery
- Patients with bony pathology of pelvis and femur
- Patients with contralateral hip pathology as evident clinically with gait abnormality and pain or restriction of movements.
- Patients with current or previous metabolic bone disease.
- Bilateral Total Hip Arthroplasty,
- Medical illness or known case of malignancy predisposed by radiation.

Post-operative radiological analysis of the version of acetabulum through X-ray images and CT images was performed. Pre & post-operative scoring according to Modified Harris Hip Score (HHS), Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) and Oxford Hip Score (OHS) was documented.

Radiographic Assessment: Radiographs were taken with a tube-to-film distance of 120 cm by a computed digital radiographic system (Philips Bucky Primary Diagnost CS System 1000mA, November 2016 Hamburg, Germany).

Technique of taking AP Radiograph

Fig 1: Shows in supine position with the bilateral hip joint in a neutral position. The radiation beam was centered on the pubic symphysis (black arrow)

The patient was placed in the supine position with the bilateral hip joint in a neutral position. The radiation beam was centered on the pubic symphysis (black arrow) as shown in Figure 1 for an AP radiograph of the pelvis and was centered on the femoral head (white arrow) as shown in Figure 1 for the AP radiograph of the operated hip joint.

Cross Table Lateral Radiographs

Fig 2: The direction of the radiation beam was parallel to the examination table and at 45° to the long axis of the body (black arrow). An X-ray film was held perpendicular to the floor using a cassette holder, and a gravity line is shown using a metal chain (white arrow)
The patient was placed in the supine position with the contralateral hip flexed to 90°. If the patient could not flex the contralateral hip to 90°, it was taken with the hip flexed as much as possible. The direction of the radiation beam was parallel to the examination table and at 45° to the long axis of the body (black arrow) as shown in Figure 2. An X-ray film was held perpendicular to the floor using a cassette holder, and a gravity line is shown using a metal chain (white arrow) as in Figure 2.

All CT scans included scanning by Antero-posterior tomogram as well as axial images of both acetabulum and femur. All angles were measured at CT work station (64 slice MDCT GE [General Electicals] Light Speed VCT XTE, April 2010, Wisconsin USA). The tomogram through the center of the acetabulum was selected for measurement of the acetabular anteversion angle, which is defined as the ventral orientation of the acetabulum related to the sagittal plane. A measuring point was assigned at the anterior edge of the acetabulum and a second at the posterior edge. The line connecting these points were drawn, and the angle formed by this line and the plane sagittal to the pelvis determined as the acetabular anteversion angle.

Methods to calculate the version
Lewinnek's method
Version = arc sin (D1 / D2)
D1 is the distance of the short axis of an ellipse drawn perpendicular to the long axis of the acetabular component;
D2 is the distance of the long axis, which is considered the maximal diameter of the implant. Therefore, Lewinnek’s method is more convenient for clinical practice and was used in the current study to calculate version angles. Woo and Morrey’s method.

This method uses cross-table lateral radiographs to measure the version of the component, this method needs no equations and distinguishes between anteversion and retroversion. The angle is directly measured between a line perpendicular to the table and a line tangential to the opening face of the acetabular component.

The imaging data of CT scans for each case was anonymized prior to interpretation and stored in an online database where patient identification was removed, and the interpreting radiologists were blinded to prior measurements. The protocol was approved by our institution’s ethics committee and written informed consent was obtained from each patient.

Statistical Analysis: Patient characteristics were summarized using means and standard deviations for continuous variables and frequencies and percentages for discrete variables. Pearson’s coefficients were determined to quantify the correlations between radiographic assessments of acetabular version on AP, cross-table lateral views. The mean differences and standard deviations between AP and Cross Table Lateral radiographs anteversion measurements were calculated. The comparison of normally distributed continuous variables between the groups was performed using Student’s t-test. Nominal categorical data between the groups were compared using the Chi-square test or Fisher’s exact test whichever was found appropriate. Non-normal distribution continuous variables were compared using Mann Whitney U test. Odds ratio and 95% confidence interval was also calculated. For all statistical tests, a p-value less than 0.05 was taken to indicate a significant difference.

Results
In this study, anteversion angles calculated on cross table lateral radiographs had mean anteversion angle of 22.41° (Range 16 – 56°), mean angle of anteversion calculated on AP Radiographs was 23.48°(Range 11-39°), and as calculated on CT Scan had mean angle of 28.64°(Range 11.10 – 50.10°). At final post-op follow-up 63.63% patients had excellent HHKS, 23.63% patients had good whereas 6 10.90% patients had fair HHKS post-operatively. Improved post-operative WOMAC score in 98.1% patients to excellent score. 78.1% patients had excellent OHS (40-48) post-operatively whereas 20% patients had good OHS (30-39). This was found to be statistically significant (p value 0.038). The correlation between anteversion angles measured on CT Scan and cross table lateral radiographs using Woo & Morrey’s method was found to be significant (p value 0.02). The correlation between anteversion angles measured on CT scan and anteroposterior radiographs using Lewinnek’s method indicated significant results (p value 0.046). Patients with higher BMI in our study had found to be consistent with CT scans values of measured anteversion angles. Nishino et al. [15] postulated that
AP radiographs are better than cross-table lateral radiographs. Nho et al. [16] recommended the use of Lewinnek’s, Woo and Morrey’s method, for measuring the anteversion of acetabular component. Arai et al. [17] compared Lewinnek’s method with Woo Morrey’s method and concluded that there was a difference of an average of 5.80 between angles measured on cross-table lateral radiographs and those measured on AP radiographs of the hip joint. Maheshwari et al. [18] in their study on Indian population measured mean acetabular anteversion of normal hips to be 19° (Range 8-35°) which was comparable to measured angle on normal non operated hips in our study. The best functional outcomes as reported by the patients on the basis of functional scores in our study was in the wider range of 12.1-36° of anteversion, which is similar to studies done in recent past. Therefore, our study supports the notion that Lewinnek’s safe zone is not a reliable predictor of stability and there is no absolute specific safe zone for acetabular component positioning. We also found that in the freehand placement of acetabular cups only a minority of the cups could be placed in Lewinnek’s safe zone as seen in 30.90% of the patients.

### Table 1: Shows in Study and Ideal Anteversion

| Study            | Ideal Anteversion |
|------------------|-------------------|
| Lewinnek et al.  | 15° ± 10°         |
| Dort et al.      | 15° ± 15°         |
| McCollum and Gray| 30° ± 10°         |
| Biedermann et al.| 15° ± 10°         |
| Barrack et al.   | 20° ± 10°         |
| Widmer and Zurluh| 20°-28°           |
| Present study    | 30 ± 6°           |

Goyal et al. [19] demonstrated significant improvement in HHS total score. The absolute position of the cup showed a very weak yet significant positive correlation in between cup anteversion and HHS pain (p=0.01), HHS function (p=0.001) and HHS total score (p=0.001). The mean anteversion was 21.8 ± 11.80 in their study compared to mean of 28.64° (Range 11.10-50.10°) in our study. The ideal position of the acetabular component is still debated in the literature. Previous studies have not examined patient satisfaction as a primary outcome. Our study shows significant improvement in post-operative HHS in terms range of motion, pain relief as reported by patients. Our study also shows that the Lewinnek’s “safe zone” does not have any direct effect on patient outcome score. Quintana et al. [20] have shown that the minimal clinically important difference (MCID) for WOMAC is between 25.91 and 29.26 points for patients with primary total hip arthroplasty. In our study, anteversion angles in the range of 24.1-36° which is well outside the Lewinnek’s safe zone reported excellent WOMAC scores which is comparable to a study done by Goyal et al. In our study, anteversion angles in range 30±6° had excellent outcomes which are fairly comparable to the study done by Sculco et al. and Grammatopoulos et al. [21,22]. In our study, the anteversion was measured in relation to the horizontal plane, and we assumed that the patient positioning was in parallel plane. Pelvic tilting and rotation of pelvis possibly while performing cross table lateral where contralateral hip is flexed can lead to tilting of pelvis during imaging can possibly lead to a change in radiographic projection and distort the measurement. Moreover, measurement done on radiographs was manual using a goniometer which theoretically can contribute to error if any in measurement when compared to more precise measurements done in CT console. In our study, possible reason for difference in measurements of anteversion angles could possibly be due to pelvic tilt (PT) although every possible precaution was taken to eliminate it. It has been found that there is a linear relationship between changes in PT and functional anteversion, anterior PT reduces functional component anteversion by approximately 0.74° per degree of PT, while posterior PT increases it by the same amount [23].

### Optimal Range of Anteversion

In our study, anteversion angles ranged from 11.10-50.10° with 30.90% patients in Lewinnek safe zone. Saxler et al. [24] concluded that safe position as defined by Lewinnek et al. was only achieved in a minority of the cups that were implanted freehand. Danoff et al. [25] advocated a sweet spot safe zone of 17.10° of anteversion. Abdel et al. [26] concluded that the historical target values for cup inclination and anteversion may be useful but should not be considered a safe zone given that the majority of these contemporary THAs that dislocated were within those target values. Cotong et al. [27] did a survey and concluded that strict usage of the Lewinnek “safe zone” cannot be justified. We too believe that ideal cup position varies from patient to patient. Our study is the first to calculate acetabular anteversion in patients operated by posterolateral approach with freehand technique. Also we have assessed functional outcomes by HHS, WOMAC and OHS and correlated this with version angles calculated on cross table lateral radiographs using Woo & Morrey’s method, AP radiographs using Lewinnek’s method and CT scan. There are limitations of this study. The first limitation was that we used goniometer to measure angles on radiographs instead of more precise computer softwares. We used free hand techniques on the basis of visual cues instead navigation controlled implantation of acetabular cup or mechanical alignment guides. There is a bias in the measurements of anteversion using radiographs which is inevitable when measuring a 3D object with a 2D projection. In our study, AP radiographs have also been used for measurement of acetabular component anteversion. However, this use of AP radiographs also has some disadvantages. It is difficult to identify the apex of the ellipse on AP radiographs, depending on the articulation type or the extent of the anteversion. If we had used the template software, we might have been able to more accurately measure anteversion on AP radiographs. The patient’s position during radiography influences the measurements. We largely eliminated the patient positioning variables (pelvic tilt and rotation) which produce error in clinical practice. These limitations must be taken into consideration when our results are applied in clinical practice. The study design was reviewed by our institutional review board, which restricted the case number because of the radiation hazard and cost of CT scans, further we did not perform multiple CT scans on the same patients because of concern for radiation exposure; thus, we have no repeatability data for the CT scans. Our study is one of the few studies done in the past which measures patient reported functional outcomes as a function of anteversion angle. In present study, we used both AP and Cross table lateral radiographs to validate the version angles measured thereby decreasing the observer bias. Defining the optimal cup position is challenging. A good understanding of anatomic, patient and implant related factors that affect the “optimal” cup position is mandatory. Creating a stable THA remains a balancing act among appropriate component positioning taking into account individual patient bony and muscular anatomy in both the static and dynamic state, soft tissue balance and tensioning, and appropriate aftercare and rehabilitative efforts. Considering the advantages of plain radiography, including low cost, low radiation level, and convenience for clinical follow-up and assessment of prosthesis position we recommend the use of Lewinnek’s method and Woo & Morrey’s method as they provide
reproducible and accurate data compared with CT. We believe that the safe zone should be tailored to the surgical approach used. It has been observed that 20–25% of squats subject their hip to deep seating and even go for squatting against advice. To avoid dislocation, the anteversion was kept about 10 degrees above the normal. If we had to err, it was towards more anteversion. This was coupled with myocapsuloplasty, as a result we had no dislocation in our patients. Further research is encouraged to investigate the ability of emerging technologies to assist surgeons in optimally positioning the acetabular components. Functional outcome measurements with improved resolution may be of great importance for clinical research in the future.

**Conclusion**

There should be flexibility in positioning the acetabular component than previously believed. If one has to err, it should be towards more anteversion. Infact to avoid dislocation, more anteversion is required to guard against unwarranted activities on part of the patient. The anteroposterior as well cross-table lateral radiographs can be used as a surrogate method for measuring the anteversion angle compared to CT Scan as it avoids radiation exposure and lessens the cost.

**References**

1. Bhaskar D, Rajpura A, Board T. Current concepts in acetabular positioning in total hip arthroplasty. Indian J Orthop. 2017;51:386-96.
2. Bosker BH, Verheyen CC, Horstmann WG, Tulp NJ. Poor accuracy of freehand cup positioning during total hip arthroplasty. Arch Orthop Trauma Surg. 2007;127(5):375-379.
3. Lewinnek GE, Lewis JL, Tarr R, Compere CL, Zimmerman JR. Dislocations after total hip-replacement arthroplasties. J Bone Joint Surg Am. 1978;60:217-20.
4. Schmalzried TP, Shepherd EF, Dorey FI, Jackson WO, dela Rosa M, Fa’vae F, et al. The John Charnley Award. Wear is a function of use, not time. Clin Orthop Relat Res. 2000;381:36-46.
5. Hedlundh U, Ahnfelt L, Hybbinette CH, Wallinder L, Weckstroöm J, Fredin H. Dislocations and the femoral head size in primary total hip arthroplasty. Clin Orthop Relat Res. 1996;333:226-233.
6. Maruyama M, Feinberg JR, Capello WN, D’Antonio JA. The Frank Stinchfield Award: Morphologic features of the acetabulum and femur: anteversion angle and implant positioning. Clin Orthop Relat Res. 2001;393:52-65.
7. Murray DW. The definition and measurement of acetabular orientation. J Bone Joint Surg Br. 1993;75:228-32.
8. Woo RYG, Morrey BF. Dislocations after Total Hip Arthroplasty. J Bone Joint Surg Am. 1982;64A:1295-1306.
9. McCollum DE, Gray WJ. Dislocation after total hip arthroplasty: Causes and prevention. Clin Orthop Relat Res. 1990;261:159-70.
10. Harris WH. Edge loading has a paradoxical effect on wear inmetal-on-polyethylene total hip arthroplasties. Clin Orthop Relat Res. 2012;470:3077-3082.
11. Kalteis T, Hanel M, Herold T, Perlick L, Paetzel C, Grifka J. Position of the acetabular cup accuracy of radiographic calculation compared to CT-based measurement. European Journal of Radiology. 2006;58(2):294-300.
12. Reikeras O, Gunderson RB. Acetabular Component Anteversion in Primary and Revision Total Hip Arthroplasty: An Observational Study. The Open Orthopaedics Journal. 2013;7(1):600-4.
13. Reikeras O, Gunderson RB. Cross table lateral radiography for measurement of acetabular cup version. Ann Transl Med. 2016;4(9):169-169.
14. Lewinnek GE, Lewis JL, Tarr R, Compere CL, Zimmerman JR. Dislocations after total hip-replacement arthroplasties. J Bone Joint Surg Am. 1978:60:217-20.
15. Nishino H, Nakamura S, Arai N, Matsushita T. Accuracy and Precision of Version Angle Measurements of the Acetabular Component after Total Hip Arthroplasty. J Arthroplasty. 2013;28(9):1644-7.
16. Nho JH, Lee YK, Kim HJ, Ha YC, Suh YS, Koo KH. Reliability and validity of measuring version of the acetabular component. J Bone Joint Surg Br. 2012;94-B(1):32-6.
17. Arai N, Nakamura S, Matsushita T. Difference between 2 Measurement Methods of Version Angles of the Acetabular Component. J Arthroplasty. 2007;22(5):715-20.
18. Maheswari A, Złowodzki P, Siram M, Jain G, AK. Femoral neck Anteversion, cebular Anteversion and combined anteversion in normal Indian adult population: A computed tomographic study. Indian J Orthop. 2010;44:277-282.
19. Goyal P, Lau A, Naudie DD, Teeter MG, Lanting BA, Howard JL. Effect of Acetabular Component Positioning on Functional Outcomes in Primary Total Hip Arthroplasty. J Arthroplasty. 2017;32(3):843-8.
20. Quintana JM, Escobar A, Bilbao A, Arostegui I, Lafuente I, Vidaurreta I. Responsiveness and clinically important differences for the WOMAC and SF-36 after hip joint replacement. Osteoarthritis and Cartilage. 2005;13(12):1076-83.
21. Grammatopoulos G, Waldstein W, Pegg E, Pandit H, Aldinger PR, et al. Comparison of Native Anatomy with Recommended Safe Component Orientation in Total Hip Arthroplasty for Primary Osteoarthritis. J Bone Joint Surg Br. 2013;95(22):e172.
22. Sculco PK, McLawhorn AS, Carroll KM, McArthur BA, Mayman DJ. Anteroposterior Radiographs Are More Accurate than Cross-Table Lateral Radiographs for Acetabular Anteversion Assessment: A Retrospective Cohort Study. HSS Journal. 2016;12(1):32-8.
23. Lazennec JY, Boyer P, Gorin M, Catonné Y, Rousseau MA. Acetabular Anteversion with CT in Supine, Simulated Standing, and Sitting Positions in a THA Patient Population. Clin Orthop Relat Res. 2011;469(4):1103-9.
24. Saxler G, Marx A, Vandevelde D, Langlotz U, Tannast M, Wiese M, et al. The accuracy of free-hand cup positioning – A CT based measurement of cup placement in 105 total hip arthroplasties. International Orthopaedics (SICOT). 2004;28(4):198-201.
25. Danoff JR, Bobman JT, Cunn G, Murtaugh T, Gorroochurn P, Geller JA, et al. Redefining the Acetabular Component Safe Zone for Posterior Approach Total Hip Arthroplasty. J Arthroplasty. 2016;31(2):506-11.
26. Abdel MP, von Roth P, Jennings MT, Hansen AD, Pagnano MW. What Safe Zone? The Vast Majority of Dislocated THAs Are Within the Lewinnek Safe Zone for Acetabular Component Position. Clin Orthop Relat Res. 2016;474(2):386-91.
27. Cotron D, Troelsen A, Husted H, Gromov K. Danish survey of acetabular component positioning practice during primary total hip arthroplasty. Dan Med J. 2017;5:1-5.

~ 821 ~