

## It's hip to be resurfaced – the tale of an aerobic instructor's battle with arthritis

By Tony Podpera

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On Monday, 26 July, 2004, I had a new hip joint installed. I was a 42 year old aerobics instructor.

Thankfully, aerobics has never been my full time job. I make my living sitting behind a desk, so, now that I've had my surgery, I can still feed myself, but I won't be teaching a full load of classes for a while.

Ironically, aerobics instruction is the activity that I feel contributed the most to the degradation of my hip joint and the development of arthritis. I've taught over 4,000 classes over the years, probably participated in as many again and at a bodyweight of over 100 kilograms, it's not surprising my joints have suffered. And all that triathlon training years ago wouldn't have helped (it didn't help my triathlon performance either, come to think of it...talk about slow!).

As very active people, many fitness leaders may at some stage develop osteoarthritis in the hip and have to consider joint replacement surgery. Fitness leaders are also likely to know or train someone who has had or is considering hip surgery. I'm writing this article to offer a little insight into an issue that many of us, directly or indirectly, might one day encounter.

### The diagnosis

Any aerobic instructor will tell you that niggling injuries are a part of the job. So, the tightness that developed in my right groin in September 2001 didn't concern me too much. I felt it would settle down by itself in a few days. But I was wrong. The muscle that I thought was injured didn't heal as I'd hoped, and there was a good reason. The tight groin muscle wasn't the problem. It was only a symptom, and one of the most common associated with osteoarthritis in the hip. An x-ray of my hip confirmed my fears - the cartilage that had acted as a shock absorber for my right hip joint for more than four decades had finally worn away. I had osteoarthritis. (See Figure 1)



**Figure 1.** This isn't my hip, but it could have been. It shows typical osteoarthritis of the hip. Notice the lack of any joint space at the top margin of the femoral ball. This what's known as 'bone on bone'. With a limp, the odd painkiller and some lifestyle changes, I got by, but after a while, it became at best, uncomfortable, but usually painful. Strangely, I could teach BODYPUMP®, Step Moves and New Body with a hip like this, without too much trouble (although I did limp a bit!)

Image taken from [www.midmedtec.co.uk/hipresurfacing.htm](http://www.midmedtec.co.uk/hipresurfacing.htm)

Of course, arthritis doesn't just happen overnight. In most cases, it develops over a number of years. In fact, many of you reading this now may have some level of hip cartilage degeneration, even though you may not know it. Your chances of developing osteoarthritis in your hips largely depends on your weight, the type and frequency of your physical activities, and the strength and resilience of the joints you were born with. In my case, years of weight training left me with a 100+ kilogram frame to move around. Not such a problem by itself, but not helpful if one should develop an interest in triathlons and aerobics, as I did.

Giving up weight training and switching to aerobic work did wonders for my fitness, but, I am convinced, started stressing my joints like never before. (I never had joint problems during eight years of intense weight training).

After arthritis was confirmed, I knew that there were measures I could take to slow down the speed of degeneration of that hip cartilage, but I also knew that eventually I would probably need a new hip joint. I decided on a two-pronged attack focussing on 1) preventing further damage and 2) researching my long term options.

### **Post-diagnosis**

My first priority was to take measures to reduce the degeneration of the remaining cartilage. My goal was to delay surgery, possibly even to the stage where medical science would come to the rescue with cartilage regrowth technology. I wasn't confident that I could keep surgery at bay for that long, but I wanted to keep going on my original hip for as long as possible so that when I did need a hip replacement, I could benefit from the latest technology.

I tried not to teach high impact classes, but when I had to, taught low impact moves with short demonstrations of high impact options. I dropped my Step Athletic and BODYSTEP® classes, but kept teaching my Step Moves classes, as they were always tap-free and flowed more smoothly and without any sudden changes of direction or weight transference. I kept teaching BODYPUMP®. I stopped running and started walking, to keep the hip joint moving and to help keep my weight down in the absence of the classes I had dropped.

The main dietary change I made involved the regular consumption of glucosamine and chondroitin, as research suggests that they can slow the degeneration of cartilage. However, I found them of little benefit. When my schedule was particularly heavy, or when, for some reason my arthritis was giving me trouble (it's true...arthritis *can* flare up on cold and wet days!) I took a painkiller called Celebrex which is widely used by people with arthritis.

The second part of my approach to arthritis was to become as well-informed as possible, about the longer-term options available to me. I obtained a referral to an orthopaedic surgeon and, while I waited for my appointment to come around, started to research hip surgery, mainly through the Internet.

## **Hip replacement versus hip resurfacing**

My research confirmed that hip replacement surgery was continuing to make rapid advances. One of those advances concerned a technique called 'hip resurfacing.' Hip resurfacing has been available in England for about ten years and in Australia for about five years. It's also available in some European and Asian countries, but is only slowly gaining acceptance in North America for a range of reasons I won't expand upon here. It's becoming the new standard in hip joint replacement for young people.

The basic problem with conventional hip replacements (often called 'total hip replacement') is that they often don't last forever. In an older person, who is less active, a good hip replacement may well go the distance. However, for the younger, more active person, a total hip replacement will endure more wear and tear and the patient will probably require what is called 'revision surgery' after as little as 10 years. In revision surgery, the whole prosthesis, or parts of it, are replaced. As you can imagine, the results would tend not to be as good as they were after the original surgery.

In very young patients, it's conceivable that a total hip replacement might eventually need more than one revision, although I should stress that total hip replacement and revision technology is continually improving (hip replacements can occur in very young people for arthritis, but also for other reasons such as congenital abnormalities of the hip, or as a result of injury or illness).

A growing worldwide demand for hip replacements has resulted in the development of new types of prosthetics and new surgical procedures. A main area of recent change has been in the materials that make up the replacement ball and socket - the moving parts of the new hip. A range of plastics, ceramics and metals have been used over the years yet the latest evidence suggests that a metal ball and metal socket may result in optimal longevity and safety. This finding, combined with a push to make hip replacements closely resemble the original hip in form and function, led to the development of 'hip resurfacing'.

With a total hip replacement the femoral component (i.e., the 'ball') is fitted on the end of a long spike which is positioned into the femur. During surgery, the ball of the original hip joint and the trochanter (the outcrop of bone which comes from the femur and supports the ball) is removed. In hip resurfacing, the original femoral head and trochanter are left intact and the femoral head is simply shaped and fitted with a metal cap (see figures 2 to 5).

The advantages of resurfacing over replacement for the younger patient include:

- Greater preservation of the patient's original bone
- Greater retention of the hip's natural anatomy and function
- Fewer dislocations post-surgery
- Faster patient recovery
- Easier revision surgery, if required.
- Fewer limitations in regard to sports and fitness activities.

Total hip replacement technology is excellent these days and helps many people lead a more fulfilling life. But for a younger person like me, who wanted to remain active

and even teach group fitness classes again, it seemed logical to have my hip resurfaced rather than replaced.



A hip resurfacing. Note that after implantation, there's a lot more bone preserved than in the figure below.

Images from  
<http://www.activejoints.com/resurfacing.html>

Figure 2



Figure 3



A conventional hip replacement. The socket component operates in a similar way to that of the resurfacing prosthesis, but the femoral component is obviously very different.

Images from  
[http://www.jri-oh.com/hipsurgery/Hip\\_Types.asp](http://www.jri-oh.com/hipsurgery/Hip_Types.asp)

Figure 4



Figure 5

## Soldiering on

In spite of the measures I took to delay the progression of my arthritis, it worsened and by March 2004, some two and a half years after the original diagnosis, I had developed a pronounced limp. This, in turn, had an effect on my lower back and my other leg joints. The groin muscle still felt tight but the main source of pain had become more closely centred on the hip joint surface itself. I knew that my time for surgery was near.

## Preparing for my new hip

Wheels were set in motion on 6 May 2004, when I visited my surgeon and told him that I'd had just about enough and I'd appreciate him resurfacing my hip. Looking at my latest x-rays, which had shown that I had no joint space at the top of my hip - much like the x-ray shown in Figure 1 above - he agreed.

The lead up to the operation was a hectic time, mentally. I was preparing myself for quite major surgery and not an hour went by that I didn't have a thought about what was going to happen and how I would cope, not just in the weeks after the operation, but in the years to come. Still, I was confident that I had made the right decision for my health and my future.

## **The surgery**

Fitness leaders should at least understand the following about this condition and the post-operative recovery.

- Hip replacement or resurfacing surgery is major surgery and post-op progress can sometimes be painful and very slow. Be patient with your clients and encourage them to do the same.
- Dislocation is a serious risk for all hip replacement/resurfacing patients, especially in the first weeks post-op. Adducting the operated leg across the midline of the body should be avoided, especially with a bent knee.
- Depending on the surgeon and device fitted, the operation requires access to the joint through muscles and connective tissues around the side and rear of the hip, which may have to be moved or cut. Early rehabilitation focuses on strengthening these tissues. Physiotherapists often provide patients of simple exercises to do post-op, such as knee lifts, standing leg abductions, quarter or half-squats, buttock lifts and clenches. Weight-bearing and walking is encouraged, as long as the patient finds it tolerable, although crutches and walking sticks will typically be used for some weeks.

## **Recovery**

I am now four months post-op. My new hip joint feels great and it's actually more flexible than my own on the other side. I still have some weakness and muscle pain on the side of my buttock but that's slowly improving (and it's a pretty big buttock so it may take some time!). I have started teaching BODYPUMP® classes again and have experienced no difficulties. I continue to swim, walk and do weight training.

I think in the future, I may expand my repertoire to include mind body classes, or maybe work with individuals in the gym. I'd still like to return to teaching my favourite class - Step Moves – and I think that is very possible. I'm still in a recovery phase, though, and in no hurry.

People with a resurfaced hip have been known to ski, do martial arts and run, so I am confident that my modest aims will be achievable. I just hope that I can keep my other hip healthy and useful at the same time. I know it may need resurfacing at some stage, but it's still hanging in there and there's no tightness in the groin yet!

As fitness leaders, you will come across people who have had hip replacements or resurfacing, who want to exercise. I hope that my story gives you a little more knowledge and confidence to deal with those people. And while you are helping your 'hip' clients, don't forget to look after your own joints at the same time.