

# Determination of the amount of bone to be resected in the Arthroscopic Surgery of Femoroacetabular Impingement Syndrome and the Effect of This Amount on the Postoperative Clinical Results

Teoman Ozan Güveli<sup>1</sup>, İbrahim Tuncay<sup>2</sup>,

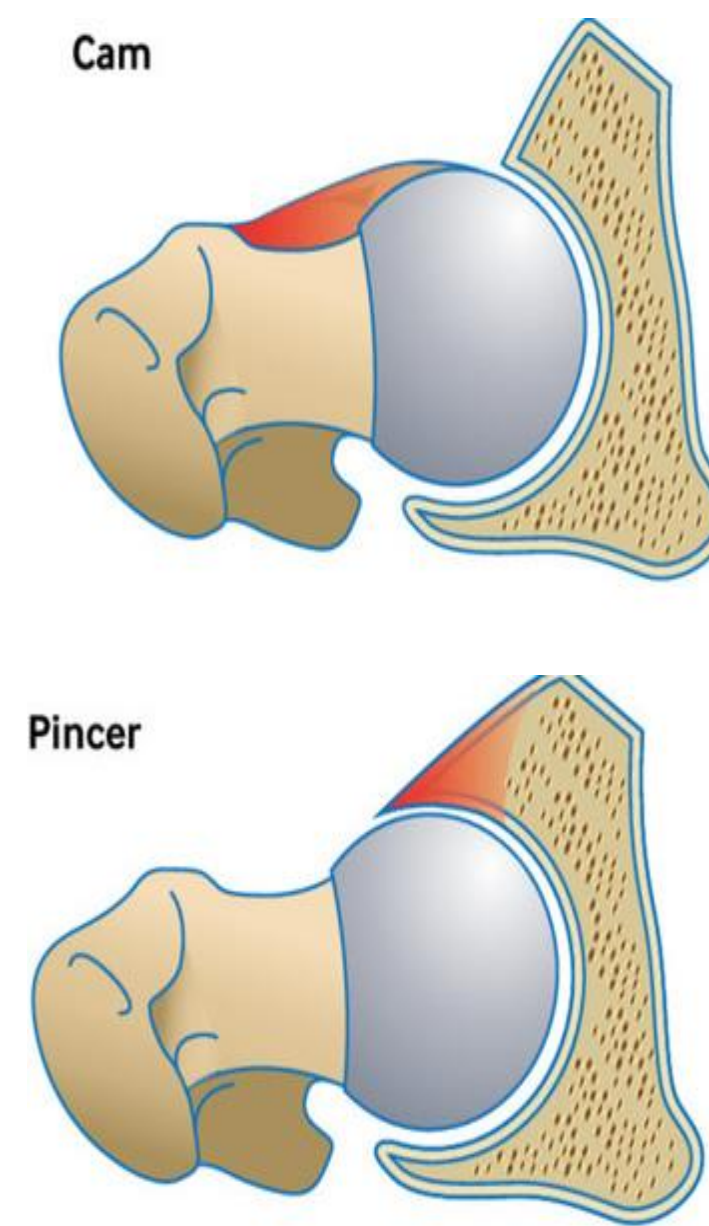
<sup>1</sup>Bezmialem Vakif University, School of Medicine, Istanbul, Turkey

<sup>2</sup>Bezmialem Vakif University, School of Medicine, Department of Orthopedics and Traumatology, Istanbul, Turkey



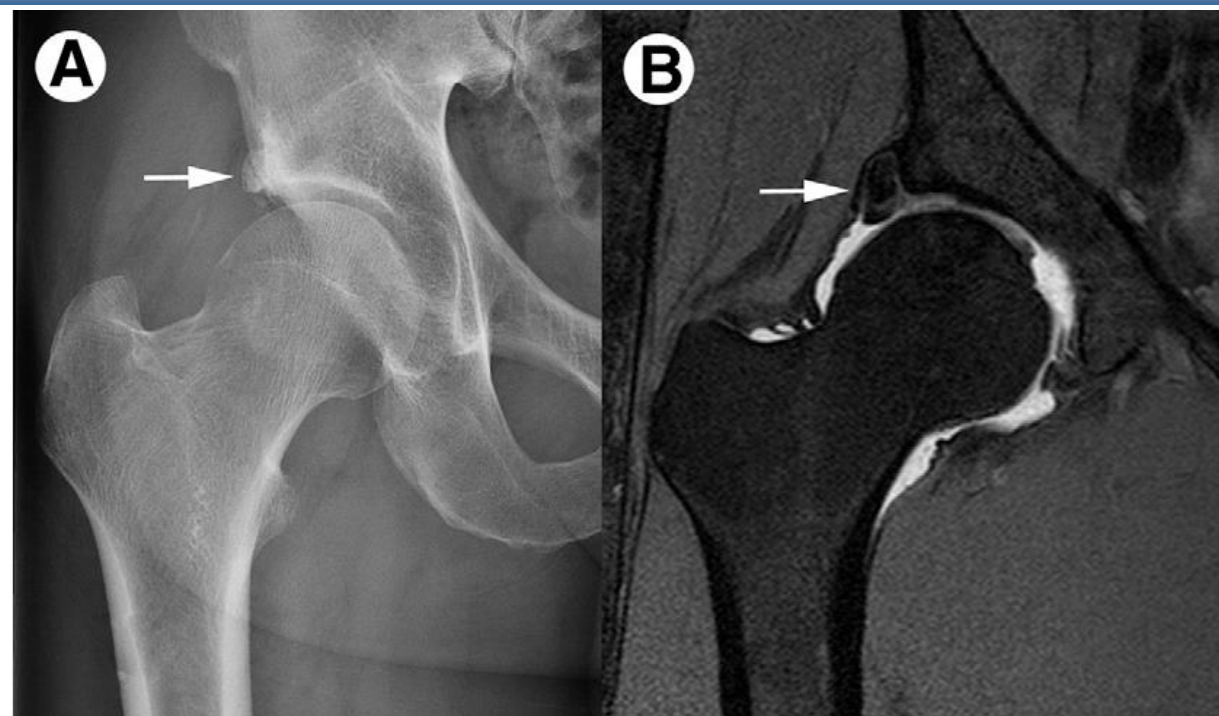
## Introduction

FAI (Femoroacetabular Impingement) Syndrome is a common condition in orthopedic clinics today and is a well-known condition in terms of diagnosis and treatment. Etiologically, it occurs with a decrease in the ratio of the head-neck junction of the femur or damage to the femoral head of the acetabulum. Its prevalence varies between 10 and 87% in the literature. This syndrome, which has 3 subtypes as CAM, Pincer and mixed; the problem that we will examine, the CAM Lesion, is in the femoral side. Sphericity loss occurs with the deterioration of globalization in the femur and the decrease in the head-neck junction.



Clinical symptoms are primarily hip and/or groin pain, limping and stiffness. Especially during the examination, the pain becomes more severe when the leg is in flexion, adduction and internal rotation. Decreased range of motion (ROM) is the biggest indicator of this. Depending on hip pain, AP and Lateral X-ray, DUNN X-ray or MRI may be requested at the beginning of the first examinations to be requested. The best guide is BT. There is a significant improvement in clinical findings after surgical treatment. In patients who do not benefit from conservative treatment, surgical treatment is at the forefront. With the resection of the CAM lesion, the clinical complaints of the patient decrease.

## Materials and Methods



The data of patients who underwent CAM resection for FAS with at least 2 years of follow-up will be retrospectively scanned. They will be divided into 2 groups of 20 people according to the amount of resection which is under 100% and over 100%. The resection amount and percentage will be calculated from the preoperative and postoperative tomography sections of the patients and the relationship between this amount and clinical results will be examined by iHot scoring.

## Results

The mean iHot score change in patients was 52.3 and significant. ( $p < 0.01$ ). There was no significant correlation between the amount of resection performed in patients with the preoperative iHot score ( $p = 0.169$ ) and the postoperative score ( $p = 0.365$ ). Group 1 preoperative iHot score was  $97.35 \pm 12.26$  SD, after  $41.9 \pm 25.62$  SD; The mean iHot score of group 2 preoperatively was  $93.3 \pm 14.51$  SD, and  $44.15 \pm 26.53$  SD after surgery. While the change in the iHot score of the 1st group was  $55.45 \pm 29.52$  points on average, it was  $49.15 \pm 32.82$  in the 2nd group and was not found significant. ( $p = 0.715$ )

Ad - Soyad	Yaş	Cinsiyet e1 k2	Operasyon Tarihi	Taraf r1 l2	Pre op femur başı ölçümü (mm <sup>3</sup> )	Post op femur başı ölçümü (mm <sup>3</sup> )	(Negatif) Delta Femur Başı	Pre op lezyon alanı (mm <sup>2</sup> )	Rezeksiyon Miktarı (%)	Pre op IHOT-12T Skoru	post op IHOT-12T Skoru	Delta IHOT-12T
A. K.	27	1	18.07.20	1	93,25	91,5	1,75	2,92	59,93	108	64	-44
A. A.	40	1	19.08.19	1	72,69	66,28	6,41	5,69	112,65	105	62	-43

## Conclusion

There is a clear clinical improvement in general in both groups of patients. The amount resected during the surgery did not have a significant relationship with the patient's pre- and postoperative iHot score, and the effect of the removed lesion rate on the iHot score was not found significant. We think that the data set we have is not enough for us, we think that we will reach a more accurate conclusion with more data.

## References

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