Modern Radiological Postoperative Diagnostics of the Hip Joint in Children and Adults

Moderne radiologische postoperative Diagnostik des Hüftgelenks im Kindes- und Erwachsenenalter

Abstract

The assessment of bone healing and loosening of endoprosthesis material was long the primary indication for postoperative projection radiography and CT imaging of the hip joint following trauma and endoprosthesis implantation. With the increasing number of joint-preserving surgery, e.g. of surgical hip luxation and hip arthroscopy for the treatment of femoroacetabular impingement (FAI), high-resolution imaging of intra-articular pathologies before and after surgery has become increasingly important. In this review article, diagnostic imaging of the hip joint is presented following common trauma surgery and orthopedic surgery interventions. The imaging modalities of projection radiography, CT and MRI including direct MR-arthrography are discussed with regard to their diagnostic capability in the postoperative assessment of the hip joint. Among others topics, imaging is discussed following hip arthroplasty, following surgical hip luxation and arthroscopic interventions for the treatment of FAI, as well as following core decompression for avascular necrosis of the femoral head. Moreover, orthopedic interventions of the hip joint in children and adolescents are presented and the dedicated reporting of postoperative imaging is outlined.

Key points:

- Consolidation of osteotomies and position of implants should be assessed in postoperative imaging.
- MRI is useful for confirming correct articulation after treatment of congenital hip dislocation.
- Radiologically assessable complications after total hip replacement are inlay wear, loosening, dislocation, periarticular ossifications and infection.
- MRI can detect and classify pseudotumours in cases of metal-metal pairing after total hip replacement.

Zusammenfassung


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Introduction

This review article first addresses postoperative hip imaging in children before proceeding to the topics of imaging performed following joint-preserving interventions as well as hip–replacement surgeries (hip endoprosthesis). The underlying diseases relevant to imaging are explained, the most common surgical procedures introduced and the criteria for evaluating or assessing the results in postoperative imaging, conventional radiographs, MRI and CT are discussed.

1. Postoperative hip imaging in children

1.1 Slipped capital femoral epiphysis

With an incidence rate of 2–10/100 000 slipped capital femoral epiphysis (SCFE) is the most common hip disease in children and adolescents [1]. This displacement of the epiphysis against the metaphysis (typically in the mediadorsal direction) primarily affects children around the pre-pubescent growth spurt (from nine years old to the end of growth) and has a male-to-female ratio of 2:1. It should be noted that approximately 50 % of cases are bilateral [2, 3]. In most cases, the affected child is significantly overweight (>97th percentile for age). The acute form is less common than the more frequently observed lenta form, thus making imaging diagnostics important particularly when patients exhibit clinically limited inner rotation (positive Drehmann sign) [2]. Radiographs show loosened epiphyseal junctions. The orthograde imaging of the femoral neck using the Lauenstein method (hip flexion around 70° and abduction around 50°) is critical for diagnosing SCFE. The Lauenstein view shows a flattened lateral convexity of the epiphyseal junction with the femoral head (Fig. 1) [1, 2]. For tilting angles up to 30°, therapy consists of stabilizing with wires or screws. Tilting angles above 30° require corrective osteotomy, e.g. Imhäuser method, i.e. ineffective and valgizing osteotomy of the proximal femur [1–3]. Following surgical treatment of SCFE, the radiologist’s task is to sufficiently evaluate the position of implants and identify any malposition (Fig. 2). It can be concluded that radiological diagnostics target the following points following the fixation of SCFE:

- Is there “secure” three-dimensional fixation of the epiphysis?
- Can intra-articular position of the implants be excluded?
- Treatment of the contralateral side or frequent examination thereof due to the 50% risk of bilateral epiphysiolyis of the femoral head.
- Does radiological imaging show osseous consolidation following corrective osteotomy sufficient for full weight to be placed on the joint?
- Evaluating the joint space and joint congruency.
- Follow-up examinations to exclude the development of hip necrosis following closed/open reposition.

1.2 Perthes disease

Perthes disease is the idiopathic pediatric osteonecrosis of the femoral head which appears between the age of five and seven and occurs at a male-to-female ratio of 4:1. It is bilateral in 15% of cases [4]. The key clinical symptoms are frequently limping with limited mobility of the hips and, in rare cases, knee pain. It should be noted that inguinal hip pain is the exception [5]. The extent of the femoral head involvement is classified into four Catterall grades on axial hip radiographs, group III and IV having an unfavorable prognosis and therefore requiring treatment. Risk signs highly suggestive of an unfavorable course include, among other findings, lateralization of the epiphysis, lateral calcification of the epiphysis and involvement of the metaphysis [4, 5]. Loss of mobility, flexion and abduction position, abduction contracture and being overweight are clinical “head at risk signs”, the collective presence thereof indicating imminent irreversible damage to the femoral head. Radiological signs of Perthes disease are visible expansion of the joint space (initial stage according to Waldenström), densification of the femoral epiphysis (condensation stage), fragmentation of the osseous core of the femoral head (fragmentation stage) and mushrooming deformation of the femoral head in the late stage [5]. When risk signs appear (particularly lateralization and lateral calcification), centering, i.e. the containment of the femoral head to prevent further deformation, by means of intertrochanteric varisation osteotomy or pelvic osteotomy according to Salter is recommended. The complication of Perthes disease is the development of pre-artritic deformation such as coxa plana and coxa magna, which can necessitate joint replacement during early adulthood [4]. The goal of treatment is to preserve mobility, thereby allowing physiological regeneration to form a spherical femoral head. Should early conservative measures, particularly physical therapy, fail to bring about the desired success, the centering of the femoral head and the rotating in of the non-endangered portions of the main load zone can be attempted through surgical therapy. When it comes to prognosis, age is of major importance, with a younger age at the onset of the disease meaning better femoral “regeneration” during the repair phase [5].

The role of imaging is to provide stage classification, detect the progress and the presence of bilateral involvement as well as assess the correct position of the osteosynthesis material or the occurrence of implant failure following surgical treatment. Surgical methods for centering the hip joint in cases of Perthes disease are intertrochanteric varisation osteotomy for stage II through IV with “head at risk signs” (Fig. 3) and, if the patient is between the age of five and eight years, pelvic osteotomy, e.g. according to Salter in patients exhibiting the aforementioned indications plus limited mobility, and a valgization osteotomy (Fig. 4) for older patients experiencing pain, hinge abduction and fixed malalignment. In addition to femoral corrective osteotomy, pelvic osteotomy (e.g. according to Salter) has established itself as another standard method for achieving better containment of the femoral head (see also Hip dysplasia surgery with corresponding diagrams and image examples in subsection 1.4). To conclude, it is the radiologist’s task to check for the following when evaluating therapy performed to treat Perthes disease:

- Development of the “head at risk”: signs
- Checking the contralateral side in bilateral cases (15% incidence rate)
In cases of surgical therapy:
- Have the osteotomy spaces consolidated?
- Correct position of implants. Can intra-articular position of implant material be excluded?
- Documentation of surgery success or the targeted improvement of containment
- Is implant failure present?

1.3 Congenital hip luxation/hip dysplasia

Dysplasia and luxation of the hip are morphological entities of various degrees [6]. Congenital hip luxation (Graf stage 3 and 4) is treated in-house through repositioning and setting a plaster cast (pelvic-leg cast/hip spica cast) under anesthesia with subsequent MRI for verifying normal articulation [3, 6]. It is important that the child is sent for imaging immediately afterward to keep the anesthesia period as brief as possible and to minimize problems with movement artefacts despite the presence of a cast in newborn patients. The sequence protocol at our hospital consists of an axial and coronal localizer and, as the most important sequences, an axial and coronal T2-weighted turbo spin-echo sequence [7] as well as an axial fat-suppressed T2-weighted turbo spin echo sequence (acquisition time for this basic protocol: 5 min 20 s). With the infant under continued sedation, supplemental sequences include a sagittal proton-dense-weighted turbo spin echo sequence performed separately on the right and left hip (Table 1). The MRI protocol can optionally be concluded with a coronal proton-dense-weighted turbo spin echo sequence in axial and coronal orientation (total acquisition time: 10 min 54 s). The examination is performed with the small flex coil lying on the abdomen and with powered up spine matrix coil (Fig. 5).
Conclusion: The role of radiology in treating congenital hip dislocation is verifying normal articulation through MRI.

1.4 Radiological evaluation of acetabuloplasty and triple osteotomies

Central Europe's most common congenital skeletal anomaly [6], hip dysplasia is diagnosed according to Graf score through hip sonography as part of a U3 examination [2]. For conservative therapy, Pavlik harness or similar are used, which frequently facilitate the curing of hip dysplasia [3, 6]. Surgical therapy is necessary when therapy for treating residual dysplasia is initiated late and serves the purpose of normalizing biomechanical conditions and curing pre-arthritic deformity. Surgery is also necessary in cases of subluxations and dysplasia of neurogenic etiology. Acetabuloplasty, e.g. Dega (Fig. 6) or Pemberton acetabuloplasty, can be used for surgically treating hip dysplasia (both congenital and neurogenic) provided that the growth plate of the acetabulum (Y-shaped growth plate) is open, i.e. in children up 10, in some cases 12, years of age [3, 6]. In the first technique specified, surgical procedure consists of making a gaping osteotomy above the acetabulum and inserting a bone graft from the iliac crest or other autologous bone graft (see diagram in Fig. 6). While Pemberton's os-

Table 1  In-house MRI protocol for congenital hip luxation in infants (3 Tesla).

<table>
<thead>
<tr>
<th>sequence</th>
<th>voxel size in mm</th>
<th>measurement time in s</th>
<th>remarks</th>
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<tbody>
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<td>coronal T2 TSE</td>
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<td>90</td>
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</tr>
<tr>
<td>axial T2 TSE</td>
<td>0.6 x 0.6 x 2</td>
<td>80</td>
<td>BLADE</td>
</tr>
<tr>
<td>axial T2 TSE fs</td>
<td>0.6 x 0.6 x 2</td>
<td>75</td>
<td>BLADE</td>
</tr>
<tr>
<td>sagittal PD TSE</td>
<td>0.5 x 0.4 x 2</td>
<td>65</td>
<td>each side</td>
</tr>
<tr>
<td>coronal PD TSE</td>
<td>0.5 x 0.5 x 2</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>axial PD TSE</td>
<td>0.6 x 0.6 x 2</td>
<td>85</td>
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TSE: turbo spin-echo; PD: proton density; fs: fat-suppressed: sequence technique for reducing movement artifacts (also PROPELLER technique).
Osteotomy differs primarily in that an aspherical osteotomy is performed, both techniques follow the same principles. In older patients with hip dysplasia, a periacetabular osteotomy (e.g., triple osteotomy) can be performed. This serves to reorient the acetabulum and normalize the deficient roofing, yet can be performed only on matured skeletons. With hip dysplasia, the labrum is typically hypertrophic and, in some cases, exhibits cystic changes with paralabral ganglion cysts. These findings are typically located in the anterior-superior quadrant [8]. The damage pattern is similar to that of femoroacetabular CAM impingement or other pathologies around the femoral head such as Perthes disease and SCFE. Triple osteotomy involves performing an osteotomy of the ischium, pubic bone, and iliac bone and then rotating and stabilizing the mobilized acetabulum with K-wires to create optimal roofing in the hip joint. Indications for this surgery are hip dysplasia and persistent ossification defect in children and adults [3]. The goal of triple osteotomy is to pivot the socket above the femoral head and to achieve optimized roofing so that the forces in the joint are transmitted over a larger surface, thus decreasing the prearthritic deformity (Fig. 6g).

Following surgical treatment of hip dysplasia, the radiologist’s role is to evaluate the consolidation of the osteotomy spaces (Fig. 6h, i) and the position of the material (Fig. 6j, k) (e.g.: Is the Y-shaped growth plate injured with epiphysiodesis? Is foreign material present in the joint space?). In summary, the primary complications following surgical treatment of hip dysplasia are osteonecrosis of the femoral head, implant failure, development of pseudoarthrosis, i.e., absence of bone healing for more than six months, as well as the recurrence of malposition. Concerning pseudoarthrosis following triple osteotomy, it must be noted that this condition is frequently asymptomatic at the pubis and ischium.

2. Imaging following joint-preserving interventions and joint-replacement surgery

2.1 Radiological evaluation after drilling into osteonecrosis of the femoral head

When evaluating the course of osteonecrosis of the femoral head, it is important that the correct stage is identified both before and after therapy. The MRI classification according to ARCO (Association Research Circulation Osseous) is as follows: In stage 0 all imaging techniques yield normal findings; in stage I signal changes are present in the necrotic segment; in stage II signs of T1-weighted hypointense demarcation margin and the double-line sign in T2-weighting with demarcation of the circumscribed osteonecrosis area with intact femoral head contour; in stage III subchondral

Fig. 3 7-year-old male patient with Perthes’ disease. This case shows the osteonecrosis of the epiphysis more pronounced on the right than on the left side using MR (a, coronal T1w, white arrow) and using X-rays b. Surgical treatment with varisating osteotomy c was performed after the patient initially presented. The goal was to improve the contact between the femoral head and the acetabular socket (containment). The following X-ray images document the follow-up over two years with increasing osseous consolidation of the osteotomy and reconstruction of the capital femoral epiphysis d–f.
fracture ("crescent sign"); and in stage IV secondary osteoarthrosis with mechanical failure of the femoral head [5, 9]. In early stages of osteonecrosis of the femoral head, the necrotic lesion can be drilled ("core decompression" or medullary decompression, Fig. 7) [10, 11]. The rational for this is reducing the intraosseous pressure in the necrosis zone to thereby lower venous intraosseous hypertension. In addition, vascularization and bone growth stimulation

Fig. 4 10-year-old male patient with Perthes’ disease, who exhibited only slight radiological progression over the first 7 months (compare a-c). After eight months there was then an unusually rapid progression with laterali-

sation and subluxation. MRI shows depleted cartilage layer at the acetabu-

lum roof and at the opposing necrotic capital femoral epiphysis (arrows) (d, transverse, contrast-enhanced T1-w fs, e, coronal STIR, f, contrast-

enhanced coronal T1-w fs). The projection radiograph after nine months illustrates the lateralization and the depleted joint space in terms of osteoarthritis g. In this case the still intact areas of the femoral head were rotated to the main load-carrying areas using (arrow) a valgizing corrective osteotomy h. The necrotic parts (see MRI) are now arranged lateral to the main load-bearing area i.
using pluripotent stem cells from blood should be performed to avert a subchondral collapse, i.e. progressing into ARCO stage III [11, 12]. The drilling should thus be performed in ARCO stages I and II. The 15-year success rates are reported to be 90% and 66% when performed in ARCO stages I and II, respectively [11, 12].

The pronounced bone marrow edema without necrotic zone (transient bone marrow edema syndrome, formerly: transient osteoporosis) is no longer seen as a preliminary stage of osteonecrosis, but rather as an independent pathology of still unclear pathophysiology and self-limiting course, which can, as so-called migrating bone marrow edema syndrome, affect other bones of the joint [10, 13, 14].

Conclusion: The role of radiology following "core decompression" is to check the progress of the necrosis and monitor the success of therapy through MRI.

2.2 Radiological diagnostics following therapy for femoroacetabular impingement (FAI)

FAI is a frequent cause of early osteoarthritis of the hip [15–17]. It affects 15% of the young population [8]. For evaluating the severity of the disease, it is important to bear in mind that the labral lesion, which is frequently the primary finding imaged, is only the tip of the iceberg. Pathology of the acetabulum and/or the femur usually involves cartilage damage [8]. A positive anterior labrum impingement test, i.e. a reproducible inguinal pain occurring when hip flexion and inner rotation are combined, is a clinical sign of a labral lesion [10, 15, 16]. The diagnostic algorithm is comprised of medical history, clinical examination (positive inguinal tenderness, anterior labrum impingement test), radiographs and subsequent MRI by means of direct MR arthrography for evaluating the labrum and car-
FAI is caused by incomplete congruence between the femoral head and the acetabulum. In the hip, distinction is made between Pincer impingement and CAM impingement [16, 17], with 86% of patients having mixed forms. A definitive diagnosis should be made only on the basis of combined appropriate clinical and imaging evidence.

Fig. 6 7-year-old boy with infantile cerebral palsy, spastic tetraparesis and neurogenic hip luxation on both sides. The radiographic Rippstein-I view (X-ray survey in 90° flexion of knee/hip and 20° abduction of the hip) shows bilaterally distinct deficient roofing with subluxation of the femoral head on the right side and bilateral fleeing and steep acetabulum roof e. Corrective surgery with reconstruction of both hips was performed including variation osteotomy with derotation and acetabular roof reconstruction according to Dega. Dega acetabuloplasty a is in house the standard of treatment and is performed as supraacetabular transiliac continuous osteotomy. Intraoperative X-rays show the curved bit, which is inserted until the Y-shaped jointing b, the spreading of the osteotomy using a spreader c and then the impact driving of the wedge of bone that has been removed from the proximal femur into the pelvic osteotomy. The wedge of bone gets pressfit jammed and the image intensifier control image shows the final situation after removal of the spreader d. Because patients with hip dysplasia present with a valgus and malpositioning in internal rotation e, treatment is varisating and derotating f. Schematic drawing of triple pelvic osteotomy g. Bony non-union within the os ilium after triple pelvic osteotomy h, i and intraarticular position of material as complication of this operation j, k.
dence [15, 17]. Only the correct roofing of the spherical head in a normal hip joint facilitates a physiological range of motion. With Pincer impingement, the excessive roofing results in premature boney contact between joint components with limited range of motion. This in turn results in damage to the labrum and joint cartilage [15]. With CAM impingement, it is the aspherical head that causes the limited range of motion and joint damage [16]. The caused is a reduced to absent offset between the femoral neck and head, a change which is referred to as “bump deformity”. The term “bump” denotes the appositional boney change from which the name “cam” is derived [15, 17]. The MR arthrography of the hip is the gold standard for detecting labral tear or detachment [18] with clearly higher sensitivity and specificity compared to normal MRI, even at 3 Tesla [18 – 20]. With axial slicing according the femoral neck the alpha angle is additionally determined using the Nötzli method (corresponding to femoral neck offset). This parameter measures the angle between point A at which the radius exits the sphericity of the femoral head (in axial slicing) and point B at which the midline through the femoral neck intersects the femoral head diameter [21].

With FAI, the goal of therapy is to surgically correct the individual pathological anatomy such that future mechanical damage to the labrum and cartilage are prevented and the impingement-free range of motion is significantly increased [8, 20]. One method would be open hip dislocation surgery [22]. The advantage of this method is that it provides an excellent intraoperative overview of the femoral head and acetabulum, allowing FAI pathologies to be visualized and treated laterally and dorsolaterally owing to the 360° joint exposure. Complications are hemorrhage, infection, overcorrection, risk of creating a bony predetermined breaking point and joint capsule adhesion. Another disadvantage of open hip dislocation surgery is the risk of pseudoarthrosis of the necessary trochanter osteotomy due to the constant muscular tension on the major trochanter by the gluteus medius and minimus muscles [8, 22]. A more minimally invasive alternative is hip arthroscopy (hip ASC) for treating localized pathologies, particularly at the anterior–superior head-neck junction [8, 23]. The advantages of this method are that it protects soft tissue and requires significantly shorter rehabilitation. Therapeutic labral resection, reduction or short-distance refixation are also possible with this method. Complications of hip ASC are likewise development of joint capsule adhesion, in particular, however, a transient but persistent anesthesia in the thigh in the innervation region of the pudendal nerve. In addition, there is a slight risk of traction damage at the sciatic nerve, since arthroscopy requires pronounced hip extension to allow instruments access to the joint space. The disadvantages of hip arthroscopy are reduced intraoperative visibility and decreased verifiability of correct resection [8, 24]. The radiologist thus has the important task of verifying post-arthroscopic success [20]. Pathological morphologies are arthroscopically trimmed back using shavers and spherical burrs (Fig. 8). Extensive or complete labral resection provides poorer clinical results than labral refixation. The goal is thus to reconstruct, and in the case of detachment, secure the labrum, e. g. through the implantation of anchors [8]. In this case, the radiologist must check that the anchors are properly positioned post-surgery. New or persistent labral lesions can also be successfully imaged and evaluated postsurgery in MR arthrography and radial sequences [8].

Post-surgical evaluation following treatment of FAI and labral pathologies is based on the following points, and the radiologist should address the following questions in his or her report [20]:

- Report checklist
  - Was the offset of the head-neck junction sufficiently restored?
  - Was a “bump” overlooked, i.e., is there residual asphericity, e.g., dorsal or medial?
  - Is there progress in cartilage damage over time?
  - Are the anchors positioned correctly following labral refixation?
  - Are there residual loose bodies present following arthroscopy?
  - Has new labral damage appeared?
  - Can a temporary instability or predetermined breaking point in the femoral neck be assumed due to an overcorrection?

Fig. 7 17-year-old female patient status post drilling because of osteonecrosis of the femoral head. Osteonecrosis of the femoral head on the right side ARCO stage II (a, coronal STIR). Underlying condition is systemic lupus erythematosus, with the osteonecrosis of the femoral head being caused by cortisone treatment. One year following drilling b, c, both cartilage and subchondral bone structure are intact (b, coronal STIR, c, transverse T2-w fs). The arrow in b points at the tract of the core decompression within the right femoral neck and head.

Fig. 8 Extensive or complete labral resection provides poorer clinical results than labral refixation. The goal is thus to reconstruct, and in the case of detachment, secure the labrum, e. g. through the implantation of anchors [8]. In this case, the radiologist must check that the anchors are properly positioned post-surgery.
2.3 Imaging following hip endoprosthesis

There has been a steady increase in the number of joint replacement surgeries in the hip and knee joints as well as the shoulders [25, 26]. In Germany, more than 300,000 joint replacement surgeries are now performed annually, with 158,000 artificial hip implantations being performed in 2008 [26]. Interestingly, there are no hard indications for hip endoprosthetic surgery [27]. In addition to frequent osteoarthritis (degenerative, post-traumatic and dysplastic), osteonecrosis of the femoral head and femoral neck fracture are typical indications for a total endoprosthesis (TEP) of the hip. Not only radiological changes, but also movement restrictions and limitations in everyday life accompanied by duration and intensity of hip pain are important factors when determining whether this therapy is indicated [27]. Hip endoprostheses can be divided into hemiprostheses (replacement of the femoral head and femoral neck, e.g. duo-head prosthesis) and total endoprostheses with replacement of acetabulum, femoral head and femoral neck according to the degree of replacement [28, 29]. Superficial replacement involving replacement of the acetabular and femoral head surfaces must also be mentioned. However, this solution is associated with poorer long-term results and is thus of subordinate clinical relevance. Furthermore, hip prostheses are commonly subdivided according to implantation technique into cemented hip TEP, especially in

![Image of preoperative Lauenstein view of a 26-year-old female with CAM impingement](image)

Fig. 8 Preoperative Lauenstein view of a 26-year-old female with CAM impingement. a. MR-arthrography shows in addition to the bump at the head-neck junction (arrow in d), which is already radiographically visible, the labral lesion (arrows in b and c, b, coronal PD-w fs, c and d, radial PD-w sections perpendicular to the femoral neck axis). Intraoperative images of an arthroscopic bump resection in case of CAM impingement. e. In case of CAM impingement the bony asphericity at the head-neck junction is removed. The Lauenstein view illustrates the removed bump and the restoration of the sphericity.
osteoopenic bones and older patients, and non-cemented hip TEPs. The later solutions are implanted primarily in younger, active patients, since they can be replaced with less loss in bone mass [28, 29]. Special forms include tumor prostheses and revision prostheses, the modularity of which allows them to adapt individually to the bone defects in the femur and pelvis [28]. When it came to long-term results, cemented prostheses were the long-reigning gold standard, showing very positive results especially in nation-wide registers for the Scandinavian countries [30]. Cement-free prosthetic systems have been steadily approaching the long-term results of their cemented counterparts and have become increasingly popular around the world because of the advantages they offer with regard to implantation and replacement [11, 29]. Today, cement-free and cemented prostheses have comparable service lives. International comparison has shown clear differences in the use of these two anchoring systems. In no way should cemented prostheses be labeled as "old" and cement-free as "modern". The choice between cemented and cement-free treatment is made on the basis of age, bone quality, concomitant diseases, previous surgery, etc. [28, 31, 32]. For cement-free systems, the pelvic bones and femur are prepared with surgical burrs and bone rasps, and the implant is inserted using the press-fit technique (i.e. adjusting the pressure of the implant going into the bone without using external materials). High primary stability is the prerequisite for secondary biological anchoring in the bone (osteointegration) [11]. Serving as sockets are widely distributed hemispherical and rough surfaced systems which are anchored in the acetabulum through press-fit with or without additional screws. Threaded cups are also still commonly used. For cement-free shafts, proven systems with meta-diaphyseal anchoring are available that can be described as long-shaft systems. The short-shaft prostheses are based on a purely metaphyseal anchoring, and the surgical technique demands preserving the medial femoral neck. In the case of standard interventions, immediate mechanical loading is permitted for both cement-free and cemented prostheses [33]. In terms of tribological pairing, hip total endoprosthesis can be divided into ceramic, metal and polyethylene sockets, which can in turn be combined with ceramic or metal heads (Fig. 9a–e). The goal is optimal tribological pairing of the head and socket to keep the constantly present wear to an absolute minimum [11]. The softer material always wears off. In the case of polyethylene-metal pairing, the biologically active polyethylene exhibits an average annual wear of 0.2 mm. The wear products activate osteoclasts via complex cascades and result in sometimes pronounced bone defects around the embedded prosthesis [29]. Metal prostheses entail the problem of metal particles resulting from wear. These particles can lead to elevated metal ion values on the systemic level and be accompanied by the development of granulomas. The key to diagnosing loosening is the appearance of a radiolucent margin of over two millimeters progressing over time as well as the migration of the prosthesis, e.g. the sinking of the shaft or the protrusion of the socket [11, 28, 40]. The appearance of a radiolucent margin only in the proximal femoral area of the prosthesis (in the intertrochanteric region) initially has no clinical relevance and physiologically results from mechanical loading and load effect further distal [28]. With cemented systems, the appearance of a radiolucent margin especially at the anchoring point is clinically relevant. Supplemental scintigraphy can be performed when radiographs as primary imaging modality and CT, which is the most sensitive at detecting the appearance of radiolucent margins, are not sufficiently conclusive [28]. The diagnostic value of these modalities, however, is undisputed, particularly in the first one or two years following implantation. Implant migration or positional change as well as breakage of components or the surrounding cement are other sensitive parameters for diagnosing a loosening. [29]. Thorough evaluation should therefore always include comparison with previous images [11]. Periprosthetic fractures (Fig. 11a–d) may occur in-
traoperatively, following surgery during mobilization and as a result of trauma. Avulsion fractures are frequently observed on the greater trochanter, the same being true of oblique or spiral fractures on the femoral shaft. Acetabular fractures around the implanted cup occur more rarely. When planning therapy, diagnosing or excluding a loosening of the prosthesis is crucial. A loose prosthesis must be replaced. In cases of doubt, supplemental CT should be performed liberally [40]. Periprosthetic fractures detected intraoperatively through fluoroscopic examination are treated immediately by means of cerclage.

Infections

Prosthesis-related infection is a formidable complication, appearing in 0.5 – 1.0 % of patients worldwide. The risk factors are advanced age, obesity, diabetes mellitus and immune suppression. Distinction is made between early infections, occurring within six weeks post surgery, and late infections [28, 42]. Early infections can be treated through attempted preservation of the prosthesis by means of debridement and purging. Late infections necessitate a single or even double implant replacement. The radiologist needs to indicate whether the infection process has made contact with the prosthesis (Fig. 11e–f) or whether a periosteal reaction or osteolysis with blurry edges is present [11, 29, 40]. Inversion recovery sequences such as STIR are better suited...
than spectral fat saturation, while T1- and T2-weighted (turbo-) spin echo sequences are better suited than gradient echo sequences at decreasing the metal artifacts of the hip endoprosthesis and detecting periprosthetic bone and soft tissue changes as well as fluid collections [36, 42, 43]. The absence of joint effusion has a high negative predictive value for an infection of 96% [36]. Because of the applicability of MRI, nuclear medicine methods such as scintigraphy or positron emission tomography (PET) are used less frequently for these clinical problems [28].

Pseudotumors

Pseudotumors appearing with polyethylene inlay are called abrasion granulomas (Fig. 12a–c). The abrasion debris of the polyethylene inlay is engulfed by macrophages, which accumulate in foreign body granulomas and usually have a density of 30 Hounsfield units in CT. In MRI they appear...
hypointense and slightly hyperintense in relation to the muscle in T1- and T2-weighted sequences, respectively, with T2-weighting showing a hypointense line to the bone marrow, and typically involve no perifocal bone marrow edema [36, 40, 42]. With metal-metal tribological pairings, the terms cyst, ALVAL (aseptic lymphocytic vasculitis-associated lesion) or ARMD (adverse reactions to metal debris) are used synonymously with pseudotumor. These cases usually involve elevated metal ions in serum [11, 35]. The patients are usually below the age of 50 and have undergone joint replacement surgery with metal-metal tribological paring (e.g. surface replacement) [34]. The incidence rate is 1–4% with a peak appearing four to five years following TEP implantation. Pseudotumors frequently expand into the iliopsoas muscle [11, 34]. The key to diagnosis is detecting a space occupation in connection with the hip joint of the prosthesis and, in the case of metal-metal pairings, solid components and/or a low-signal wall in T2-weighting (Fig. 12d–j) [42, 43]. Multiple grading systems for soft tissue changes occurring with metal-metal prostheses have
been proposed. According to Hauptfleisch, pseudotumors appearing with metal-metal pairings can be categorized into three types [34]:

▶ Type 1: cystic, wall ≤ 3 mm, usually minor symptoms
▶ Type 2: cystic, wall > 3 mm
▶ Type 3: primarily solid with the highest revision rate

It is the consistency of the pseudotumor rather than its size alone that determines the signs and symptoms [34].

Luxations

Recurring luxation of hip TEP (Fig. 12k, l) is a complication that has decreased in incidence since the introduction of prosthesis planning involving restoration of the patient-specific anatomy. It can be caused by incorrect cup position (excessively high inclination angle, incorrect version (with correspondingly different frequency depending on surgical access pathway used)) as well as incorrect shaft position (excessive/insufficient antetorsion) [29]. Besides eliminating the cause, recurring luxation following hip total endoprosthesis can be treated by lengthening the prosthesis neck to create more tension on the soft tissues or using an inlay with a cambered cup rim [33]. Enlarging the diameter of the prosthetic head increases the degree of freedom of motion of the prosthesis to the effect that the prosthesis planning involving restoration of the patient-specific anatomy.

Fig. 12   Pseudotumor in a 62-year-old female patient post status metal-metal pairing of the left hip six years before a–c. Abrasion-induced synovialitis and effusion with release into the iliopsoas bursa (type 1 pseudotumor) visible on MRI (d, transverse T1-w, e, coronal STIR, f, transverse T2-w) and ultrasound g. Revision surgery involving changing from the Metasul inlay to a polyethylene inlay and to a ceramic head was therefore indicated. Pseudotumor in a 71-year-old female patient with implanted total hip arthroplasty and space-occupying lesion dorsal and medial to the femur as well as erosion and lysis of the cortex of the femoral shaft. A granuloma due to abrasion of the polyethylene inlay was histologically verified using CT-guided puncture h–j. Luxation of total hip arthroplasty cranially in a 84-year-old female patient and status post proper repositioning k, l.

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neck does not strike against the rim of the cup (impinge-
ment) and thereby damage the cup or lever the prosthesis
head out of the cup (luxation, subluxation) [29, 33]. The lar-
ger the prosthesis head, the lower the risk of luxation.

**Heterotopic ossifications (PAO)**
While the rate of incidence of heterotopic ossifications is
very high especially over the long term at 40 – 50 %, it is
asymptomatic in 70 % of patients [11, 40]. Heterotopic ossifi-
cations appear in the area of the former capsule and the para-articular soft tissue. The risk of developing PAO is in-
creased in patients with diffuse idiopathic skeletal hyperos-
tosis (DISH), Parkinson’s disease, Paget’s disease, Bechterew’s
disease or a past history of PAO [11]. Muscle-preserving sur-
gical techniques and prophylaxis with nonsteroidal anti-
flammatory drugs can reduce the appearance of PAOs. Pro-
nounced PAOs following primary implantations have thus become less common. According to Brooker, heterotopic ossification in the hip is categorized into four grades (Fig. 13) [44]:
- Grade I – bone islets in soft tissue
- Grade II – osteophytes emanating from the femur or pelvis
- Grade III – same as grade II but with bone spurs being spaced less than 1 cm apart
- Grade IV – complete boney ankyloses.

**Metal artefacts in cross-sectional imaging**

In MRI, signal dropouts and noise at the phase interfaces of primarily magnetic materials (e.g. metal) are referred to as susceptibility artefacts. While in principle these can appear with any pulse sequence, spin echo sequences are less sensitive in this area owing to their pulse characteristics. In routine diagnostic testing, artefacts can be reduced through the following measures:
- Using spin echo and turbo spin echo sequences instead of gradient echo (GRE) sequences as well as using STIR sequences instead of frequency-selective techniques for fat suppression
- Interchanging phase and frequency direction
- Imaging with higher sensitivity bandwidth, if applicable orienting the longitudinal axis of the metal implant along the primary direction of the magnetic field
- Using modern artifact-reducing sequences, e.g. SEMAC (slice-encoding for metal artifact correction) or MARVIC (multiple-acquisition variable-resonance imaging combination; GE Healthcare, Milwaukee, WI) [40, 42].

CT involves primarily hardening artifacts along metallic non-radioopaque materials. For iterative reconstruction there are already commercially available algorithms for these cases (e.g. O-MAR, Metal Artifact Reduction for Orthopedic Implants) [45]. With this technique, the first, uncorrected image is reconstructed and regularized, before then being compared with the gathered raw data. As long as these fail to match, other reconstructions are generated, thus constituting what is referred to as filtered back-projection. Image quality increases with the number of reconstructions. However, the disadvantage of this technique is the increased radiation dose required. Even CT scanning itself can considerably reduce artifacts through dual-energy techniques, allowing the same bodily region to be examined at two different energy levels [40].

**Summary and core statements on imaging after hip endoprostheses**

Problems occurring over the course of time with hip endoprostheses must be addressed through imaging as described below. Projection radiography examinations constitute the basic diagnostic means for evaluating implant position and detecting periprosthetic fractures, any loosening or soft tissue ossification. Computed tomography is the primary diagnostic method to enlist when radiographs yield unclear findings and periprosthetic fractures are suspected [29]. Modern prostheses such as those made of titanium alloys generate few artifacts. Sonography is suited for detecting or excluding joint effusion or postoperative seroma, while allowing direct fluid puncture and draining [25, 29]. MRI is indicated for suspected infection or tumor recurrence in the case of tumor prostheses and pseudotumors. It is important that many clinical questions can be answered through thorough evaluation of conventional radiographs over the course of time. In this process it is also imperative that the entire prosthesis is imaged completely.

**References**

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