# FROM THE **OCM APPROACH** TO THE **AMIS**

Interview with **Dr. Martin Nolde**,
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## FIRST QUESTION: WHAT ARE THE PHASES OF YOUR CAREER?

I had my education at the Red Cross Hospital in Munich from 1986 until 1991 under PD Dr. Jürgen Radke. The emphasis at the Clinic is on knee and hip prosthetics. Since 1991 I have been in-patient doctor in the orthopaedic department of St. Elisabeth Hospital in Dillingen. The department has 21 beds for orthopaedics. I operate about 130 THP per year and in about 98% of the cases I use cement free implants.

## SECOND QUESTION: WHAT DO YOU THINK IN GENERAL ABOUT MIS FOR HIPS?

At the beginning of my training I learned the Watson-Jones technique and then the Bauer technique. These two conventional approaches have advantages, of course, but unfortunately they also have many disadvantages. Splitting the tractus ileotibialis very often causes patients problems later, because for this operation the abductor muscles have to be released or cut. Generally, such procedures result in relatively high loss of blood, post-operative pain and high patient morbidity.
If the MIS techniques can solve these problems, then I am for them. But be careful, not all MIS techniques are effectively minimally invasive!

## THIRD QUESTION: WHICH MIS TECHNIQUES DID YOU DO FIRST?

Starting 2005 I learned the so-called OCM technique of Dr. Röttinger. It is a modified version of the Watson-Jones approach, but with the patient in the side position. The problems mentioned above clearly improved, but unfortunately the learning curve was flat despite the workshop and operation accompaniment.

## FOURTH QUESTION: WHAT WERE THE PROBLEMS?

There were still a lot of complications like femur fissures, larger problems in positioning the cup (due to the side position) and also still some soft tissue damage of the tractus ileotibialis, tensor and gluteus medius. Unfortunately only about 70% of the patients are operated with the OCM technique; the other 30% are not suited for the following reasons: previously operated patients, cup protrusion, advanced osteoporosis, muscular men and adipose patients.

## FIFTH QUESTION: DID AMIS SOLVE THESE PROBLEMS?

Yes, in most cases it did. First I can say that thanks to the patient's supine position the cup positioning has become more secure. Determining the leg length is also easier due to the possibility of intra-operative fluoroscopy. The anaesthesia is also uncomplicated, which was not the case with the OCM technique. With AMIS I operate without stress and this technique also brings a financial advantage for the insurance, for the hospital/clinic and for the patient. I only need one assistant thanks to the mobile leg positioner, the post-operative care is noticeably less and the stationary treatment and the rehab requirement are shorter.

## SIXTH QUESTION: DO YOU OPERATE ALL PATIENTS WITH AMIS?

No, but almost. In my department I operate about 98% of the patients with AMIS. Only pre-operated patients or patients with severe hip dysplasia cannot always be operated with AMIS.

## SEVENTH QUESTION: WHAT DO YOUR PATIENTS THINK OF AMIS?

They notice clear advantages from AMIS as opposed to the conventional approach. They are satisfied that the post-operative treatment is practically painless. And only having a small scar is appreciated.

## LAST QUESTION: WHAT DO YOU EXPECT FROM AMIS ON THE LONG TERM (10-15 YEARS POST-OPERATION)?

Naturally I expect that the clinical results will at least match today's standard or even surpass it. After about one year's follow-up I can say that my patients have fewer remaining complaints and very minimal complications. I am convinced that thanks to the minimal muscle and soft tissue damage (unchanged anatomical situation) the patient have advantages in case of any revision of the prosthesis.

AMIS is **the** new soft way to implant an artificial hip joint!




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