Femoral Head-Trunnion Dissociation in Metal-on-Polyethylene Total Hip Arthroplasty – A Unique Case Report

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Abstract

**Background:** Gross trunnion failure (GTF) after total hip arthroplasty is a rare complication and has only been reported in a few case series. Some of the associated risk factors have been described in the literature and include larger femoral heads, greater offset, and increased BMI. Despite this, the mechanism behind GTF is poorly understood and early diagnosis and treatment continues to be challenging.

**Case Presentation:** We present the case of complete femoral head and trunnion dissociation in a 63 year-old female nine years after total hip arthroplasty. Unique to this case is the lack of classic patient and implant risk factors for GTF along with the acute onset nearly nine years after implantation.

**Discussion:** This case presentation highlights the fact that the contributing factors and mechanism behind GTF continue to be poorly understood. There is a need for future research to help better understand this phenomenon and to help potentially identify those at risk for GTF.

Background

The use of femoral head modularity with a trunnion and bore has been the gold standard in hip arthroplasty due to ease of use, leg length and offset adjustability, and improved exposure in revision settings. Despite frequent use of modular components, corrosion at the head-neck junction or trunnionosis has only recently received increased attention [1]. Severe trunnion corrosion can lead to mechanical deformation of the trunnion resulting in gross trunnion failure (GTF) [2]. The specific implant and patient factors that contribute to trunnionosis and GTF continue to be poorly understood. Several implant specific characteristics have been reported including titanium-alloy modulus, trunnion volume and contact area, taper-angle mismatch, varus-neck angle, high-offset, larger head, and dissimilar metals [3]. Potential patient specific factors include high activity level, obesity, and male gender [3]. Incomplete trunnion cleaning at time of surgery and inappropriate impaction force of the head-neck have also been described [4]. We describe a case of GTF in a patient without the classically reported risk factors.

Case Presentation

At initial presentation in 2007, the patient was a 55 year old female with BMI of 22.8 and past medical history consisting of lumbar radiculopathy. She reported a multiple year history of progressive left sided hip and groin pain and was found to have end stage left hip osteoarthritis on radiographs (Figure 1). After failure of conservative measures, the patient underwent elective left total hip arthroplasty in

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**Level of Evidence:** AAOS Therapeutic Level IV

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October 2007 and tolerated the procedure well. Her hip implants consisted of an Accolade I TMZF size 2.5 femoral component with 127° neck angle, Trident 52mm E acetabular shell, 32mm +4 cobalt-chrome (CoCr) head ball, and an X3 32mm, 0 degree crosslinked polyethylene liner (Stryker Mahwah, NJ) (Figure 2). She had an unremarkable post-operative course. The patient returned to clinic in 2016, almost nine years after her initial surgery, now 63 years old and with a BMI of 23.5. Her complaints included 3 weeks of painless clunking and left hip mechanical symptoms. Imaging revealed significant metallic debris about the hip joint along with interval alignment change at the head-trunnion interface with the head ball now residing in a more varus conformation (Figure 3). Based on these findings suggesting trunnion compromise, surgical intervention was felt warranted and revision hip surgery was scheduled. Several days after evaluation, the patient presented to the emergency room with acute onset of significantly worsened left hip pain and found to have complete dissociation of the femoral head and trunnion (Figure 4).
The patient was admitted and underwent revision left hip arthroplasty without complication. Intraoperative images from her revision surgery are shown in Figure 5. She was found to have extensive metallosis in the soft tissues surrounding the left hip along with advanced corrosion and loss of material at the femoral trunnion. Her femoral component was replaced with a long stem modular implant fitted with a 36mm ceramic head ball and her polyethylene liner was exchanged (Figure 6). Plasma chromium level was 10.0 μg/L (Ref range 0.1 – 2.1) and serum cobalt level was 20.9 μg/L (ref range 0.0 – 0.9). Since the revision surgery, the patient has done well with minimal hip pain and good mobility.

Discussion

Despite an increasing body of literature on trunnionosis, there has been little reported on the unique mechanism of GTF. The few previous small case series have attempted to describe patient, implant, and surgeon factors that may contribute. In a series of five GTF’s with the Accolade I TMZF stem (Stryker, Mahwah, NJ), Matsen et al. noted that male sex, BMI > 30, head size 36mm or greater, lateral offset (127°) neck angle, and increased head offset were commonly associated factors [5].

In a case series involving multiple manufacturers, Banjeree et al. discuss the lack of data to implicate one single taper or neck geometry [2]. They too note the association with male gender and increased femoral offset. They surmised that the increased offset in the head may lead to stress and micro-motion in the taper with eventual fatigue and gross failure.

Confounding the issue have been reports of abnormal reactions to Beta titanium (TMZF) and concerns over its decreased modulus of elasticity being able to withstand cyclic loading. In a paper by Kirin et al., the authors postulate that the impaction of the femoral head or cyclic loading removes the oxide passivation layer creating crevices in the taper junction [6]. This allows for fluid ingress within the
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The patient’s demographics and implant characteristics are not typical of what has been reported in the literature with GTF and underscores the fact that the mechanism of femoral head-neck dissociation is still poorly understood. The patient in this case is female, with a BMI of 23.5 and an implantation time of nine years as compared to most other reports of male patients with BMI > 30. This demonstrates that gender and BMI may be patient specific risk factors, but are not predictive of corrosion or failure. From an implant standpoint, the patient had a 32mm femoral head, not the typical 36mm or greater femoral head sizes suggested by previous authors as risk factors. The neck angle in this case is 127° (varus neck) with an increased offset head (+4) on a Beta titanium stem with greater flexibility. These circumstances highlight that the cause of GTF may be multifactorial, but micromotion at the head-neck may be the common denominator. It remains difficult to suggest which patients should be monitored with x-rays, serum ion levels, and cross sectional imaging across all manufacturers. However, it is reasonable to identify patients who received recalled implants and provide surveillance with potential to intervene before GTF occurs. The typical lack of symptoms prior to GTF makes early diagnosis and treatment challenging, and a high index of suspicion is required for early intervention. Future research is clearly needed to better understand this phenomenon and to help further identify those who are at risk for corrosion and GTF.

References: