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Every day in this country a woman falls and breaks her hip. Hip fractures most commonly occur in females 70 years or older. Hip fractures are more common in women and it is estimated that as many as 1 in 3 women will sustain a hip fracture during their lifetime. The fastest growing segment of our population is the elderly which is largely responsible for the growing number of hip fractures occurring yearly; consequentially hip fractures are a major public health concern. It is predicted by the year 2050, 6.3 million hip fractures will occur per year. Hip fractures are the second leading cause of hospitalization among the elderly.

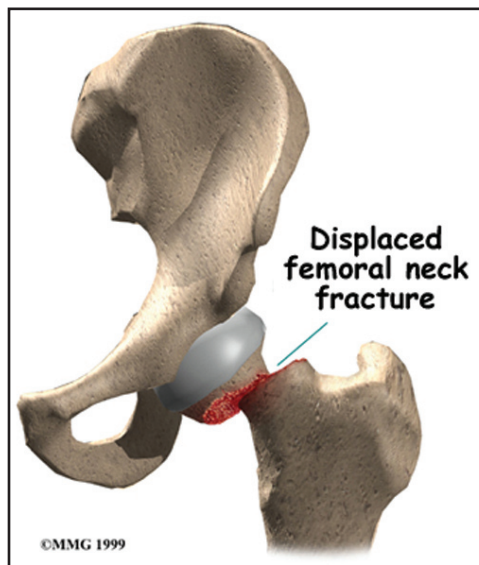
There are several types of hip fractures but the two most common types are referred to as femoral neck fractures and intertrochanteric fractures. The treatment is different for each.



Intertrochanteric fractures have good blood supply with excellent healing potential. This type of fracture is generally fixated with some kind of orthopedic implant; plate, rod, and/or screws. Femoral neck fractures are at risk for non-union (non-healing) and therefore the treat-

I've fallen and I can't get up! It's not a joking matter.

ment is usually a prosthetic replacement. Multiple studies evaluating the use of prosthetic replacement in the elderly have consistently demonstrated predictable pain relief, functional improvement and low revision rates. Post operative care for a prosthesis requires certain restrictions known as "hip precautions." Both surgical techniques allow for early weight-bearing.



Surgery should be performed as soon as reasonably possible and preferably within 48 hours. Medical problems that can be reversed or easily correctable should be completed before surgery. Non-surgical treatment should be considered in non-ambulating patients who are deemed too medically ill for surgical intervention or are in terminal stages of life.

The goal of anesthesia is to eliminate pain, allow for appropriate intra-operative positioning, and achieve muscle relaxation to effect reduction. Regional anesthesia or spinal anesthesia is a preferred technique to lessen the complications of post-operative confusion, deep venous thrombosis, and cardiopulmonary complications.

So what should we do? Most fractures should be stabilized surgically to allow for early mobilization and weight-bearing. The complications of non-operative care are those of prolonged bed rest which include but are not limited to inability to ambulate, pneumonia, DVT (deep vein thrombosis or blood clots), and decubiti (bed sores). Osteoporosis evaluation and treatment may help to prevent this injury. Certainly, before and after the fracture, a well balanced

diet, exercise and balance program, sunlight exposure, not smoking, vitamin D and calcium supplementation at the least should be considered. Exercise programs reduce falls and improve performance in frail patients. Making the home safe; eliminating loose carpets, moving exposed cords out of pathways, and installing safety rails in showers have been shown to prevent hip fractures. Have a family meeting and decide on an advance directive and health care proxy. Realistically be aware, life may not be the same for the patient and their family after hip surgery.

This event, most commonly caused by a simple fall, has life-altering implications for the patient as well as their family. Family dynamics change with added requirements to the younger generation and loss of lifestyle control in the elderly. Who will decide on treatment and care choices? Will the patient return to the same level of activity, ambulation, cooking, cleaning and maintaining a home? Who takes care of the husband, who often hasn't cooked for over 50 years? Often the husband needs assistance, especially, with the wife not present. Do not forget our pets. Who is taking care of Fido? These are major social-economic issues that must be considered during and after hospitalization.

Additionally, families are often faced with making major medical decisions with little information or forethought. Who has the power of attorney and/or health care proxy; the legal right to make medical decisions on behalf of those who are incapacitated? Someone, if the patient is not mentally competent, in the family will have to make decisions. To have surgery or not are consequential decisions with risks and long term implications. Disposition as far as short-term and long-term placement will need to be decided in regard to post-hospitalization care. Do we take mom home? Can she care for herself? What about Pop? Do we go to a rehabilitation facility, a nursing home, or arrange for a visiting nurse?

Along the same theme, "advanced directives" should be decided in advance as well. We are referring to advance health care directives also known as living wills. These are instructions given

by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity. In the event of a terminal or incurable illness along with a hip fracture, certain life-sustaining measures may be withheld and others pursued. Withholding of Cardio-Pulmonary-Resuscitation yet maximizing pain management are common directives given by patients.



All of us prefer not to think about the potential of mom or dad having this sort of injury. But, statistics indicate that many of us will unfortunately witness a parent or loved one having this occur. To ease the stresses and tensions that can be placed on everyone potentially involved in the care of this person have a family discussion around the "what ifs". Talking about and having formal plans on who will take care of what will prevent heartaches down the line and provide a smoother road to recovery.



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