THE APPROACH TO THE HIP JOINT

Orthopaedic surgeons have the good fortune to follow a craft as well as to encompass a science. Like other craftsmen, we have often two ways at least of doing the same job, the success of which is dependent upon the character and integrity of the man. "Approaches" are for us both physical and psychological: in the case of the hip joint it seems clear that there is more than one good method and that, for the sake of those we train, we should keep an open mind.

On the continent of Europe there has been an almost rigid adherence to the methods of Kocher, Langenbeck and Ollier, with exposures of the hip joint from the posterior or lateral aspect. Though some surgeons use the Murphy approach, there is in the English-speaking world a greater tendency to follow the anterior Smith-Petersen approach. For us in Great Britain, Foley has recently drawn attention to the advantages of a posterior exposure for ischio-femoral arthrodesis. In this number of the Journal, Alexander Gibson describes in greater detail his use of the Kocher-Langenbeck exposure during thirty-five years. Gibson's advocacy is so persuasive that when the present writer first read this paper he decided to try one case, even though tempered by the natural doubt inculcated by a conservative upbringing. There was, however, *no* doubt when the operation had been done, and one immediately wondered why Kocher's approach had gained the reputation—which it has in America and Britain—of being sanguinous and shocking. Such was the ease that for the last thirty cases it has been the method of choice. Haemostasis is not required, for there is no bleeding. Dislocation of the femoral head is so easy that there is no shock. Transfusion is often unnecessary. Every element of the hip is available adequately for treatment with tools. Because the acetabulum forms the floor of the wound, reamers can be applied with great mechanical efficiency. These matters possibly are of little importance to the surgeon who approaches the hip joint with the meticulous care of a Smith-Petersen. Are there still other advantages?—It seems that there may well be. Certainly, by the Kocher approach one can avoid the denudation of the gluteal surface of the ilium, the disturbance of the abdominal muscles and the harsh retraction of the hip flexor muscles. The less we interfere with muscles the better, for the greatest difficulty in the rehabilitation of patients following arthroplasty of the hip is the restoration of muscular competence. And here is a further feature in the posterior approach: the insertions of the deep gluteal muscles can be given greater mechanical advantage by transplantation to a lower level upon the femur. Though Gibson does not mention it, both the approach and this reattachment are facilitated by osteotomy through the base of the great trochanter: a feature well demonstrated by Charles Gray in his excellent moving picture shown at the meeting of the British Orthopaedic Association at Bristol in October 1949.

In practice one finds that the incision is much more nearly a vertical curve than is suggested by the illustrations in Gibson's paper. Obviously nothing new has been presented; nevertheless, it is good that interest should be revived in a neglected method of such real value for the many operative procedures commonly performed upon the hip joint. The method goes a long way to support the author's view that it is *facile princeps*.

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