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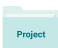

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Introduction:

Simultaneous BTKR is still somewhat controversial. Although with severe deformity it is important to perform a Simultaneous BTKR in order to correct deformity in both legs. The purpose of this scientific exhibit is to review recent literature about Simultaneous BTKR and to share our experience with simultaneous bilateral knee replacement for over 4500 cases that we have performed. Also the purpose of this exhibit is to show surgeons how to set hospital and medical team and establish the proper protocols in order to avoid higher complication rates.

Material and methods:

From the year 2015 we performed over 4500 cases of simultaneous BTKR. All surgeries were performed by a single surgeon. Due to the severe deformity that we usually encounter in our patient population and the need for full flexion after TKR, the senior surgeons in the series has favored doing simultaneous BTKR. However this decision was not made promptly. Extensive negotiation and consultation were made with diff depts. in the hospital. The patient for simultaneous BTKR was initially picked based on their medical background. However, as protocol and OR team got more accustomed to simultaneous BTKR the rate of simultaneous BTKR increased significantly. Last year 81% surgeries were done as simultaneous BTKR at our institution. The simultaneous BTKA was done in one setting.

We have initially tried diff modalities in order to see what would be most appropriate for the OR team and at this point the OR team consist of a senior surgeon, two assistants and one scrub nurse only. Normally the surgeon start on the first knee and after cementing the implant the assistant start the other leg and the first assistant clean up the excess cement and close. We have found that using one set of TKR is more practical starting with two teams simultaneously has proved to be difficult and challenging to the OR staff creating some technical difficulty. Normally on average the simultaneous BTKR took 2 hours and 23minutes based on the difficulty of the case.

Post- operatively, the patient was taken to intensive care unit for observation overnight and the H&H were checked q.8 hours and during output and blood pressure was monitored carefully. We compared the result of those simultaneous BTKR with 1736 cases of single TKR which was performed with the same surgeon. We compared morbidity and mortality. Also we have followed up the literature for long time past simultaneous BTKR.

This literature showed that the Asian surgeons were performing simultaneous BTK more often .Initially there was a great reluctance from the North American surgeons to do such a surgery. However it is becoming common now. We developed multiple protocols for SBTKR. Our anesthesia and medical rteam had a great impact on the post-operative course. The post op follow up were carried on by the operating surgeon and as well as with the medical team which consisted of an internist , physiotherapist as well as the consultant - as deemed necessary by the medical team leader. Our average hospital stay was 6 days for simultaneous BTKR compared to 4 days for single TKR.

Dr. Samih Tarabichi

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