Reflection:
Inside The University of Washington's Surgery Center

By Eve L. Russell '05

It is 7 a.m. Bleary eyed and blinded by the harsh white light I wind my way through the long hallways. In the locker room I pull on sky blue scrubs, grab a mask, booties and a cap - go time. The surgery center at the University of Washington never sleeps. The schedule posted in the entrance way is covered with names, conditions, procedures and time limits. It is easy to be overwhelmed here, but now I am used to the frantic pace and the urgency that floats in the air. For the last month I have been interning for an orthopedic surgeon learning all there is to know about what goes on behind the scenes in a hospital. I have followed him in clinic, watched surgery, and done research. I have worked 12 hour days, missed lunch, and seen how this one doctor's work changes lives.

For the last three days, I have been tucked away in the medical library rifling through pages of medical texts, journal articles, and surgery reports looking for Femoral Acetabular Impingement. I have gone through more than one hundred patient histories, clinical evaluations, surgical procedures, and follow up data. I have compiled a database, made a questionnaire, and begun a second draft of a clinical research paper on the outcomes of elective hip arthroscopy for Femoral Acetabular Impingement. Femoral Acetabular Impingement syndrome in the hip is caused by the impingement of the acetabular labrum (cartilage) between the acetabulum (hip socket) and the femoral head. In patients with this syndrome, the femoral head presses on the labrum or surrounding acetabular cartilage causing hip and groin pain. Irregular femoral head shape can also be noted as a cause of impingement when hip is in positions of flexion or internal rotation. In the patients that were positive for impingement syndrome, the anterior labrum buckles with compression and further evidence of impingement is indicated by the early detachment of the cartilage from the subchondral bone. The purpose of the study is to describe the process of arthroscopic resection or debride-ment of the labrum that I observed, and to evaluate this procedure and its effectiveness to reduce pain caused by Femoral Acetabular Impingement syndrome.

Our study focuses on patients who underwent elective hip arthroscopies. Patients have either positive radiographic, clinical, or intra-operative indications of impingement syndrome. There are cases where the labrum had totally split longitudinally through its entire anterior extent, but the cartilage has not detached or degenerated. Instead of resecting the labrum and leaving the anterior acetabular bone bare, the Arthrocare device is used on very low power setting to "thermally weld" the longitudinal tear in the labrum in hopes that it will heal.

In this study, the age range of patients is 14 – 72 years and the most common symptoms are hip and groin pain often accompanied by mechanical symptoms in the hip joint (such as a clicking sensation). The amount of time the patients experienced symptoms ranged from 8 days – 13 years. Prior to surgery most patients have failed conservative management and pain control via anti inflammatories or more significant pain medications. Of the study group, some patients have some form of other degenerative disease (arthritis, Pigmented Villonodular Synovitis, or Avascular Necrosis).

Radiographs are taken of all patients in anterior/posterior and frog leg lateral views. They are fairly accurate at identifying labral tears.
and may be useful for indicating impingement within the joint. However, impingement syndrome is more accurately diagnosed with clinical evaluation when the symptomatic hip is put through a range of motion tests (internal/external rotation, flexion etc.). MRI and CT scans are also helpful for recognizing labral tears but are used predominantly to rule out other degenerative diseases such as Pigmented Villonodular Synovitis or Avascular Necrosis and are not used alone to diagnose femoral acetabular impingement.

In order to understand how this syndrome is combated, I have observed the arthroscopic procedures. The general procedure is to insert small cameras and tools into the hip joint anterolaterally and examine specific areas known to be vulnerable to cartilage damage and to fix that damage if possible. In each patient, the entire acetabular cartilage both anteriorly and posteriorly is examined. In patients who appeared to have femoral deformities that could contribute to impingement (that the femoral head was not sitting directly in the middle of the femur), the anterior femoral neck, anterior capsule, and the tissue are evaluated. In some patients, the prominent bone or damaged labral cartilage is excised. All loose bodies and debris found in the joint space is removed and all hips are thoroughly lavaged (washed out) and then injected with antibiotics and pain killers.

It is now 7:30 p.m. My legs are heavy and my feet are sore from standing all day. I peel off my scrubs, wash my face and walk back through the winding halls of the hospital into the warm summer night, leaving the wonders of the operating room behind me. Having been both a patient and now an observer, I have seen both sides of the table. This summer, I have learned to read doctor scribbles, medical charts, and x-rays. I have seen hip replacements, knee arthroscopy and tumor resections. I have listened to the concerns of patients, the worries of families, and the noises of the operating room. But most of all I have gained perspective—something that I lose all too easily.

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