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## Technical Note

### **Minimally invasive posterolateral hip approach with SPARTAUUS (Spare the Piriformis And Respect The Active QUadratus femoris and gluteus mediUS) technique**

Romain **Gérard**<sup>a,b,\*</sup>, Joël **Savéan**<sup>b,d</sup>, Christian **Lefèvre**<sup>b,c,d</sup>

a Service de Chirurgie Orthopédique et Traumatologique, Centre Hospitalier Privé Brestois, Clinique Pasteur-Lanroze, 29200 Brest, France

b LaTIM, Inserm, UMR 1101, SFR IBSAM, UFR médecine, 22, avenue Camille-Desmoulins, CS 93837, 29238 Brest cedex 3, France

c Service de Chirurgie Orthopédique et Traumatologique, Centre Hospitalier Régional Universitaire, 29200 Brest, France

d Université de Bretagne Occidentale, UBO, 3, rue des Archives, CS 93837, 29238 Brest, France.

\* **Corresponding author:** Romain Gérard,

Department of Orthopedics and Traumatology

Clinique Pasteur-Lanroze, 29200 Brest, France

Email = dr.romaingerard@gmail.com

## Abstract

Interest in the different surgical approaches to total hip arthroplasty remains high, but without any real consensus on which approach is the most beneficial. Several recent technical

innovations have made it possible to reduce the risk of dislocation and therefore improving the efficacy of the posterolateral approach. Since 2003, we have been using a modified minimally invasive posterolateral approach called SPARTAUUS (Spare the Piriformis And Respect The Active QUadratus femoris and gluteus mediUS) which spares the piriformis tendon, the quadratus femoris muscle and the gluteus medius muscle, and involves direct capsular repair. The “active posterosuperior hammock” effect of the piriformis tendon is therefore coupled with the “passive posterosuperior hammock” effect of the capsular repair, thus limiting the risks of posterior dislocation of the prosthetic hip joint.

Key words: posterior approach, total hip arthroplasty, dislocation

## **1. Introduction**

Interest in the different surgical approaches to total hip arthroplasty remains high, but without any real consensus on which approach is the most beneficial [1,2]. However, two approaches stand out in terms of efficacy, rapid postoperative recovery, preservation of the abductor apparatus and low dislocation rate. The anterior approach has a steep learning curve, often requires a specialized table and ancillary equipment, and has a significantly higher incidence of intraoperative fractures and injury to the lateral femoral cutaneous nerve [3,4]. The posterior approach, historically purported to have a higher dislocation rate [5,6], has had the same excellent functional outcomes as the anterior approach [3,4], and remains the most commonly used technique worldwide [7-9]. Several recent technical innovations have greatly reduced the risk of dislocation [9-11] and therefore improving the efficacy of the posterolateral approach [12-16], originally described by Moore in the 1950s [17]. Since 2003 [18], we have been using a modified minimally invasive posterolateral approach called

SPARTAUUS (Spare the Piriformis And Respect The Active QUadratus femoris and gluteus mediUS) which spares the piriformis tendon, the quadratus femoris muscle and the gluteus medius muscle, and involves direct capsular repair without reinsertion of the remaining lateral rotator group of muscles. This modified posterolateral SPARTAUUS approach is presented below.

## **2. Technique**

The patient was placed in the lateral decubitus position (video SPARTAUUS.wmv). The curvilinear incision was centered over the greater trochanter (2/3 proximally and 1/3 distally) and measured approximately 10 +/- 2 cm. The aponeurosis of the gluteus maximus muscle and the tensor fasciae latae were exposed and opened in an arciform manner. The gluteus maximus muscle was split in line with its fibers without detaching it. The gluteus medius and gluteus minimus muscles were retracted and therefore completely preserved. The short lateral rotators were exposed when retracting the layer of fat. The sciatic nerve is sometimes visualized, but never dissected. The interval between the gluteus medius and piriformis muscles was identified. The piriformis tendon, appearing as a dense pearly white strip running obliquely downward and outward (Fig. 1) (video of opening), contrasted with the red fibers of the adjacent muscles. An L-shaped incision in the lateral rotator group of muscles was performed distally to the inferior border of the piriformis tendon and ending at the anterior border of the quadratus femoris muscle (Fig. 1). The remaining lateral rotator group of muscles (superior and inferior gemelli, obturator internus and obturator externus) were released close to the intertrochanteric line using an electric scalpel and will not be reinserted. The resulting muscle flap was detached from the capsular plane and reflected backwards to protect the sciatic nerve. A capsular incision was made along the inferior border of the

piriformis tendon, that was carried down along the intertrochanteric line and ended next to the base of the femoral neck, under the deep surface of the quadratus femoris. It was then possible to release the zona orbicularis and free the neck from its capsular attachments. The arciform incision in the capsular plane produced a flap with a clearly distinct free border that was thick, and solid, especially in the proximal area (Fig. 2), that was easily sutured with number 2 absorbable thread once the prosthesis was implanted (Fig. 3) (video of closure).

### **3. Results**

We reported in Table 1 the results from a single-center, single-operator (RG) study of 296 scheduled total hip arthroplasties that were performed in 2018 using the posterior “SPARTAGUUS” approach and a surgical navigation system (Orthokey™, Florence, Italy). There were no dislocations or periprosthetic fractures in this continuous study (Table 1).

### **4. Discussion**

The lateral rotator group of muscles (piriformis, superior gemellus, obturator internus, inferior gemellus, obturator externus, and quadratus femoris) are considered the “rotator cuff” of the hip [21]. Anatomically speaking, the piriformis exhibits continuity and thick dense tendons, and plays a significant role in the active stabilization of the acetabulofemoral joint (“posterior stabilizer of the hip” [22]), as well as hip abduction and external rotation [23]. The quadratus femoris, a large and powerful muscle [24], also plays an important role in external rotation, adduction and active stabilization of the hip. However, the combination of superior gemellus-obturator internus-inferior gemellus, called the triceps coxae [24], and the obturator externus forms a thin and weaker musculotendinous unit that is not very involved in the external rotation of the hip [25]. Given these anatomical and functional reasons, we now use the

minimally invasive window between the piriformis tendon and the quadratus femoris for all posterior total hip arthroplasties. The piriformis tendon is completely spared, which by its active role in hip stabilization and joint coaptation [22,24], reinforces the posterosuperior corner of the acetabulofemoral joint, and thus significantly reduces the risk of posterior dislocation. Furthermore, it can act as an indicator of muscle and soft tissue tensions after the final prosthetic components are implanted. Repairing the capsule is essential [10,26-28]. The relative risk of dislocation is six to eight times higher if the capsule is not repaired [10,28]. Preservation of the entire piriformis is essential and useful [29]. Indeed, suturing of the piriformis tendon after dissection is not reliable [30], because of fatty degeneration and marked atrophy. Preservation of the quadratus femoris is important because it acts as an active external rotator and hip stabilizer. Its sectioning away from the posterior border of the greater trochanter to preserve the blood supply from the medial circumflex femoral artery is not indicated, because the risk of injuring the sciatic nerve is then greater [31]. Its repair is unreliable and greatly decreases the active coaptation capacities of the acetabulofemoral joint [24] because its thick musculature makes it impossible to perform a solid direct suture and scarring is not uniform. Lastly, this technique makes it possible to preserve in most cases, the medial circumflex femoral artery and perfusion of the greater trochanter (via the insertion of the quadratus femoris muscle), to reduce the risk of demineralization of the proximal femur [31,32] and proximal loosening of uncemented femoral stems [33]. Although the transosseous repair of the short external rotators (inferior and superior gemelli, obturator internus and obturator externus) has been recommended to increase internal rotational stability of the hip [12,13,16], we believe it to be ineffective as it is not very functional [34-36], given that the frailty of the muscle tissue makes a strong stitch anchorage impossible [34,37]. In our experience, the cases of coxa profunda, diffuse coxarthrosis, hip dysplasia with a well-

centered femoral head and the use of dual-mobility prostheses are not limiting factors in the use of this approach.

## **5. Conclusion**

The positioning of the implants, especially acetabular cups [28,38,39], the diameter of the prosthetic femoral head [40] and the anatomical restoration of femoral offset [41] limit the risk of dislocation of THA performed via the posterior approach [42]. However, insufficient or no repair of the posterior capsular plane combined with the dissection of two powerful muscles of the lateral rotator group (quadratus femoris and piriformis), remains just as damaging [28], and contributes to perpetuating the poor reputation regarding dislocation of Moore's posterolateral approach. The main appeal of the SPARTAQUUS technique is that it combines a capsular flap that can be properly sutured with sparing of the piriformis muscle, thus producing a hammock that is both passive and active, in the posterosuperior aspect of the hip joint; the real area of weakness in the posterior dislocation of a THA.

**Disclosure of interest:** The authors declare to have no conflicts of interest related to this article. Unrelated to this work, RG is a consultant for Ceraver Osteal, Protheos Ouest and Newclip Technics. CL is a consultant for Ceraver Osteal, Stryker and Newclip Technics.

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**Author Contributions:** RG conceived the study and was responsible for the procedures and their assessment, as well as the acquisition and analysis of data. CL conceived the study,

designed the technique, and participated in the drafting and final revision of the manuscript. JS directed and edited the surgical video.

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Table 1: Results of a single-center, single-operator study (RG) of 296 total hip arthroplasties (THA), except in the case of trauma, performed using the SPARTAQUUS posterior approach with a surgical navigation system (Orthokey™, Florence, Italy), over a one-year period (2018).

Cases	<b>296</b>	
Age (years)	66 (36-85)	
Sex (F/M)	151/145	
Indication	Primary coxarthrosis	266
	Osteonecrosis	17
	Dysplasia	13
THA	Uncemented, CoC (heads Ø 28 mm/32 mm)	207 (39/168)
	Uncemented, dual-mobility, head Ø 28 mm	89
BMI	28.6 (22-40)	
OHS-12 (0-48) [19]	20.8 (13-27) preop	39.1 (32-46) 2M postop
PMA (0-18) [20]	11.7 (5-14) preop	16.2 (12-18) 2M postop
DVT	0	
Dislocation	0	
Postoperative LLI**	0 +/-1 mm (navigation)	
Acute infection	3	

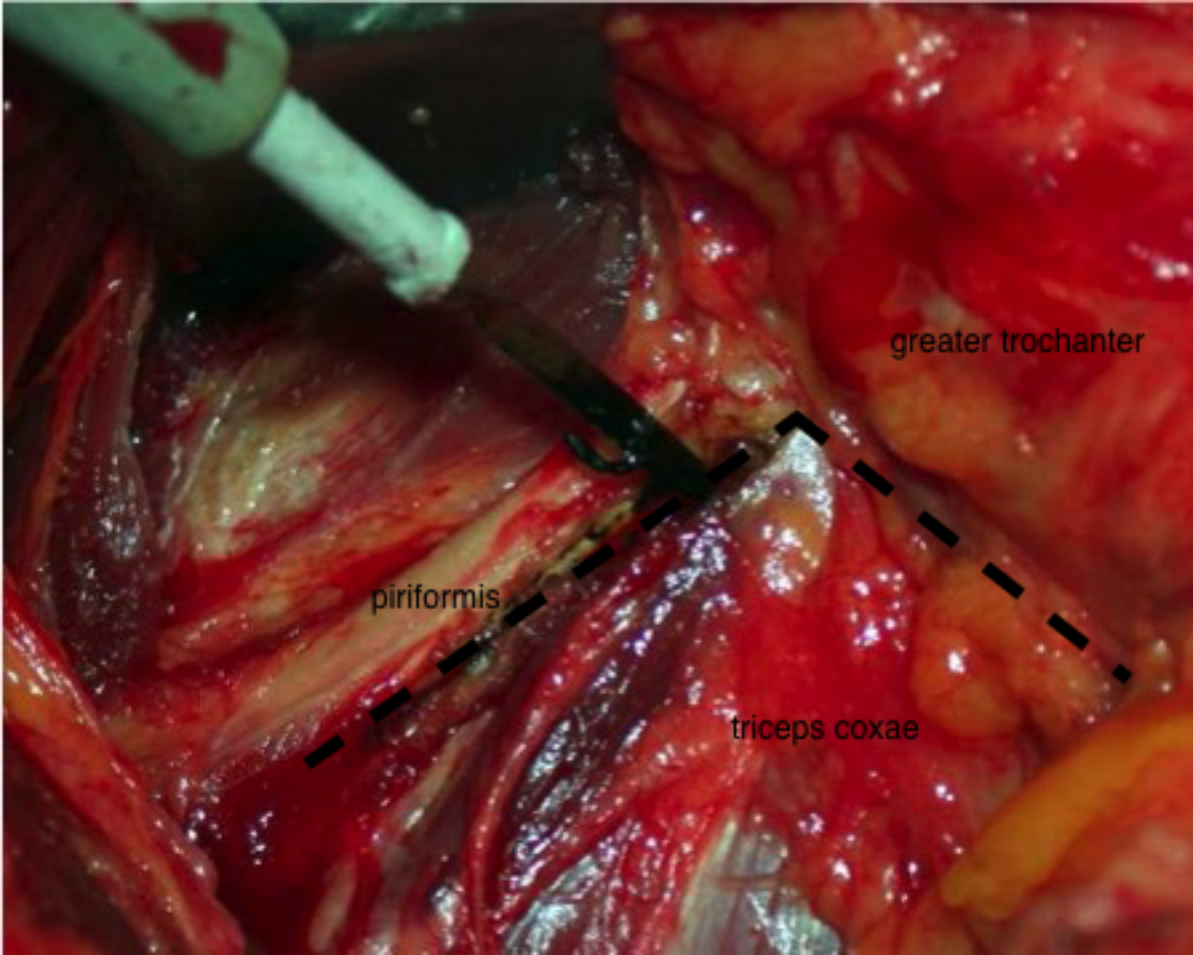
*F: female; M: male; LLI: Leg length inequality; PMA: Postel Merle d'Aubigné score; DVT: deep vein thrombosis; IMC: body mass index; OHS-12: Oxford 12 Hip Score; CoC: ceramic-on-ceramic; 2M: 2nd month.*

\*\* We do not have all the millimeter data for the preoperative LLI. We only know that the correction target in terms of length and overall offset, if necessary, was restored in all cases (+/- 1 mm) thanks to the computer-assisted surgery we use for all our primary total hip arthroplasties.

### Figure Legends

Figure 1: Operative view of the L-shaped incision of the lateral rotator group of muscles, sparing proximally the piriformis tendon and distally the quadratus femoris muscle. The capsulotomy will follow the same course.

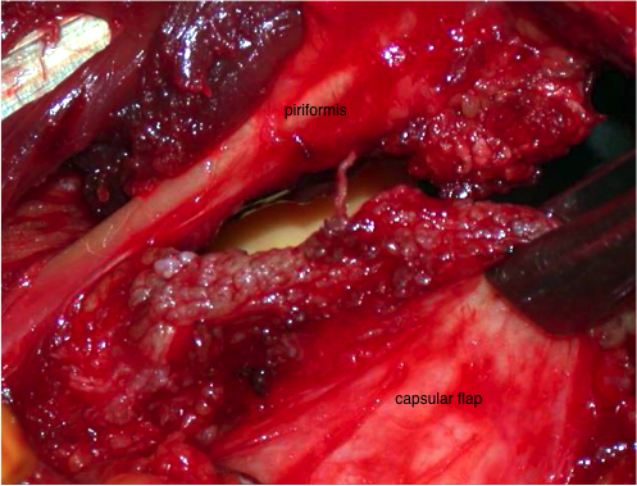
Figures 2 and 3: Operative view of the implanted total hip prosthesis and the posterosuperior corner of the SPARTAQUUS posterior approach involving the piriformis tendon and the posterior capsular flap before suturing.



greater trochanter

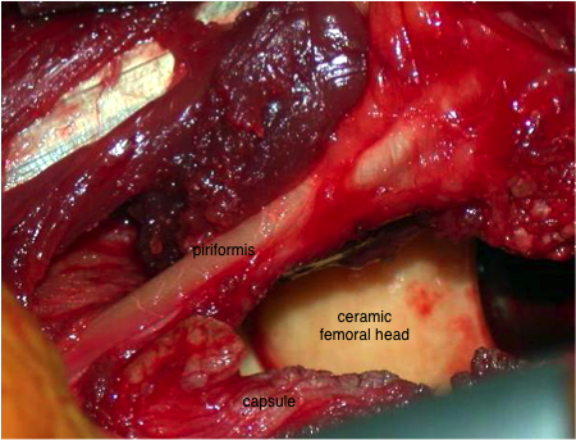
piriformis

triceps coxae



piriformis

capsular flap



piriformis

ceramic  
femoral head

capsule