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# MESSAGE FROM THE PRESIDENT

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## Obesity and total joint replacement

Orthopaedic practice in our country faces many challenges. The latest challenge is that some medical aid funders do not want to cover their overweight members for total joint replacement (hip and knee). The reason given is that the complication rate in these individuals is too high.

Total joint replacement is one of the most rewarding operations. It is as successful in pain relief as the dentist's operation of removing a rotten tooth. We have seen how grateful these patients are when they come for follow-up – provided there have been no complications! To deny an arthritic patient this operation because he/she is obese borders on inhumanity.

We know that losing weight is difficult. It is even more difficult for patients with a painful hip or knee. Literature shows that those patients who have lost weight before the operation actually regain the weight. Moreover, the complication rate is not much higher than in patients with normal weight.

The complications are often attributed to the associated co-morbidities like diabetes, hypertension and heart disease. All surgeons doing total joint replacement refer patients to physicians pre-operatively to have these diseases controlled. Also in some of these obese patients the fat is distributed around the trunk and hips, leaving a relatively normal knee for a total joint replacement.

Various studies have shown good outcomes of joint replacements in obese patients. A paper presented at a recent Canadian Orthopaedic Association Congress showed minimal complications (one wound breakdown) in a large series of super obese individuals (BMI >50). Some members of this association, in their series on joint replacement patients, reported no increase in complications in their obese patients. Unfortunately, these reports are not published and lack statistical analysis.

In the light of this argument it is clear that BMI alone cannot be used to exclude patients from total joint replacement operations.

While all of the above is true, more truth is to follow.

Medical aid administrators will at some stage look at the cost drivers in their health systems and try to reduce these. Total joint replacement has been identified as one of the cost drivers. In trying to reduce costs, the medical aid administrators have picked on the obese as a population group to limit this cost-driving component of health care delivery. The other type of surgery that is subject to the same scrutiny as that of the obese patient is surgery for gastro-oesophageal reflux.

Obesity is a big public health concern and orthopaedic surgeons should all be aware of this new epidemic. All over the world the number of obese individuals is increasing. It is a disease that is often associated with other diseases. Like any other medical disease, the public health doctors would like these obese patients to be optimised, as we do with other medical conditions. This, we are informed, involves getting them on a diet and a muscle-conditioning programme. The medical administrators would like doctors to look at the patient's health in general, then the hip and knee. The medical fund administrators are even prepared to finance these rehabilitation programmes.

I would say that medical aid administrators should go even further by educating their members on obesity, and telling their prospective members about the funds' attitude to obesity. This will clear up the misunderstanding about the motives behind their obese care policy.

The arthroplasty surgeon has, among others, the responsibility to treat end stage arthritis successfully with total joint replacement. The medical aid administrator, or public health practitioner, is obliged to deliver health care, including to the obese arthritic, with minimal cost. If there is a contradiction between the two, the arthroplasty surgeon and the administrator need to talk and find common ground.



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