

## INFORM Guidelines for the Management of Hip Periprosthetic Joint Infection

These guidelines are based on best evidence from the six-year National Institute for Health & Care Research funded INFORM programme (RP-PG-1210-12005) and have been developed by a consensus panel of 20 clinical experts in orthopaedic infection, primary care and rehabilitation, and healthcare commissioning, including members of the British Hip Society.

### INCREASED VIGILANCE AND MONITORING

- 1: Hip replacement patients with post-operative complications such as slow wound healing or unexplained pain should prompt high suspicion of infection.
- 2: Modifiable risk factors should be optimised (e.g., diabetes control).

### DIAGNOSIS

- 3: All patients with persistent fluid discharge, worsening erythema or worsening pain arising from the joint should be investigated for infection.
- 4: Any patient within the first four weeks of primary joint replacement, with increasing discharge or reduction in function or worsening erythema should prompt discussion with a specialist orthopaedic colleague within 48 hours.
- 5: A patient with a previously well performing hip replacement, who develops symptoms consistent with infection (such as fluid discharge, new or worsening erythema and new or worsening pain) which persist for more than 48 hours, should prompt discussion with an arthroplasty specialist within 72 hours from presentation.
- 6: Improve education and patient and clinician information to enable earlier recognition of signs and symptoms of infection.
- 7: Increase vigilance amongst primary and secondary care for patients at high risk of periprosthetic joint infection. This includes optimising an open-door policy to allow patients to be referred back to the treating orthopaedic team promptly.

### TREATMENT

#### Debridement, antibiotics and implant retention (DAIR)

- 8: When infection is diagnosed with well-fixed implants, and DAIR is considered, it should be performed promptly. This consists of a radical debridement with exchange of modular components where possible, and NOT a wound wash-out.

#### Revision

- 9: Single stage revision should be performed whenever surgeons believe it is feasible, and within the bounds of a well-established dialogue with the patient, characterised by a plain language explanation of treatment options, with adequate time for the patient's questions to be answered.
- 10: Surgeons should consider the use of standard components fixed with antibiotic loaded bone cement as an articulating spacer.

#### Postoperative management

- 11: Patients need appropriate levels of patient-centred rehabilitation as determined through assessment from early on in their journey.
- 12: Patients with infection should be asked about their need for psychological and social support and this offered from the point of diagnosis onwards to long-term recovery.
- 13: Patients should be assessed and provided with appropriate aids and equipment to support their recovery and rehabilitation.
- 14: Patients should remain under the care of an infection multidisciplinary team whilst on antibiotics and monitored for side-effects and tolerance.

This study is funded by the National Institute for Health & Care Research (NIHR) as a Programme Development Grant (NIHR202943). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

REFERENCES:

