



ICL Case Presentation Moderator Instructions

What is a Case Presentation ICL and how does it work?

This one-hour, interactive session features **one moderator and 10 orthopaedic faculty table facilitators**, with one facilitator assigned to each table. The moderator presents **4–6 cases**, and faculty guide table discussions to develop a treatment plan. Each table shares its proposed approach before the moderator presents the actual treatment and outcome, supported by evidence-based data, key teaching points, and references.

Faculty Limit: 11 total — 1 moderator + 10 table facilitators.

Handout: A course handout is required and must be submitted by the moderator.

Your Role as Moderator

As moderator, you are responsible for coordinating the session and ensuring your faculty are prepared for the Case Presentation format.

Before the Annual Meeting

- Communicate with your 10 table facilitators and ensure everyone understands the session format and their role.
- Select and prepare **4–6 cases** for discussion.
- Plan the timing of each case to keep the session within the allotted **60 minutes**.
- Ensure cases provide meaningful opportunities for table discussion and treatment-plan development.
- Prepare the final treatment and outcome for each case, supported by **evidence-based data, key teaching points, and references**.
- Review your session content for bias and commercialism.
- Prepare and submit the required course handout by the designated deadline.

Handout Requirement

A handout is **required** for all Case Presentation ICLs and may only be submitted by the moderator.

Your handout should include:

- Key takeaways for each case presented.
- A bibliography/references supporting each case.
- The required course/session information.

Detailed **handout requirements, formatting guidelines, submission instructions, and deadlines** will be provided separately.

During Your Session

The moderator leads the overall session and keeps each case moving through the Case Presentation format:

1. Present the Case

Introduce the case and provide the information necessary for discussion.

2. Table Discussion

Allow faculty facilitators to guide discussion at their assigned tables and help participants formulate a treatment plan.

3. Share Treatment Plans

Invite tables to present their proposed approach to the case.

4. Present the Outcome

Share the actual treatment and outcome, incorporating evidence-based data, key teaching points, and references.

Repeat this process for each of the **4–6 cases**.

Maintaining Balance & Managing Disclosures

As moderator, you are responsible for helping ensure the session remains **fair, balanced, evidence-based, and free of commercial bias**.

- Be alert to bias or commercialism from both faculty and participants.
- Avoid promotion of a specific company's product, device, or treatment.
- When discussing products or treatment options, encourage balanced consideration of available alternatives.

- Clearly identify emerging or new content that is not yet supported by established evidence.
- Address potential conflicts or bias during the discussion when necessary.

Faculty disclosures will be displayed at the start of the session. If a disclosure does not display properly, direct attendees to the disclosure information available through AAOS Annual Meeting resources.

Day-of Reminders

- Arrive early and confirm your faculty facilitators are present and at their assigned tables.
- Keep the session moving so all planned cases can be completed within **60 minutes**.
- Encourage discussion and audience participation.
- Make sure each table has an opportunity to participate.
- Keep discussion focused on the educational objectives and evidence.
- Allow adequate time to review the treatment, outcome, and teaching points for each case.

Questions?

For questions regarding your Case Presentation ICL, please contact the AAOS Education team.

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ICL Case Presentation Sample Handout:

Case Presentation ICL 181

A Case Based Approach to Revision Total Hip Arthroplasty: Covering the Bases from Simple to

Complex Moderator: Matthew P. Abdel, MD

Instructors: Nicholas Bedard, MD
 George Haidukewych,
 MD James
 Huddleston III, MD
 William Jiranek, MD
 Harpal Khanuja, MD
 Professor Fares
Haddad Professor Carsten Perka
 Steve MacDonald, MD
 Wayne Paprosky, MD
 Rafael Sierra, MD

Case 1: Infection and Two-stage with Articulating Spacer

- Discuss diagnostic workup of infection
- Discuss one-stage vs. two-stage exchange arthroplasty for chronic infection
- Discuss articulating vs. non-articulating spacers

Case 2: Infection and Two-Stage with Non-Articulating Spacer

- Discuss diagnostic workup of infection
- Discuss one-stage vs. two-stage exchange arthroplasty for chronic infection
- Discuss articulating vs. non-articulating spacers

Case 3: Recurrent Dislocations with MOM Bearing

- Use preop MRI to direct debridement of adverse local soft tissue reaction. Removing as much of the extra pelvic ALTR burden as possible is desirable to reduce metal burden and get rid of symptoms
- Choose which implants to remove based on need to get rid of metal-metal bearings and Co-Cr implants involved in corrosion. In selected well-fixed, well-positioned, well-designed, monoblock cups a matching dual mobility implant may be considered.
- Remember hip stability may be a concern if abductors or GT notably damaged by ALTR.

Case 4: Pelvic Discontinuity Treated with Cup-Cage and Pelvic Distraction

- Main treatment options are cup-cage, pelvic distraction, custom triflange.
- Getting the pelvis fracture to heal may be difficult.
- Implants that span the fracture and bone loss unitize the pelvis and act as a segmental replacement of the bone. Acetabular distraction works in this way by using the elastic recoil of the pelvis to stabilize the implant and hopefully allow bone healing to upper and lower parts of the construct.
- Be aware sciatic neuropathy is a risk and, in some cases, identifying the nerve visually is helpful.

Case 5: Recurrent Instability Mandating Acetabular Component Revision

- Establish the direction of hip instability
- Determine the likely cause or causes of instability (implant malposition, intra- or extra-articular impingement, soft tissue laxity, or abductor deficiency) and perform an operation that solves the main causes of instability.
- In most cases add further technology to further reduce the likelihood of instability: large-diameter fixed head or dual mobility head. Reserve constraint for problems that cannot be solved another way such as notable abductor deficiency.

Case 6: Vancouver B2

- Establish that the femoral component is loose (if well fixed, ORIF usually is better option)
- Choose an approach that will allow implant removal and access to the joint with minimal soft tissue stripping. Osteotomy often is a good option. Splitting the proximal bone in mid coronal plane can work well.
- Place a prophylactic cable around the femur just distal to the fracture to avoid extension during reaming, trialing, and implantation.
- In most cases a fluted tapered modular implant is most reliable implant option because these implants provide axial and rotational stability in good bone distal to the fracture.
- Reassemble proximal bone around the implant but do not strip the bone of soft tissue. A perfect reduction usually is not necessary.

Case 7: PE Wear and Osteolysis Treated with Head & Liner Exchange and Bone Grafting

- Head and liner exchange if cup well fixed and well supported
- Think about hip stability (most common complication is dislocation) when choosing operative approach and femoral head size.
- Graft lesions if accessible. Use crosslinked PE as bearing in most cases.
- Think about whether cup has sufficient remaining fixation for long term stability.

Case 8: Total Femur

- Discuss use of modular fluted tapered stems in most cases and when a total femur is required
- Discuss how to ensure appropriate rotation and patellar tracking

- Discuss constrained liners and tibial cones

Case 9: Custom 3D Acetabular Reconstruction

- Substantial advancements in imaging, 3D printing, and implant manufacturing allow for simplification of complex and salvage cases
- Discuss importance of planning, fixation, and stability

Case 10: Infection Treated with Two-Stage and Repeat ETO

- Recognize the cases in which exposure will be difficult and in which you will need extra exposure:

Stiff Hip

Removal of well-fixed femoral

components Removal of extensive

femoral cement Notable acetabular or

femoral bone loss

Proximal femoral deformity/over-hanging greater trochanter