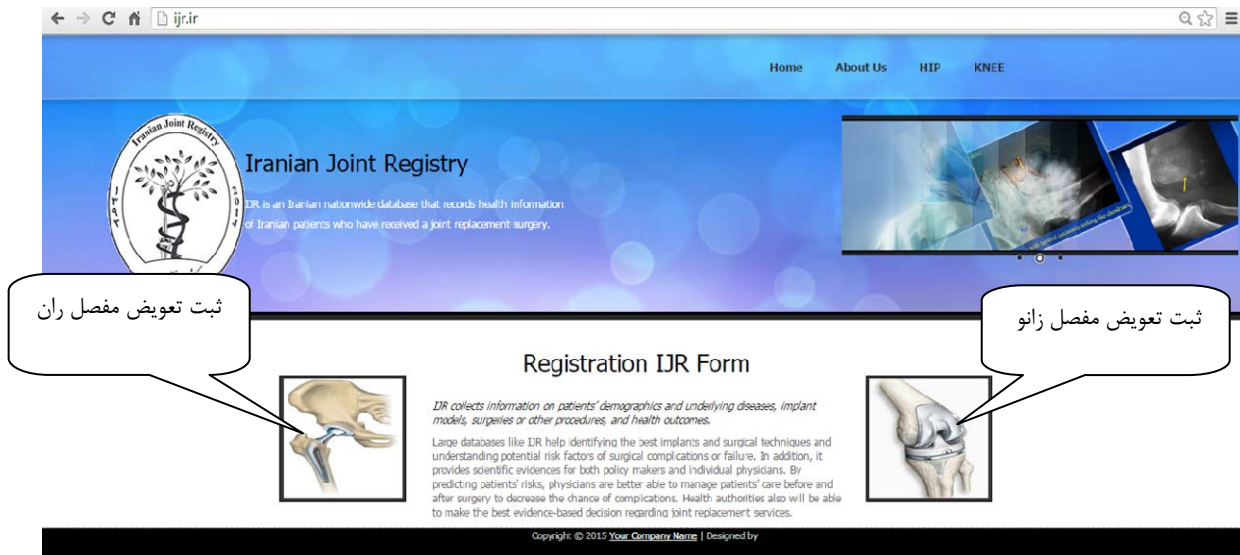


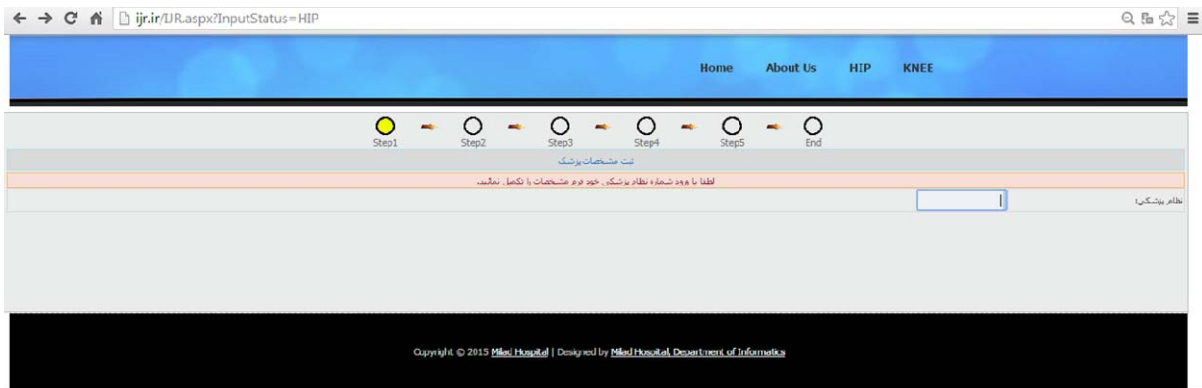
راهنمای استفاده از سایت مرکز ثبت مفاصل زانو و ران

در صفحه اصلی سایت می‌توانید برای ثبت تعویض مفصل اقدام نمایید:

بر روی صفحه اصلی بر روی عکس سمت راست (زانو) و تصویر سمت چپ (ران) کلیک کنید:



در صفحه وارد شده شماره نظام پزشکی خود را وارد کنید



در صفحه بعدی مشخصات خود شامل نام و نام خانوادگی، نام پدر، کد ملی، تخصص و شماره تلفن همراه خود را وارد کنید (وارد کردن این اطلاعات تنها برای بار اول الزامی است پس از آن کلیه اطلاعات جراح ذخیره شده و از بار دوم به بعد تنها با

وارد کردن شماره نظام پزشکی قادر خواهید بود به صفحه دسترسی داشته باشید):

در صفحه بعد در صورتیکه بیمار فرم رضایت را امضا کرده باشد گزینه رضایت بیمار را کلیک کرده و شماره ملی او را وارد نمایید

پس از باز شدن صفحه بعد اطلاعات هویتی بیمار شامل نام و نام خانوادگی بیمار، نام پدر بیمار، قد و وزن و ... را وارد نمایید:

سپس در صفحه باز شده مشخصات عمومی جراحی را انتخاب کنید که شامل نوع بیمه، نام استان، شهر، بیمارستان، تاریخ عمل جراحی، نوع بیهوشی، درجه ریسک و سمت جراحی می باشد:

در این مرحله فرم اصلی برای جزئیات عمل جراحی باز می شود که لازم است مشخصات اختصاصی هنگام عمل ثبت گردد. این اطلاعات شامل موارد زیر است:

علت تعویض مفصل

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Step1 Step2 Step3 Step4 Step5 End

Primary Hip Arthroplasty Details

PRIMARY HIP PROCEDURE DETAILS

Indications For Implantation

<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Inflammatory Arthropathy	<input type="checkbox"/> Congenital Dislocation-Dysplasia of the hip
<input type="checkbox"/> Avascular Necrosis	<input type="checkbox"/> Trauma - Acute (Neck of femur)	<input type="checkbox"/> Failed Hem - Arthroplasty
<input type="checkbox"/> Perthes	<input type="checkbox"/> Metastatic Cancer- Malignancy	<input type="checkbox"/> Trauma - chronic
<input type="checkbox"/> Previous Hip Surgery - non trauma related	<input type="checkbox"/> Previous infection	<input type="checkbox"/> Slipped capital femoral epiphysis
<input type="checkbox"/> Skeletal dysplasia	<input type="checkbox"/> Other	

پوزیشن بیمار هنگام جراحی و اپروچ جراحی

SURGICAL APPROACH

Patient Position: Lateral Supine

Approach: Hardinge Posterior Trochanteric osteotomy Other

Computer Guided Surgery Used? Yes No

Minimally Invasive Technique Used? Yes No

نوع ترومبوپروفیلاکسی شیمیایی و مکانیکی

THROMBOPROPHYLAXIS REGIME

Chemical: Aspirin LMWH Pentasaccharide

Other Warfarin Direct Thrombin Inhibitor (eg Dabigatran)

Factor Xa Inhibitor (eg Rivaroxaban/Apixaban) None

Mechanical: Foot Pump Intermittent Calf Compression TED Stockings

Other None

استفاده از سیمان و گرافت

BONE GRAFT USED

Femur: Yes No

Acetabulum: Yes No

Implant Data

Prosthesis: Total Bipolar Partial

Cemented: Femoral Component Acetabular Component All None

نوع کمپوننت استابولوم، فمور، سر و لاینر

Acetabular Component	
Type:	<input type="text"/>
Lot Number:	<input type="text"/>
12-Digit Unique ID:	<input type="text"/>
Femoral Component	
Type:	<input type="text"/>
Lot Number:	<input type="text"/>
12-Digit Unique ID:	<input type="text"/>
Liner	
Type:	<input type="text"/>
Lot Number:	<input type="text"/>
12-Digit Unique ID:	<input type="text"/>
Head	
Type:	<input type="text"/>
Lot Number:	<input type="text"/>
12-Digit Unique ID:	<input type="text"/>

استفاده از کیج، رینگ و آگمنتیشن

Cage Or Ring Was Used?	<input type="radio"/> Yes <input type="radio"/> No
Augmentation Was Used Acetabular Side?	<input type="radio"/> Yes <input type="radio"/> No
Augmentation Was Used Femoral Side?	<input type="radio"/> Yes <input type="radio"/> No

حوادث هنگام جراحی

INTRA OPERATIVE EVENT	
Unoward Intra Operative Event:	<input type="radio"/> None <input type="radio"/> Calcar Crack <input type="radio"/> Pelvic Penetration <input type="radio"/> Shaft Fracture <input type="radio"/> Shaft Penetration <input type="radio"/> Trochanteric Fracture <input type="radio"/> Other
ثبت و ادامه	

در این مرحله با زدن دکمه ثبت و ادامه صفحه آخر باز میشود که کد جراحی انجام شده را نشان می دهد. برای پیگیری های بعدی ثبت و نگهداری کد پیگیری لازم است.

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🔍 🌟 ☰

Step1
End

The page at ijir.ir says:

کد پیگیری این جراحی 543 می باشد. با تشکر مراحل ثبت به پایان رسید.

OK

نوع فرم	شماره پیگیری	BMI	سبمت	نوع جراح	تاریخ تولد	کد ملی	نام پدر	نام و نام خانوادگی	جاب
H1	543	31	چپ	m m	60/02/24	0533058414	d	hasan h	<input type="checkbox"/>

بارگشت

با کلیک کردن بر روی دکمه "OK" شما قادر خواهید بود شرح عمل بیمار را پرینت گرفته و در پرونده نگهدارید.

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Step1 Step2 Step3 Step4 Step5 End

لیست اطلاعات ثبت شده برای بیمار

نوع فرم	شماره بگیری	BMI	سبقت	نام جراح	تاریخ تولد	کد ملی	نام پدر	نام و نام خانوادگی
K1	545	37	راست	m m	60/02/24	0533058414	d	hasan h

چاپ

نمونه ای از یک شرح عمل

شرح عمل بیمار
مرکز ثبت معاملات اوراق

نام استان: آذربایجان شرقی
نام شهرستان: لنگرود
نام بیمارستان: امام خمینی (ره) لنگرود

نام و نام خانوادگی: hasan h
نام عمل: Primary Hip Arthroplasty
نام متخصصین: نام متخصصین بهوشی
Circular Nurse
Scrub Nurse

INDICATIONS FOR OPERATION:

This is a (54y)birthDate with (M) MHH because of the increased amount of pain as well as severe effect on activities of daily living and uncontrollable pain with medication, the patient has elected to undergo the hip replacement. The patient was noted to have on some degenerative hip joint due to (Perhaps Metastatic Cancer- Malignancy). The procedure, risks, complications, and benefits of primary hip arthroplasty were discussed. The patient understood that the risks included, but were not limited to infection, scar, dislocation, need for further surgery, risk of anesthesia, deep vein thrombosis, and implant failure. Incomplete relief of symptoms, stiffness, weakness, wound healing problems, malalignment, lower limb discrepancy, loosening and blood loss requiring transfusion. The patient understood all these risks and was willing to continue further on with the procedure. The patient underwent a full preoperative including medical and cardiology clearance and consent was obtained prior to the surgery. The patient signed informed surgical consent.

DESCRIPTION OF OPERATION:

The surgical site was aseptically prepared and the patient was wheeled back to the operating room. Anesthetic Type: Regional-Epidural ASA II- with risk degree 2. The patient was then positioned. All bony prominences were well padded. At this time, the left hip and lower extremity was then prepped and draped in the usual sterile fashion for this procedure. The IV antibiotics were given prior to the procedure. The approach was from posterior approach to the hip was made. The fascia was identified and split in line with its fibers. Once this was performed, Hohmann retractors were then inserted superiorly and inferiorly underneath the femoral neck. At this time, a capsulotomy was then performed using a fibrous cautery and the capsulotomy was done edged over the acetabulum. At this point, a large bone hook was then inserted over the neck and with gentle traction and external rotation, the femoral head was dislocated out of the acetabulum. At this time, we had an exposure of the femoral head, which did reveal degenerative changes of the femoral head and once the acetabulum was visualized, we did see degenerative changes within the acetabulum as well as osteophyte formation around the rim of the acetabulum. At this time, a femoral stem guide was then used to measure proximal femoral neck cut. We made a cut approximately a fingerbreadth above the lesser trochanter. At this time, with protection of the soft tissues an oscillating saw was used to make femoral neck cut. The femoral head was then removed. At this time, we removed the leg out of the hip and Hohmann retractors were then used to expose the acetabulum. A long-handled knife was used to cut through the remainder of the capsule and remove the plicoid labrum around the rim of the acetabulum. With better exposure of the acetabulum, we started reaming the acetabulum. We started with a small size progressively reamed to a desirable size we obtained excellent bony bleeding with good remainder of bone stock both anteriorly and posteriorly as well as superiorly within the acetabulum as well as anterior and posterior within the acetabulum. Then the trial cup was put in place we did visualize that the cup was well seated on to the internal portion of the acetabulum. The aa cup was then impacted into place at position of desire degrees of abduction and anteversion. The overhanging osteophytes were removed. At this time, more than screws were placed within the superior table for better approaches securing the acetabular cup. At this time, a plastic liner (III) was then inserted and impacted. A lap sponge was used to protect the cup. The leg was then placed back in the bag. A Bennett retractor was used to retract the tensor fascia lata and femoral elevator was used to elevate the femur for better exposure and at this time, we began working on the femur. A retractor was used to lateralize over the greater trochanter. A box osteotome was used to remove the cancellous portion of the femoral neck. An awl was then used to cannulate through the proximal femoral canal. A reamer was then used to ream the lateral aspect of the greater trochanter in order to provide maximal lateralization and prevent varus implantation of our stem. At this time, we began broaching. We started with a small size and progressively worked up to a desirable size broach. Once the final broach was inserted in place, it was seated approximately 1 mm below the calcar. A calcar reamed smoothly. A neck as well as a plastic head was then placed and a trial reduction was then performed. Once this was performed, the hip was taken to range of motion with external rotation, horizontal traction as well as flexion and revealing good stability with no impingement or dislocation. At this time, we removed final broach and we then exposed the proximal femur one more time. At this time, a final stem III was impacted in place. Once it was well seated on the calcar, we double checked to assure that there was no evidence of calcar fracture. Femoral head III was then impacted in place. Next, the hip was reduced within the acetabulum and again we checked range of motion as well as stability with gentle traction, external rotation, as well as hip flexion. We were satisfied with components as well as the alignment of the components. Copious irrigation was then used to irrigate the wound. Then the wound closed. Then dressing was applied, the patient transferred to recovery in stable condition. Postop is good.