Smith+Nephew

RI.HIP: Achieving optimal implant placement for improved clinical outcomes[1–5]

Instability following THA is a leading cause of failure, with component malpositioning being a known surgical risk factor.[6–9] Lately, there has been an increased focus on spinopelvic mobility as a further contributing factor, with Heckmann et al., reporting that 90% of late dislocations were associated with spinopelvic imbalance.[10]

Pre-operative

RI.HIP MODELER

A personalised THA surgical planning application designed to reduce the risk of dislocation[11]

Measures and classifies spinopelvic mobility based on Stefl et al., to allow acetabular component positioning to compensate for patients' spinopelvic imbalance[12]

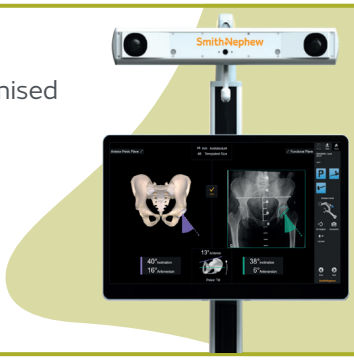
Evaluates implant-specific impingement risk for activities of daily living, including stem anteversion considerations

Intra-operative

Computer-guided THA with CORI◊ Surgical System

Empowers surgeons to execute an individualised THA plan, resulting in optimised implant placement and accuracy, compared with conventional THA[1]

Significantly reduced deviation from target component positioning (p<0.001)[1]



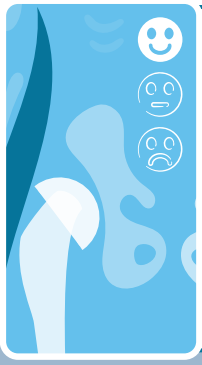
Post-operative

RI.HIP Outcomes

Significantly improved patient outcomes, compared with conventional THA*[2–5]

Significantly **improved impingement-free ROM**[2–4] (p≤0.05)

Significantly **lower risk of revision at 10 years** (1.06 vs 3.88%; p=0.005), when used in combination with Smith+Nephew acetabular components[5]



Significantly **higher patient satisfaction** (p=0.003), when used in combination with Smith+Nephew acetabular components[5]

*Outcomes based on RI.HIP Navigation only.

For detailed product information, including indications for use, contraindications, precautions and warnings, please consult the product's applicable Instructions for Use (IFU) prior to use.

Abbreviations: ROM = range of motion; THA = total hip arthroplasty.

References: 1. Naito Y, et al. *BMC Muscoskeletal Disorders.* 2021:1:1-8. **2.** Palit A, et al. *Sci Rep.* 2017;7:7238. **3.** Weber M, et al. *J Arthroplasty.* 2016;31(11):2514–2519. **4.** Renkawitz T, et al. *Bone Joint J.* 2015;97:890–89. **5.** Davis ET, et al. *JBJS Open Access.* 2021;6(3):e21.00006. **6.** Upfill-Brown A, et al. *Arthroplasty Today.* 2021;11:88–101. **7.** Cui BC, et al. *World J Orthop.* 2012;3(8):122–130. **8.** National Joint Registry: National Joint Registry for England and Wales: 2022 Annual Report. Available at: https://www.njrcentre.org.uk/research/njr-research-publications-and-outputs/. Accessed July 24, 2023. **9.** Attenello JD, et al. *Hawai'i J Health & Soc Welf.* 2019;78(11):31–40. **10.** Heckmann N, et al. *JBJS.* 2018;100(21):1845–1853. **11.** Smith+Nephew 2021. Model credibility plan design description. Rev C. Internal Report. DD0119. **12.** Stefl M, et al. *Bone Joint J.* 2017;99(B):37–45.

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