

Final Program



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25



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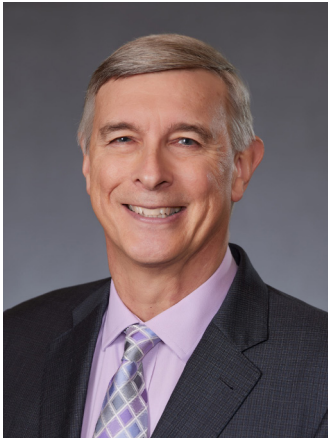


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EDUCATIONAL ACTIVITY SCOPE

The 2025 AAHKS Annual Meeting is designed to provide practicing orthopaedic surgeons with research-based, state-of-the-art information on diagnosis, surgical and non-surgical treatment options and overall management of hip and knee conditions. This educational activity includes the review of the most current scientific research study findings, faculty and participant discussions and interactive symposia. It covers multiple clinical topics such as primary and revision total hip arthroplasty, primary and revision total knee arthroplasty, non-arthroplasty, infection, complications other than infection as well as health policy. It is aimed at improving overall surgeon competence related to the care of patients with arthritis and degenerative diseases.

OBJECTIVES

Upon completion of this educational activity, participants will be able to:

- Synthesize the most current research study findings in hip and knee condition management
- Evaluate various surgical and non-surgical treatment options (e.g., primary total joint arthroplasty, revision total joint arthroplasty, non-arthroplasty) in hip and knee condition management
- Assess the efficacy of new treatment options through evidence-based data
- Interpret relevant health care policy



ACCREDITATION AND CME CREDIT

The American Association of Hip and Knee Surgeons (AAHKS) is accredited by the Accreditation Council for Continuing Medical

Education (ACCME) to provide continuing medical education for physicians.

AAHKS designates this live activity for a maximum of 18 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

CLAIM CME CREDITS

Once the meeting concludes, AAHKS will send an email and an app notification with a link to the Annual Meeting evaluation. At the end of the evaluation, you will be redirected to claim CME credit. It is the meeting attendee's responsibility to claim credits based on the hour-for-hour participation in the educational activity.

DISCLAIMER

The material presented at this 2025 Annual Meeting has been made available by AAHKS for educational purposes only. This content is not intended to represent the only method or practice appropriate for the medical situations discussed; it is intended to present a balanced and scientifically sound view, approach, statement or opinion of the faculty, which may be helpful to others who face similar situations, or afford a forum to discuss, debate and explore new and evolving topics. The presentation of topics and any data about clinical practices should not be interpreted as advocating for, or promoting, practices that are not, or not yet adequately based on current science, evidence and clinical reasoning.

CONSENT AGREEMENT

By attending the Annual Meeting, participants acknowledge and agree that AAHKS and/or its agents may record the Program and related events, use audio and video recordings, photographs, and presentation materials such as slides and abstracts for AAHKS's purposes, including but not limited to other educational products, news, advertising and promotional purposes, without compensation.

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Some pharmaceuticals and/or medical devices demonstrated or discussed at the Annual Meeting have not been cleared by the US Food and Drug Administration (FDA) or have been cleared by the FDA for specific purposes only. The FDA has stated that it is the responsibility of the physician to determine the FDA clearance status of each pharmaceuticals and/or medical device he or she wishes to use in clinical practice. The AAHKS policy provides that "off label" status of the device or pharmaceutical is also specifically disclosed (i.e. that the FDA has not approved labeling the device for the described purpose). Any device or pharmaceutical is being used "off label" if the described use is not set forth on the product's approved label.



DISCLOSURE

Each planner, presenter or contributor to the Annual Meeting has been asked to disclose if they have received something of value from a commercial company or institution, which relates directly or indirectly to the subject of their presentation.

AAHKS does not view the existence of these disclosed interests or commitments as necessarily implying bias or decreasing the value of the author's participation in the course. **Note that AAHKS takes measures to mitigate all relevant financial relationships.**

For the most up to date disclosure list, please visit www.AAHKS.org/Meeting.



Presenting the 2025 Lawrence D. Dorr, MD Humanitarian Award to Mark W. Woolf, MD



AAHKS is proud to present the 2025 Lawrence D. Dorr, MD Humanitarian Award to Mark W. Woolf, MD. An accomplished orthopaedic surgeon, Dr. Woolf has served consistently with Faith In Practice since 2006 as a mission team leader and lead surgeon on more than 25 surgical mission teams.

Through Faith In Practice, Dr. Woolf has participated in many short-term medical missions to Guatemala providing knee replacement surgery to underserved patients over the last 20 years. That consisted of two or three trips each year, recruiting 40+ volunteers of orthopaedic surgeons, anesthesiologists, nurses, physical therapists and support staff. Generating monetary and in-kind donations in excess of 1.5 million dollars, the funds were used for implants, medicines and supplies. It's estimated that Dr. Woolf has performed more than 500 total knee replacement surgeries and cared for 700+ patients in the screening clinics of Guatemala.

Although Dr. Woolf retired in 2023, that didn't end his service with Faith In Practice. This new journey created an opportunity for Dr. Woolf to serve Guatemalan patients in a different way. Today, he's providing patient care by serving the medical clinic missions. With this transition, Dr. Woolf is able to continue his passion of serving patients in Guatemala while also expanding his impact within Faith In Practice. He also continues to serve as a board member and sits on several Faith In Practice committees.

Dr. Woolf doesn't think of the past 20 years as just time spent but refers to it as a spiritual journey. One that gave him purpose and meaning. One that taught him to step out on faith and saying "yes" when called to do so.

Dr. Woolf graduated from the University of Texas Medical Branch in Galveston and completed his residency at the Fort Worth affiliated hospital program.

The Lawrence D. Dorr, MD Humanitarian Award recognizes AAHKS members who have distinguished themselves by providing humanitarian medical services and programs with a significant focus on musculoskeletal diseases and trauma including the hip and knee in the United States or abroad.

For more information on the Lawrence D. Dorr, MD Humanitarian Award, please go to www.AAHKS.org/Humanitarian.



Presenting the 2025 Presidential Award to Adam J. Rana, MD



Each year, the AAHKS Presidential Award is presented to an AAHKS member who exemplifies exceptional service to AAHKS and the profession. This year, AAHKS President R. Michael Meneghini, MD is proud to bestow the 2025 Presidential Award on Adam J. Rana, MD, for his many contributions to the organization.

A committed member of AAHKS since 2011, Dr. Rana served as the 2012-2013 Health Policy Fellow and then joined the Advocacy Committee in 2013. Dr. Rana currently serves as chair of the Health Policy Council and the Advocacy Committee. Dr. Rana's diligent work as an advocate for AAHKS has consisted of tireless work in developing health policy resources, advocating for AAHKS with CMS and in Congress. His contributions have had great impacts for both patients and physicians in hip and knee surgery. His devotion to the field consistently furthers arthroplasty surgery, education and practice.

In honoring Dr. Rana with the 2025 Presidential Award, President Meneghini stated "Dr. Rana has served AAHKS and our members for over a decade in Advocacy, which is one of our most intellectually and time-consuming missions. Advocacy can be stressful, frustrating and exhausting, yet Dr. Rana has persevered with tireless commitment, perseverance and dedication to maintain access to our members and their patients with hip and knee disease. As the current Health Policy Council Chair and Advocacy Committee Chair, along with his decade of service to AAHKS, I cannot think of another person more deserving of the Presidential Award."

AAHKS acknowledges not only his extensive list of accomplishments in advocacy but also the embodiment of leadership and education. Dr. Rana's scientific contributions have included a vast amount of published material that have improved the practice of hip and knee surgery.

Dr. Rana currently serves as Arthroplasty Director at Maine Medical Center in Portland, Maine and Associate Clinical Professor at Tufts School of Medicine. He graduated from Colby College with a bachelor's degree with honors in economics and biology. He attended SUNY Downstate for medical school and Boston University Medical Center for internship and residency. Dr. Rana continued his training at the Hospital for Special Surgery with a Fellowship in adult reconstruction, arthritis and joint replacement surgery.

It is with great pleasure that we recognize Dr. Rana as this year's Presidential Award recipient, an honor bestowed upon a dedicated member who has made significant contributions and created a lasting legacy in the field.



Presenting the 2025 Diversity Award to Audrey K. Tsao, MD



AAHKS and the Diversity Advisory Board are proud to present the 2025 AAHKS Diversity Award to Audrey K. Tsao, MD. This award is bestowed upon a recipient who has demonstrated an exceptional commitment to making the practice of hip and knee arthroplasty more diverse and more accessible to all patients, while working diligently to eliminate disparities in arthroplasty care through education, research and community engagement. Dr. Tsao easily embodies it all.

Aside from being an accomplished arthroplasty surgeon, she uses her gifts to mentor up and coming surgeons, empowering and increasing the number of women and underrepresented minorities in orthopaedics. She has been recognized by the Ruth Jackson Orthopaedic Society for her outstanding commitment to mentoring and empowering women in orthopaedics, always a tireless advocate for equity and inclusion.

Also, something very dear and passionate to Dr. Tsao is her humanitarian efforts. She is a co-founder and volunteer with Women Orthopaedist Global Outreach (WOGO), an organization comprising female arthroplasty surgeons that perform free knee replacements nationally and internationally. Dr. Tsao understands the unique needs of women who develop knee arthritis more frequently and experience more advanced stages of joint disease but, as a woman, she knows her assignment has been to lend her expertise to make a lasting impact and difference on a global scale for all women.

Dr. Tsao's impact within AAHKS is equally profound. She served as the inaugural Chair of the Women in Arthroplasty (WIA) Committee, which she structured to be more inclusive of both formal and informal volunteers. She has led programming on critical issues like work-life balance and ergonomics, championed outreach partnerships with like-minded organizations and inspired a culture of collaboration and sponsorship within AAHKS leadership. During her time with AAHKS, Dr. Tsao has served as the chair of the AAHKS Membership Committee, currently serving as the Associate Editor for the *Journal of Arthroplasty* and as a Member-at-Large for the AAHKS Board of Directors. In recognition of her leadership, dedication and mentorship, Dr. Tsao was previously honored with the 2020 AAHKS Presidential Award.

Please congratulate Dr. Audrey K. Tsao on her extraordinary leadership, mentorship and lifelong dedication to advancing diversity in arthroplasty. The recipient of the 2025 AAHKS Diversity Award truly exemplifies the spirit of this award through her excellence, advocacy and commitment to lifting others.

Dogma Under the Knife: Challenging the Status Quo in Primary TKA

This symposium will critically examine long-held beliefs in primary total knee arthroplasty, offering a fresh look at the evolving science behind alignment strategies, fixation methods, bearing surface designs and patellar resurfacing. Through focused presentations by leading experts, including video tips and tricks and an interactive case-based discussion, attendees will explore how emerging evidence is reshaping surgical norms. The session is designed to provoke thought, challenge dogma and equip surgeons with the knowledge to deliver more individualized, evidence-driven care in primary TKA.

1. Describe the rationale, techniques and clinical implications of individualized alignment strategies in primary TKA, including mechanical, kinematic and functional approaches.
2. Analyze the kinematic principles and clinical outcomes associated with various bearing surface designs, including posterior stabilized, cruciate retaining and other conforming bearings.
3. Critically evaluate the current evidence comparing cemented and cementless fixation techniques in primary TKA.
4. Discuss the indications, controversies and outcomes related to patellar resurfacing in primary TKA.

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Robotic-Assisted Surgery and Kinematic Alignment in TKA: The RASKAL Registry-Nested Randomized Trial

Introduction: There is uncertainty on whether robotic-assisted surgery (RAS) or kinematic alignment (KA) improve outcomes in total knee arthroplasty (TKA). This study assessed the individual and combined effectiveness of RAS and KA to improve clinical, operative and functional outcomes when compared to computer-assisted surgery (CAS) and mechanical alignment (MA).

Results: No interactions between technology and alignment strategies were found for any outcomes. There were no differences comparing RAS to CAS in KOOS-12 at three months, six months, and one year (mean difference 0.6 over one year; 95%CI; -2.9,4.1;p=0.73), and no differences comparing KA to MA at three months, six months and one year (mean difference 2.4 over one year; 95%CI; -1.3,6.1;p=0.21). No differences in Oxford Knee Score, Forgotten Joint Score, EQ-5D-5L, satisfaction, joint-related improvement, pain, OMERACT-OARSI responder criteria and PASS thresholds were found comparing technology or alignment groups. RAS had a shorter mean operative time of 11.5 minutes (95% CI; 7.3,15.9; p< 0.001) and better mean PCL macroscopic soft tissue injury score (mean difference 0.7, 95% CI; 0.3,1.1; p=0.001) compared to CAS. MA had higher rates of soft tissue releases than KA (44.8% versus 8.1%; odds ratio 9.2 (95% CI; 4.6,18.3); p< 0.001). Surgeons preferred use of robotics and KA in most cases.

Conclusion: Robotic-assisted surgery and kinematic alignment were not superior to computer-assisted surgery and mechanical alignment in improving clinical and functional outcomes at up to one-year post-TKA.

Does Changing the Native CPAK Affect Clinical Outcomes in Mechanically or Functionally Aligned TKA?

Introduction: Changes to native Coronal Plane Alignment of the Knee (CPAK) phenotypes following total knee arthroplasty (TKA) may influence outcomes, particularly with mechanical alignment (MA). This relationship has not been evaluated with functional alignment (FA). This study compared the magnitude of coronal alignment change between MA and FA, and whether this influenced patient-reported outcomes.

Results: FA resulted in smaller changes in alignment compared to MA (Δ aHKA $p = 0.01$; Δ JLO $p < 0.01$) and more frequent restoration of the preoperative CPAK phenotype (42.9% vs. 10.3%, $p < 0.01$). In the MA group, restoration of CPAK phenotype was associated with significantly higher FJS, while no such relationship was observed in the FA group. A dose-response relationship was identified in the MA group: greater changes in JLO were negatively correlated with FJS. This correlation was not seen with FA.

Conclusion: Functional alignment more closely preserved native coronal alignment and restored CPAK phenotypes compared to mechanical alignment. In MA cases, larger deviations from native JLO and CPAK phenotypes were associated with poorer patient-reported outcomes. These findings suggest anticipating alignment changes may support optimal strategy selection in TKA.

Be Wary of Severe Tibial or Femoral Component Varus in TKA: Long-Term Analysis of Over 19,000 Cases

Introduction: Alignment in total knee arthroplasty (TKA) is increasingly debated, and its impact on long-term outcomes remains unclear. This study evaluated the impact of pre- and postoperative coronal and sagittal alignment, including changes between them, on implant survivorship and clinical outcomes in primary TKA.

Results: Overall, the 15-year survivorship free of any aseptic revision was 95%. When analyzed by postoperative alignment, preoperative valgus knees that remained in valgus postoperatively had substantially lower 15-year survival at 84%. Femoral component varus with a LDFA $>90^{\circ}$ (HR 2; $p=0.02$) or tibial component varus with a MPTA $<85^{\circ}$ (HR 1.3; $p<0.01$) were associated with an increased risk of aseptic revision. Tibial component varus with a MPTA $<85^{\circ}$ was also associated with increased risk of revision for aseptic loosening (HR 1.9; $p<0.01$). Postoperative Knee Society Scores were substantially improved from preoperative scores at 2, 5 and 10 years ($p<0.01$).

Conclusion: The 15-year survivorship of over 19,000 primary TKAs was excellent regardless of alignment strategy. However, severe varus positioning of the femoral component ($\text{LDFA} > 90^\circ$) or tibial component ($\text{MPTA} < 85^\circ$) was associated with an increased risk of aseptic revision. Preoperative valgus knees left in valgus postoperatively were also at increased risk of revision. As alternative alignment strategies emerge, surgeons should consider boundaries in implant positioning to decrease revision risk.

Kneeling After Total Knee Arthroplasty: Does Resurfacing the Patella Affect the Ability to Kneel?

Introduction: Difficulty and pain with kneeling is a common postoperative complaint after TKA, but the cause of this issue has not been identified. The purpose of this study was to investigate the effect of patella resurfacing on a patient's ability to kneel after TKA with consideration of preoperative presence of patellar osteoarthritis (P-OA).

Results: There were 132 knees in the no P-OA, unresurfaced group; 110 in the P-OA, resurfaced group; and 121 in the no P-OA, resurfaced group. Preoperative and postoperative KOOS-JR were equivalent across groups. More patients in all cohorts reported worsening of their kneeling ability after TKA than reported equivalence or improvement, with no differences in difficulty in kneeling across cohorts. Patients without resurfaced patellae reported non-significantly lower mean pain scores for kneeling on different surfaces. With respect to their ability to kneel postoperatively, patients in all groups were more likely to report being very satisfied or satisfied, but patients without P-OA were more likely to be dissatisfied or very dissatisfied if their patellae was resurfaced.

Notes

Is Patella Resurfacing an Absolute Indication in Total Knee Arthroplasty for Inflammatory Arthritis?

Introduction: Inflammatory arthritis (IA) is considered an absolute indication for patellar resurfacing (PR) in total knee arthroplasty (TKA), yet limited contemporary data exists to support this. The purpose of this study was 1) to determine if clinical outcomes of TKA without PR differ between IA and osteoarthritis (OA) and 2) to compare outcomes of TKA for IA with and without PR.

Results: Among TKA without PR, 20 (5.7%) IA and 13 (3.7%) OA patients underwent reoperation ($P=0.28$); 2 (0.6%) patients in each group underwent revision ($P=1.0$). There were no differences in aseptic (3.4% IA vs. 2.3% OA; $P=0.50$) or septic (2.3% IA vs. 1.4% OA; $P=0.58$) reoperations. Four (1.1%) IA vs. 0 OA patients underwent secondary PR ($P=0.12$). Among TKA without PR, there was no difference in AKP between IA (4.9%) and OA (7.8%) ($P=0.16$). Among TKA for IA, there were no differences in AKP (4.9% IA vs. 5.3% IA-PR; $P=0.58$). The PR group had more aseptic reoperations (3.4% IA vs. 13.1% IA-PR; $P=0.02$) and revisions (0.6% IA vs. 13.2% IA-PR; $P<0.01$).

Notes

Higher Viscosity and Antibiotic Cement are Linked to Increased Mechanical Failure in Primary Total Knee Arthroplasty

Introduction: The mechanical properties of polymethylmethacrylate (PMMA) cement in TKA can be influenced by both viscosity and the addition of antibiotics. The independent and combined effects of viscosity and antibiotic additives on revision risk remain subject to debate. Thus, this study sought to evaluate the impact of antibiotic additives and cement viscosity on the risk of revision surgery after primary cemented TKA, with a focus on mechanical loosening and periprosthetic joint infection (PJI).

Results: A total of 472,922 TKAs were included. Antibiotic cement was used in 90,958 cases (22.4%). Compared to non-antibiotic cement, antibiotic cement was associated with a significantly higher risk of all-cause revision (HR 1.21, 95% CI 1.11-1.32; $p < 0.0001$) and revision for mechanical loosening (HR 1.35, 95% CI 1.18-1.54; $p < 0.0001$), with no difference in infection-related revision ($p = 0.5381$). Compared to LVC, both HVC (HR 1.27, 95% CI 1.12-1.44; $p = 0.0002$) and MVC (HR 1.98, 95% CI 1.70-2.31; $p < 0.0001$) were associated with increased risk of revision for mechanical loosening. HVC was also associated with increased all-cause revision (HR 1.13, 95% CI 1.05-1.22; $p = 0.0016$). No differences were observed in infection-related revision across viscosity groups.

Conclusion: In this large national registry study, both antibiotic use and higher cement viscosity were independently associated with increased risk of revision for mechanical loosening in primary TKA. Importantly, antibiotic cement was not associated with decreased rates of infection-related revision.

Preoperative Subcutaneous Cryoneurolysis Increases Pain Post Total Knee Arthroplasty

Introduction: The volume of total knee arthroplasties (TKA) has risen significantly in the past decade and strategies are needed to improve postoperative analgesia in this population. Ultrasound-guided percutaneous cryoneurolysis, branded iovera[®], is indicated for prehabilitation and TKA rehabilitation and recovery for up to 90 days. By applying cryoneurolysis prior to TKA, patients are expected to experience better postoperative pain control, improved functional outcomes, and reduced opiate consumption.

Results: Cryoneurolysis patients experienced significantly more pain at 1 week (6.14 vs. 5.02, $p=0.024$) than those who did not receive a block. No significant differences in pain were reported at later time points, but the cryoneurolysis group trended higher throughout the time course (e.g. 8 weeks; $p=0.108$, 12 weeks, $p=0.055$). The percentage of patients using narcotics was similar across all groups, peaking at 1 week post surgery and falling swiftly thereafter.

Notes

Symposium II

Navigating the ASC Setting: How to Go from Operating in the ASC to Thriving

Moderator: R. Michael Meneghini, MD

This symposium will help hip and knee surgeons thrive in the ambulatory surgical center (ASC) setting and will focus on patient selection, patient care, efficiency, financial profitability and enabling technology. Faculty will highlight how to safely increase the volume of surgical candidates through proper screening and protocols; describe how to optimize types of patients not previously considered ASC candidates and transition them into the ASC setting; and discover methods to optimize perioperative and clinical throughput and surgical efficiency. Attendees will discover how time transparency and defined staff roles can remove waste, enhance patient care and ASC profitability. Lectures will discuss contracts, negotiation, implants, and how to maximize profits and minimize costs without disrupting care, diving into how to manage finances and to develop partnerships. Finally, the symposium will address robotics and enabling technology in the ASC and how to utilize technology in a cost-efficient manner to limit inventory and create efficiency in the operative suite.

Learning Objectives:

- 1. Understanding proper candidates for outpatient surgery.
- 2. Understanding surgeon and team member roles.
- 3. Learning how to create efficiency in the ASC setting.
- 4. Increasing surgical volume while maintaining quality and patient care.
- 5. Understanding basics of finances in the ASC setting.
- 6. Gaining insight on improving margins and maintaining profitability.
- 7. Learning about creating protocols and standardization.
- 8. Understanding the role of robotics in the ASC.
- 9. Learning how to create standardization and utilize space.

Outline:

Introduction

R. Michael Meneghini, MD

Everyone is an ASC Candidate: Expanding the ASC Candidate Pool

Adolph V. Lombardi Jr., MD

The Value of Time in the ASC

Charles A. DeCook, MD

Making Your ASC Profitable: The Business Side of Owning an ASC

Michael P. Ast, MD

Robotics in the ASC: How to Create Efficiency and Standardization

John M. Dundon, MD

Discussion

All Faculty

Notes

Effect of Concomitant Use of Potent Anticoagulation and Anti-Inflammatories on Early Outcomes of THA

Introduction: The use of non-steroidal anti-inflammatory drugs (NSAIDs) in patients receiving potent anticoagulation (AC) following THA may increase risks of bleeding and related complications. We evaluated early postoperative pain, opioid consumption and complications in patients undergoing primary THA with and without concomitant NSAID use.

Results: The mean $\pm$ standard deviation changes in VAS pain scores six weeks postoperatively were -45.5 ± 26.9 for the AC group and -47.2 ± 27.6 for the NSAID group. Mean total 90-day opioid consumption was 560 ± 557 MME in the AC and 596 ± 710 MME in the NSAID group. After adjusting, this difference was not significant (4.7 MME [95% CI -39.7-49.2]). Similarly, there was no evidence of a difference in 90-day local complication rates between AC vs. NSAID groups, respectively: prolonged wound drainage (1.3% vs. 1.7%, odds ratio (OR) 0.7 [95% CI 0.4-1.3]), hematoma formation (0% vs. 0.2%), and PJI (0.1% vs. 0.6%, OR 0.2 [95% CI 0.02-1.3]).

Notes

A Synthetic Form of Cannabinoid Does Not Decrease Opioid Use After Total Knee Arthroplasty

Introduction: Self-reported cannabis use in patients undergoing total knee arthroplasty (TKA) has increased since its legalization. Despite its endorsement, its efficacy has never been studied in a prospective randomized study in orthopaedic surgery. Therefore, the purpose of this study was to determine whether a synthetic delta-9-tetrahydrocannabinol (sTHC), dronabinol, decreases opioid use after TKA.

Results: There were no differences for in-hospital MME consumed (sTHC 40+/-75.5 vs. placebo 39.3 77.8, $p=0.1$). No differences in total MME were noted at two weeks (sTHC 370.9+/-302.6 vs. placebo 372.6+/-248.8, $p=0.1$). Self-reported pain ($p=0.769$), hours of sleep per night ($p=0.1$) and nausea/vomiting ($p=0.7$) showed no differences between the groups at two and four weeks. No differences in patient reported outcomes at six weeks (ROM, KOOS, KSS, VR-12 MCS, VR-12 PCS) were noted between the groups. No drug or placebo related complications were noted in either group.

Notes

Cementless Ceramic Hip Resurfacing: Minimum Three-Year Follow-Up of a 250 Patient Multicenter Study

Introduction: The aim of this study was to report the safety and effectiveness of a contoured cementless anatomic ceramic hip resurfacing device.

Results: Eight revisions have taken place out of 250 cases, with a minimum follow-up of three years. Five of these were for femoral neck fractures. Hip scores reached a median of 100% within 12 months of surgery. Female hips and those with small implants have clinical results indistinguishable from the large men for whom hip Metal-on-Metal hip resurfacing is currently indicated. Radiographically good bone-implant interface stability was observed on the acetabular side. Femoral subsidence was observed in 46 cases, strongly correlated with poor femoral implant orientation. With four years of further follow up, subsidence appears to be clinically benign.

Notes

Symposium III

Solving Intraoperative Challenges of Total Hip Arthroplasty: A Video-Based Symposium

Moderator: William G. Hamilton, MD

Surgeons commonly encounter intraoperative challenges during total hip arthroplasty. The ability to work through these occurrences safely and efficiently helps to optimize outcomes and avoid catastrophe. This symposium will focus on common areas where surgeons experience these challenges, including exposure, acetabular-sided, femoral-sided, leg length, offset and stability. Exposure can be one of the challenging steps of a successful hip replacement, with good exposure allowing for an uncomplicated procedure. Our faculty are widely experienced in both anterior and posterior approaches and will present practical solutions to obtaining great exposure in the toughest cases. On the acetabular side, common problems that surgeons experience include inability to gain good fixation, acetabular fracture or reaming misadventures, like reaming through the anterior or medial walls. A roadmap to avoiding but more importantly getting out of these predicaments will be presented. On the femoral side, surgeons encounter femoral fracture, perforation or difficulty in obtaining good fixation with suboptimal bone quality or compromised anatomy. Lastly, the proper restoration of leg length, offset, and maximizing hip stability are keys to patient satisfaction. We'll present an algorithm for surgeons to use and techniques to ensure proper restoration of anatomy and stability. The faculty will use video-based presentations to review these most common challenges encountered and describe a stepwise approach to safely dealing with each.

Learning Objectives:

- 1. Outline the most common challenges encountered in primary THA.
- 2. Using video-based presentations, present attendees with pragmatic solutions to each of these intraoperative hurdles.
- 3. Describe evidence-based solutions with associated data to inform attendees of the outcomes of each scenario.
- 4. Leave attendees with practical solutions they can immediately implement when returning to their practice.

Outline:

Introduction

William G. Hamilton, MD

I Can't Get the Exposure I Need: Tips and Tricks for Enhanced Exposure in the Most Complicated THA Patients

Michael J. Taunton, MD

Acetabular Mishaps and How to Fix them: Inadequate Fixation, Reaming Errors and Acetabular Fractures

Cameron K. Ledford, MD

Femoral Sided Speed Bumps: What to Do if I Experience a Femoral Fracture, Perforation or Suboptimal Fixation

William G. Hamilton, MD

Solving Problems with Hip Stability, Length and Offset: An Evidence-Based Algorithm to Get It Right Every Time

Eric M. Cohen, MD

Discussion

All Faculty

Notes

No One-Size-Fits-All: Surgical Approach Dictates Optimal Bearing Choice in 30,000 THAs Over 25 Years

Introduction: Dislocation remains a common and consequential complication following primary THA. While both surgical approach and bearing surface individually influence dislocation risk, few studies have evaluated their combined impact. This study assessed the long-term dislocation risk stratified by surgical approach and bearing construct to develop approach-specific recommendations for bearing selection.

Results: The absolute risks of dislocation at 10 years in posterior, AL and DA THAs were 4%, 2% and 1%, respectively. In posterior THAs, DM constructs significantly reduced relative dislocation risk ($RR < 0.5$, $p < 0.01$) compared to standard PE liners. In AL THAs, standard PE liners had the lowest absolute dislocation risk (1%), whereas elevated rim/face-changing PE liners were associated with double the relative risk of dislocation (RR 2, $p < 0.01$). In DA THAs, bearing surface had no impact on dislocation risk.

Conclusion: A one-size-fits-all approach to bearing surface is suboptimal, and surgical approach should guide bearing selection in primary THAs. For posterior approach, DM constructs significantly reduced the relative risk of dislocation and should be considered in high-risk cases. For AL approach, standard PE liners had the lowest absolute dislocation risk. Finally, all DA THAs had a lower dislocation risk regardless of bearing selection.

Posterior Approach Hip Precautions and Dislocation Risk After Primary Total Hip Arthroplasty

Introduction: The effectiveness of posterior hip precautions in preventing dislocation after primary posterior approach total hip arthroplasty (THA) remains uncertain. Such precautions may delay patients' return to daily activities and functional recovery. This study aimed to determine whether postoperative THA hip precautions impacted hip dislocation rates.

Results: The unrestricted and restricted groups included 522 and 535 patients, respectively, with no significant demographic or surgical differences (all $P>0.245$). Follow-up was similar between groups (mean 1.3 ± 1.4 years; range 0.62–102.9 months; $P=0.645$). Overall, ten dislocations (0.94%) were reported at 9.1 ± 10.5 months postoperatively, with 6 in restricted and 4 in unrestricted patients, showing no significant difference (OR: 0.60; 95% CI: 0.17–2.17; $P=0.753$). At 6-weeks, Hip Disability and Osteoarthritis Outcome Scores (HOOS) were higher in the unrestricted group (77.7 vs. 73.9, $P=0.001$), with no significant difference in baseline scores (52.5 vs. 51.7, $P=0.517$). No differences were observed in 90-day complications or revisions (all $P>0.209$).

Notes

Long-Term Follow Up of Thin Polyethylene Liners in Total Hip Arthroplasty

Jessica H. Leipman, BA, Neeku Salehi, BS, Camilo Restrepo, MD, Eric B. Smith, MD,
James J. Purtill, MD, **Yale A. Fillingham, MD**

Introduction: Using thin polyethylene liners with large diameter femoral heads in total hip arthroplasty (THA) may decrease the risk of instability. The purpose of this study was to investigate the long-term survivorship of thin highly crosslinked polyethylene (HXLPE) liners.

Methods: This was a retrospective cohort study of patients who underwent primary THA for osteoarthritis at a single institution. Patients who received an HXLPE liner with a thickness of 3.9, 5.9 or 7.9 mm and a variety of femoral head and cup sizes were included. Demographic, surgical information, patient-reported outcome measures and long-term outcomes were collected.

Results: Of the 4,951 cases included, 92 utilized a 3.9 mm liner, 2,690 utilized a 5.9 mm liner, and 2,169 utilized a 7.9 mm liner, with respective mean length of follow up of 4.48 (range 1.23 – 12.17), 6.13 (range 1.0 – 12.12), and 6.05 years (range 1.0 – 12.35). There was no significant difference in revisions or reoperations between the cohorts. Among those revised, 7.9 mm liners were more likely to have the indication of instability when compared to 5.9 mm liners (0.092% vs. 0.038%), while the 3.9 mm group had no revisions for instability. No 3.9 mm liners were revised for polyethylene wear. At 6 months postoperatively, HOOS-JR was significantly greater in patients with a 3.9 mm liner ($P=0.004$). At 2, 5, and 10 years postoperatively, HOOS-JR was equivalent across all groups ($P=0.76$, $P=0.098$, $P=0.685$, respectively). At 5 years postoperatively, the 3.9 mm group had a significantly lower improvement in HOOS-JR ($P=0.036$), but this difference equalized between groups at 10 years.

Conclusion: Thin and standard size HXLPE liners in THA have similar long-term functional and clinical outcomes. Liners of 3.9 mm may safely be used while providing the benefit of reduced revision for instability.

Notes

Leg Length Discrepancy and its Relationship to the Forgotten Joint Score in Total Hip Arthroplasty

Introduction: Leg length discrepancy (LLD) following THA may negatively influence patient satisfaction. We aimed to compare patients with and without perceived LLD (P-LLD) and examine the impact of P-LLD on Forgotten Joint Score (FJS).

Results: We included 110 patients, 32 of whom (29%) had a P-LLD. The cohorts did not show differences in age (64 ± 8.59 vs. 62 ± 11.27 , $p=0.363$), BMI (29.21 ± 6.03 vs. 28.26 ± 5.46 , $p=0.449$), sex distribution (43.8% female vs. 34.6% female, $p=0.982$) or race (91% White, 9% Black, 0% Asian vs. 96% White, 3% Black, 1% Asian $p=0.287$). Additionally, cohorts did not show any difference in postoperative measured leg length discrepancies: inter-teardrop line to greater trochanter (5.83 ± 4.91 mm vs. 4.93 ± 4.08 mm, $p=0.401$), inter-ischial tuberosity to lesser trochanter (3.48 ± 2.66 mm vs. 4.07 ± 3.01 mm, $p=0.33$), teardrop to tibial eminence (3.93 ± 4.49 vs. 3.67 ± 3.62 , $p=0.908$), teardrop to tibial plafond (2.91 ± 2.07 vs. 3.25 ± 3.25 , $p=0.77$). Univariate analysis showed significantly lower FJS (63.90 ± 26.08 vs. 79.35 ± 23.89 , $p=0.003$) in P-LDD patients. Multivariate analyses revealed significantly lower FJS in P-LDD patients (OR 0.98, 95% CI: 0.96-0.99, $p=0.007$). There was no correlation between perceived and measured LLD.

Conclusion: These results state that P-LDD has a clear negative relationship to FJS. Surgeons should counsel patients who are at risk for P-LDD, such as those with contractures and scoliosis, prior to THA.

Too Late to Matter? Time-to-Positivity Beyond Five Days Still Identifies Clinically Relevant PJI

Introduction: The conventional five-day incubation threshold for diagnosing periprosthetic joint infection (PJI) may miss slow-growing organisms, leading to culture-negative diagnoses and empiric treatment. This study evaluates whether culture positivity beyond five days remains clinically meaningful and compares outcomes across early-positive, late-positive and culture-negative PJIs.

Results: Among culture-positive PJIs, 42.3% turned positive after day five. Commonly identified slow-growing organisms included *Cutibacterium acnes*, anaerobes and coagulase-negative staphylococci. Failure rates were similar between late- and early-positive groups ($p = 0.78$), and on adjusted analysis, delayed positivity was not associated with increased failure (OR: 1.1, 95% CI: 0.7–1.7, $p = 0.82$). The overall failure rate among culture-positive PJIs was 31.4%, compared to 60.1% in culture-negative cases ($p < 0.001$).

Notes

Wandering Protocol May Lead to Increased Patient Risks in Arthroplasty Cases: Single Center Evaluation

Michael P. Bolognesi, MD, **Sean P. Ryan, MD**, Samuel S. Wellman, MD, Thorsten M. Seyler, MD, PhD,
William A. Jiranek, MD

Introduction: The Joint Commission defines a sentinel event for unintended retention of a foreign object as the object being discovered after the completion of final skin closure, even if the patient is in the operating room under anesthesia. At the investigating institution, an RFID wand policy was implemented to be performed before the final suture was placed to attempt to prevent this sentinel event definition from occurring. We evaluated the periprosthetic joint infection (PJI) rate in the setting of wand use over an unclosed wound during primary total joint arthroplasty (TJA) procedures.

Methods: Institutional wanding policy took effect July 1, 2023. Patients undergoing primary total joint arthroplasty were included in the analysis. For 6 months the policy was in effect, at which point it was phased out and ultimately changed in April 2024. Patients from January 2022 – December 2024 were included. Patients from January – April 2024 during policy wind-down were excluded. Multivariate logistic regression models controlling for age, gender, BMI and ASA score were created to evaluate the wanding policy durations impact on the primary outcome of interest: PJI.

Results: 3,457 primary hip and 3,727 primary knee arthroplasty procedures were included in the analysis. The PJI rate during the 6-month period of investigation was 1.3% compared to 0.6% during the control period. In multivariate regression, surgery during the wanding over unclosed wounds protocol was significantly associated with PJI: OR 2.093, 95% CI 1.124-3.897, $p=0.020$. It represented the strongest predictive variable for PJI in the multivariate regression model.

Conclusion: The introduction of wandering over unclosed wounds in response to the joint commissions sentinel event definition was associated with increased PJI risk. While no causation can be determined in this retrospective review, we caution the incorporation of any additional variables prior to wound closure that may contribute to surgical site contamination.

Notes

Unexpected Positive Cultures in 230 Aseptic Revision THAs: High Midterm Survivorship Free of PJI

Introduction: Unexpected positive cultures in aseptic revision THA are frequently reported in the literature. However, their risk of subsequent PJI remains unclear. The goals of this study were to determine the management strategies of unexpected positive cultures after aseptic revision THA, midterm survivorship free of PJI and risk factors for infection after index revision.

Results: Of the 230 revision THAs with unexpected positive cultures, 68% received postoperative antibiotics, with 65% prescribed two weeks or less of oral antibiotic therapy. The five-year survivorship free of PJI was 96%. There were nine subsequent revisions for PJI. One of the nine hips had multiple positive cultures isolated at index revision, and four of the nine (44%) had the same organism isolated during both aseptic revision and subsequent PJI. Postoperative antibiotic therapy and the number of positive cultures at index revision were not associated with infection risk.

Conclusion: In this series of 230 aseptic revision THAs with unexpected positive cultures, the five-year survivorship free of PJI was excellent at 96%. Nearly half of hips with subsequent PJI had the same organism isolated during both the index revision and subsequent PJI. However, there was no association between antibiotic therapy or number of positive cultures during index revision and infection risk.

Practice Management Strategies Among Attendees of the 2025 AAHKS Annual Meeting

A survey will be conducted regarding practice management strategies at the 2025 AAHKS Annual Meeting of AAHKS members and arthroplasty professionals. The live and virtual meeting audiences will be polled at the Annual Meeting using an audience response system (ARS) available in the AAHKS Mobile App, and the results will be reviewed in real time. The results of the survey will be compared to prior membership surveys to determine if there have been changes in practice patterns.

1. To learn the present practice strategies of AAHKS members and other arthroplasty surgeons.
2. To identify any changes in practice patterns compared to prior surveys.

Jay R. Lieberman, MD

PJI Power Hour: Surgical Tips, Tricks, and Can't-Miss Video Clips

This high-impact, video-based symposium will deliver the most current strategies and real-world surgical insights for managing periprosthetic joint infection (PJI). Through expert-led presentations, practical pearls and controversy-driven case discussions, attendees will gain actionable knowledge on DAIR, intraosseous antibiotics and complex one- and two-stage exchange techniques of the hip and knee. A must-attend for any surgeon managing PJI today.

1. Review the latest evidence and evolving best practices for managing acute and chronic PJI in THA and TKA.
2. Understand indications, techniques and outcomes associated with DAIR and intraosseous antibiotic delivery.
3. Explore technical execution of one- and two-stage exchanges, including spacer construction, timing and reimplantation, with video-based demonstrations from experienced surgeons.

Matthew P. Abdel, MD

Synovial Metal Ions in “Nickel Free” vs. Standard Cobalt-Chrome Containing Total Knee Replacement

What Is the Ideal Technique and Construct in Aseptic Revision Total Knee Arthroplasty?

Wayne T. Hoskins, FRACS, PhD, Charles Gusho, MD, Michael J. McAuliffe, FRACS, Chris Wall, MD, Qunyan Xu, MS, Kelly G. Vince, MD

Introduction: Revision TKA (RTKA) involves various techniques, constructs and fixation strategies. This study assessed re-revision outcomes based on what components were revised, implant choice and construct fixation.

Methods: A national registry-based retrospective cohort study was performed. Aseptic RTKAs (excluding infection) from September 1999 to December 2023 were included. The components exchanged (femur, tibia and/or liner) and revision constructs used (stems and/or cones/sleeves) were recorded. Comparisons among RTKA constructs were performed, with comparison to revision of the femoral and tibial component with the use of stems and cones/sleeves. The primary outcomes were (1) re-revision for all-causes, and (2) re-revision for component loosening. Age, sex, BMI, ASA, bearing surface and surgeon-volume were adjusted as covariates in a Cox proportional hazards model.

Results: A total of 21,499 aseptic RTKAs were identified, with 2,345 having both the femoral and tibial component revised with stems and cones/sleeves (mean age 70.2 (SD9.4); follow-up 4.3 (SD3.5) years. This construct was compared to other constructs. When the femur and tibia were revised with stems but without cones/sleeves (n=4128; mean age 69.4 (SD9.2); follow-up 5.6 (SD4.0) years), there was no difference in all-cause re-revision but higher rates of component loosening (1.5 year+ HR 1.82 (95%CI 1.17-2.83), p=0.01). Higher all-cause re-revision and component loosening occurred with total revision with only a tibial stem and without sleeves/cones; when no stems or sleeve/cones were used; and when partial revision of the tibia or femur occurred (all p< 0.05). Higher all-cause re-revision (HR 1.41; 95% CI 1.21-1.64; p< 0.001) and component loosening (HR 1.60; 95% CI 1.17-2.20; p=0.003) occurred with isolated liner-exchanges, the most common revision procedure (n=8027; mean age 68.0 (SD9.4); follow-up 5.9 (SD4.7) years).

Conclusion: In aseptic RTKA, exchange of both femoral and tibial components with stems and cones/sleeves in the revision construct has the lowest re-revision and component loosening rates.

Notes

Maximizing Bearing Diameter Markedly Lowers Dislocations in Primary Total Hip Arthroplasty

Introduction: Modern polyethylene allows larger bearings in fixed-bearing THA, but any stability benefits of fully maximizing bearing diameter (e.g. 36-mm in 48/50-mm cups) are not well established. We hypothesize that maximizing bearing diameter reduces odds of dislocation in primary fixed-bearing THA.

Results: Bearing diameter was maximized in 835 (9.8%) of 8,607 patients, whereas 7,309 received the second-largest bearing available. There were 79 dislocations (0.9% overall); none occurred with maximized bearing diameters ($P=0.003$). On univariate analysis, dislocation risk also varied with intraoperative technology use, surgical approach and liner geometry ($P=0.017$, $P=0.008$, $P=0.007$, respectively). On LASSO regression including these variables, along with age, sex and body-mass-index, maximized bearing diameters heavily protected against dislocation ($OR=0.14$). Robotic surgery ($OR=0.35$), computer navigation ($OR=0.90$), lateral ($OR=0.48$) and anterior ($OR=0.62$) approaches were also protective. Lipped ($OR=1.2$) and offset ($OR=1.4$) liners were associated with slightly higher odds of dislocation but were commonly used with posterior approach and non-maximized bearing diameters. Sub-analysis of 4,185 patients with smaller bearings and posterior approach revealed that liner geometry did not impact dislocation odds within this sub-group, nor did receiving the second-largest available bearing demonstrably reduce dislocation odds compared to smaller bearings.

Notes

Robotic UKA Demonstrates Better Early Recovery Than Robotic TKA: A Remote Monitoring Study

Introduction: Unicompartmental knee arthroplasty (UKA) and total knee arthroplasty (TKA) have been compared in clinical studies for decades. However, prior comparisons rely upon manual surgical techniques and subjective outcome measures, collected at discrete time points, limiting the ability to detect meaningful differences during early recovery. The purpose of this prospective study was to compare early recoveries following robotic-assisted UKA (rUKA) and robotic-assisted TKA (rTKA) utilizing continuous remote patient monitoring for the first 90 days after surgery.

Results: rUKA patients experienced greater improvement in pain compared to rTKA (mean change in VAS pain from preoperative to 90 days: -2.7 vs. -1.6; $p=0.004$). At 30 days, UKA patients had better Forgotten Joint Scores (37 vs. 25; $p=0.015$), Oxford Knee Scores (33 vs. 29; $p=0.003$), and Normal Knee scores (64 vs. 50; $p=0.002$). rUKA patients also had higher daily step count at all time points, with a smaller decline from preoperative levels (94.5% of preoperative steps vs. 73.6% of preoperative steps at 30 days; $p<0.001$). rUKA patients discontinued walking aids earlier (19 days vs. 32 days; $p<0.001$) and had consistently greater knee flexion at all time points. Opioid consumption was similar between groups.

Notes

Do TJA Patients Need to Stop NSAID Use Prior to Surgery? A Prospective, Blinded, Randomized Controlled Trial

Introduction: Nonsteroidal anti-inflammatory drugs (NSAIDs) are commonly used in both pre- and postoperative settings for TJA. Despite their efficacy, NSAIDs are routinely held seven days before surgery for concerns of perioperative bleeding and related complications. The purpose of this study was to challenge this dogma and investigate the safety of continuing NSAID use prior to TJA.

Results: There were no statistically significant differences in hemoglobin reduction between NSAID and Control groups at POD0 (-0.52 +/- 1.32 vs. -0.38 +/- 1.21; p=0.52) or two weeks (0.33 +/- 1.66 vs. 0.16 +/- 1.76; p=0.56). There were no statistically significant differences in intraoperative blood loss, surgical exposure score, operative time, ROM or six-week PROMs (p>0.05). No patients required a blood transfusion. Two control patients and one NSAID patient experienced bleeding from the incision on POD0/1, which resolved with staple application. Four control patients returned to the OR (four MUAs) vs. three NSAID patients (two MUAs, one infection at six weeks). This was not statistically significant (P=1).

Notes

Revision TJA at the Ambulatory Surgery Center: Comparable Outcomes to Inpatient Procedures

Introduction: The safety and efficacy of outpatient primary TJA in appropriately selected patients has been established. As rates of revision TJA (rTJA) continue to increase, there is growing interest as to whether these procedures can be safely performed in the outpatient setting. The purpose of this study was to compare outcomes of inpatient revision TJA procedures to those performed at an ambulatory surgery center (ASC).

Results: Patients undergoing rTJA at an ASC had an increased risk of mechanical complications (OR: 3.08; 95% CI: 1.01-9.39; $p=0.049$) relative to inpatient controls. However, these patients had a lower risk of hip instability (OR: 0.14, 95% CI: 0.02-0.81; $p=0.028$), reoperation (OR 0.14, 95% CI: 0.05-0.41; $p<0.001$), and medical complications (OR 0.04, 95% CI: 0.01-0.31; $p=0.002$). ASC patients who underwent modular component exchange had a reduced risk of any complication (OR: 0.45, 95% CI: 0.22-0.92; $p=0.028$). No differences were seen for the remaining outcomes.

Notes

Single- vs. Dual-Component Revision Following TKA Failure for Isolated Tibial and Femoral Loosening

Introduction: Aseptic loosening is a leading cause of failure in total knee arthroplasty (TKA), frequently necessitating revision surgery. When limited to either the femoral or tibial component, the choice between isolated and dual-component revision remains debated.

Results: At 10 years, re-revision occurred in 9.7% (15/154) of isolated and 11.2% (16/143) of complete cases ($P=0.413$). There were no differences in surgical or medically related complication rates ($P>0.05$). Both cohorts demonstrated significant improvements in ROM and PROMs postoperatively. ROM was significantly greater in the isolated group pre- and postoperatively ($P<0.05$), while PROMs were comparable between groups ($P>0.05$). Cox regression identified no independent predictors of re-revision, including revision strategy ($P>0.05$).

Conclusion: In patients with isolated femoral or tibial loosening, both isolated and dual-component revision TKA offer comparable re-revision rates and functional outcomes. These findings support the use of surgeon discretion in determining component retention during revision TKA.

Is Corrosion at the Modular Junction of Revision Total Knee Arthroplasty Actually a Problem?

Introduction: Corrosion at modular junctions in revision TKA is recognized but poorly understood in relation to implant failure. The purpose of this study was to evaluate the junctions of modular revision TKA components for corrosion and assess the correlation with clinical failure.

Results: Tapered junctions demonstrated significantly more fretting corrosion than threaded designs ($p < 0.001$). Median mGS for tapered components were 4 (femoral component), 3 (femoral stem) and 2 (tibial component and stem). Threaded junctions showed minimal damage across all interfaces (median score=1). Junction damage was characterized by fretting wear, fretting corrosion features and dark deposits. The median (min., max) material loss for female junctions with mGS of 4 was 0.54 (0.0, 27.7) mm³. The corresponding material loss from the male stem extension junction was 0.14 (0, 1.2) mm³. Corrosion severity did not correlate with localized radiographic findings and reason for explant.

Conclusion: In modular revision TKA components, tapered junctions exhibited significantly more corrosion than threaded junctions. However, no direct association was observed between corrosion severity and radiographic findings. Corrosion products different from those typically observed in THA, indicating potentially different corrosion mechanisms. Further research is required to determine the clinical consequences of corrosion at this junction.

Distal Femoral Replacement in Complex Primary and Revision TKAs: 10-Year Survivorship of 292 Cases

Introduction: Distal femoral replacements (DFRs) are a salvage option for complex total knee arthroplasties (TKAs). There is a paucity of data correlating methods of femoral component fixation to long-term implant survivorship. This study evaluated implant survivorship, femoral component fixation methods and radiographic results of TKAs with DFRs in the largest series to date with long-term follow-up.

Results: The 10-year survivorships free of revision for aseptic femoral loosening, any femoral revision, any revision and any reoperation were 87%, 79%, 60% and 46%, respectively. Modular component exchange (53%) was the most common revision performed. An increase in ratio of femoral component length to femoral stem length ($p=0.03$), prior femoral canal instrumentation ($p=0.05$) and cementless femoral fixation ($p<0.01$) were associated with higher risk of any femoral revision. As our technique evolved, 16 patients had impaction grafting at the time of index DFR, and only one underwent subsequent femoral component revision. Femoral cones were not protective of revision surgery. Radiographic loosening was observed in 17 unrevised DFRs (6%).

Notes

The Multiply Revised Knee: Video-Based Techniques for What to Do Next

Failed total knee arthroplasty is a growing problem with devastating implications, and the revision TKA burden is rising. Using more metal may or may not be the answer. Preservation of remaining bone stock, mechanical stability, zonal fixation and respect for bony biology are critical to a successful outcome. In this symposium, we will utilize video-based techniques to provide a roadmap and tips and tricks for the latest novel techniques in revision total knee arthroplasty to allow for durable fixation and improved outcomes in these complex patients.

1. Understand a systematic approach to appropriate exposure techniques and soft tissue reconstructive options for multiply revised TKAs.
2. Video-based education on advanced techniques for impaction bone grafting of the canals and reconstructing severe bone loss.
3. How to manage the patella in multiply revised knees to maximize function and preserve bone stock.

All Faculty

Preoperative Contralateral Joint Pain and/or Back Pain Impact Achieving the SCB for HOOS-JR

Introduction: CMS has identified contralateral joint and back pain as risk factors that may influence achieving substantial clinical benefit (SCB)—defined as a 22-point improvement on the Hip injury and Osteoarthritis Outcome Score for Joint Replacement (HOOS-JR)—following primary THA. We aimed to compare baseline PROMs and one-year SCB achievement among Medicare patients undergoing primary THA with and without preoperative contralateral joint and/or back pain.

Results: Patients without any pain had higher median baseline HOOS-Pain (50.0 vs. 38.9), HOOS-Physical Function Shortform (HOOS-PS) (58.0 vs. 48.8), Veterans RAND 12-Item Health Survey Mental Component Summary (57.1 vs. 48.6), and HOOS-JR (52.5 vs. 42.3) scores compared to those with both pain types (all $p < 0.001$). They were more likely to present with the favorable PROM phenotype (Pain+, HOOS-PS+, MCS+; 43.5% vs. 15.7%, $p < 0.001$) and less likely to exhibit the least favorable phenotype (Pain-, HOOS-PS-, MCS-; 10.6% vs. 33.2%, $p < 0.001$). At 1-year, back pain (odds ratio [OR]=1.55, $p < 0.01$), contralateral joint pain (OR=1.73, $p=0.01$), and both pain types (OR=3.11, $p < 0.001$) were associated with the risk of failure to achieve SCB-JR.

Conclusion: Preoperative contralateral joint and/or back pain were associated with worse baseline function and decreased likelihood of meaningful improvement after THA. These findings support integrating musculoskeletal comorbidity assessment into preoperative planning, particularly under the CMS PROMs mandate.

The Addition of Regional Blocks Does Not Improve TKA Early Recovery: A Prospective Randomized Trial

Introduction: The relative efficacies of regional blocks, including adductor canal (ACB) and infiltration between popliteal artery and capsule of knee (IPACK), and periarticular injection (PAI) in TKA are unknown. Therefore, this study examined the effect of regional blocks (ACB + IPACK) and PAI vs. PAI alone on TKA early recovery using continuous remote patient monitoring.

Results: Pain scores peaked on postoperative day (POD)3 in both groups and declined thereafter. The PAI-only group reported lower POD1 VAS pain (3.24 vs. 4.01, $p=0.019$); scores were otherwise comparable. Peak opioid use occurred on POD3 in both groups, but the PAI-only group consumed less MME on days 2 and 10 (33 vs. 38, $p=0.046$ and 23 vs. 28, $p=0.034$, respectively). OKS was improved for PAI-only at POD7 ($p=0.037$) but did not achieve the minimal clinically important difference. Satisfaction with pain and function was similar between groups.

Notes

Obesity and Chronic Opioids Do Not Prevent THA Patients From Achieving CMS Mandated HOOS JR Scores

Introduction: The Centers for Medicare and Medicaid Services (CMS) will begin mandating improvement thresholds for the Hip Disability and Osteoarthritis Outcome Score, Joint Replacement (HOOS JR) following total hip arthroplasty (THA) starting in 2026. They have established a 22-point improvement target. Data from surgeons and institutions will be publicly reported, which may inadvertently limit patient access if surgeons avoid patients with risk factors for poor outcomes. The purpose of this study was to identify predictors of HOOS JR improvement based on the upcoming CMS-mandated improvement thresholds.

Methods: 1,682 consecutive primary THAs were retrospectively reviewed. Patient data including the presence of fibromyalgia, autoimmune disease, avascular necrosis, depression, chronic narcotic usage and lumbar spine disease were manually extracted from a state-wide healthcare system. Predictors of improvement in HOOS JR scores were evaluated accounting for the minimal clinically important difference (MCID) and substantial clinical benefit (SCB) thresholds. Multivariate statistical analyses were performed with $P < 0.05$ considered significant.

Results: At mean follow-up of 22 months, mean improvement in HOOS JR score from preoperative baseline was 36.0 points (range, -44 to 100). 76.8% of patients met the HOOS JR SCB of 22 suggested by CMS, and 95.5% met the MCID threshold of six. In multivariate analysis, only increasing body mass index was associated with greater improvement in HOOS JR scores ($P=0.006$). Interestingly, chronic narcotic use was not associated with achieving HOOS JR SCB, MCID, or improvement scores in HOOS JR ($P\geq 0.336$, $\text{power}\geq 91.6\%$).

Conclusion: This study demonstrated that patients with characteristics traditionally associated with poorer outcomes were still able to achieve meaningful improvement in HOOS JR scores following THA. Furthermore, based on the variables collected in this study, very few patient characteristics were significantly associated with meeting the CMS-defined improvement threshold, calling into question the appropriateness and validity of the proposed benchmark.

A Concise Update on Decision Making and Optimal Techniques in Revision THA

This symposium will address implant removal made easy, covering topics including new techniques to facilitate acetabular explantation, when to ETO, removal of ingrown femoral components and disaster scenarios to avoid. It will provide an algorithm for acetabular reconstruction, discussing bone loss pre-operatively and intraoperatively, when to use a hemisphere and when not to, the role of augments and cages in 2025 and the absolute indications for custom components. Learners will also hear an algorithm for femoral reconstruction, including how to evaluate the available femoral bone, reconstruction options with or without extended trochanteric osteotomy, when modularity is a must and various salvage options. Finally, faculty will cover optimizing stability in revision THA, addressing decision-making in single component revision, head size, indications and concerns for dual mobility, constrained cups and when abductor reconstruction is necessary.

1. To help surgeons choose the optimal approach and technique.
2. To provide strategies to avoid unexpected challenges in revision.
3. To help surgeons deliver the best outcomes.

All Faculty

“Two Strikes, You’re Out”: Natural History of Instability after Posterior and Anterior Approach THA

Introduction: Historical studies suggest that (1) ~30% of THA patients who experience instability require revision THA (rTHA) and (2) ≥ 3 dislocations indicate necessity for rTHA. We used a modern cohort of posterolateral (PL) and direct anterior (DA) approach THA patients to analyze rates of dislocation and revision.

Results: There were 285 patients with at least one dislocation (0.7%; mean follow-up 5.7 years). PL patients had higher rates of dislocation (0.87% vs. 0.22%; $P < 0.00001$), recurrent dislocation (76.9% vs. 40.1%; $P = .01$) and revision for instability (84.9% vs. 68.2%; $P = 0.02$) than DA patients. Among all patients, 35.1% dislocated exactly once, 41.3% dislocated exactly twice and 23.6% dislocated 3+ times. Revision rate increased with number of dislocations (69.1%, 93.9% and 98.5% for 1, 2 and 3+ dislocations respectively; $P < 0.00001$). Revised patients had higher mean number of dislocations (2.1 vs. 1.2; $P < 0.0001$) and longer time from THA to first dislocation (311.6 vs. 96.4 days; $P < 0.0001$) than non-revised patients. Late dislocators (first dislocation >90 days from THA) were more likely than early dislocators (first dislocation ≤ 90 days) to undergo revision (97.0% vs. 74.9%; $P < 0.0001$). Among one-time dislocators, late dislocators were revised more frequently than early dislocators (86.4% vs. 57.3%; $P = 0.01$).

Notes

Concordance of Dislocation Direction and Surgical Approach is an Approach-Dependent Risk For Recurrent Instability Following Total Hip Arthroplasty

Introduction: The purpose of the study was to quantify the risk of recurrent hip dislocation in relation to concordance of dislocation directionality and surgical approach.

Results: One hundred and ten patients (112 hips) experienced dislocation after THA between January 1, 2013 and April 14, 2025. Posterior approach was most common (61.6%), followed by anterior (27.7%) and direct lateral (10.7%). Median time to first dislocation was 41 days [18, 102.5] and most were posteriorly dislocated (64.3%). Five patients (4.5%) required an open reduction and revision after index dislocation. Fifty-six patients experienced at least two dislocations, accounting for 52.3% of patients that weren't revised at initial dislocation. Median time to second dislocation was 94 days [44, 344]. For posterior approaches, 61.8% of posterior dislocations, recurred, while just 28.6% of anterior dislocations recurred ($p=0.02$). For anterior approaches, 42.3% of posterior dislocations and 41.2% of anterior dislocations recurred ($p=0.94$).

Notes

Risk Factors for Dislocation After Total Hip Arthroplasty: Does Head-to-Cup Size Ratio Matter?

Introduction: Dislocation is a known complication after THA. Utilizing a large femoral head to increase jump distance may reduce this risk; however, large head sizes may not be available for smaller cups depending on manufacturer. The head-cup ratio may be a more tailored measure of determining optimal head size to prevent dislocation. This study aims to determine if the head-cup ratio predicts 90-day dislocation rate after primary THA.

Results: Eighty-six patients (1.4%) sustained a dislocation within 90 days postoperatively. We observed a temporal trend of increasing head size over this period, as well as decreasing dislocation rate. The optimal head-cup ratio to prevent dislocation was identified as ≥ 0.7 (AUC 0.61; sensitivity 79.1%, specificity 43.0%). Seventy-three of 86 dislocations (84.9%) occurred in patients with head-cup ratio < 0.7 . In our univariate analyses, a higher head-cup ratio ($p < 0.01$) and use of robotic technology (0.2 vs. 1.5%, $p = 0.02$) were associated with lower dislocation rate. Our logistic regression analysis demonstrated that higher head-cup ratio ($p = 0.01$), robotic use ($p = 0.04$) and lower Elixhauser scores ($p < 0.01$) were associated with decreased odds of dislocation.

Notes

The Effect of Dual Mobility Articulations on Re-Revision After Revision for Dislocation

Introduction: Recurrent instability and subsequent revisions remain persistent challenges after revision total hip arthroplasty. Dual mobility acetabular constructs may reduce dislocation and early re-revision risk, though long-term comparative data remain limited. This study evaluated whether dual mobility cups used during revision for instability are associated with lower re-revision rates than traditional fixed-bearing constructs.

Methods: A retrospective analysis of the Michigan Arthroplasty Registry Collaborative Quality Initiative identified 796 patients who underwent revision of elective primary total hip arthroplasty for dislocation between February 15, 2012, and December 31, 2023. Resurfacing, conversion and urgent cases were excluded. The primary outcome was time to re-revision. Cumulative percent revision (CPR) curves were compared using log-rank testing. A multivariable logistic regression model was used to evaluate odds of revision within two years, adjusting for age, sex, body size, smoking status and comorbidity status.

Results: The two- and five-year CPR for re-revision were 12.6% (95% CI, 10.1–15.0) and 17.1% (95% CI, 14.1–20.0), respectively. Dual mobility constructs had significantly lower CPRs than non-dual mobility (log-rank $p = 0.022$). At one year, CPR was 4.7% (95% CI, 1.8–7.5) vs. 11.3% (95% CI, 7.7–14.8); at two years, 6.8% (95% CI, 3.3–10.2) vs. 14.2% (95% CI, 10.2–18.0). By five years, confidence intervals overlapped: 12.3% (dual mobility) vs. 20.2% (non-dual mobility). The early protective effect persisted after adjustment; non-dual mobility constructs had significantly higher odds of revision within two years (odds ratio, 2.04; 95% CI, 1.2–3.5; $p = 0.009$).

Notes

Anterior Approach Is Associated with Lower Dislocation Risk for Isolated Head-Liner Exchange

Introduction: Isolated head-liner exchange (HLE) can be utilized as a less invasive option for specific indications in revision THA. Historically, the most common complication following HLE is dislocation. The objective of this study was to determine if the direct anterior approach (DAA) with medial capsule preservation results in a lower incidence of dislocation when compared to the posterolateral approach (PLA) for HLE.

Results: Femoral head size was increased in 53% of PLA and 35% of DAA. Elevated liners were placed in 36% of PLA HLE vs. 7% of DAA, and dual mobility construct (DMC) or a constrained liner in 10% and 6% of PLA, respectively, but in none of the DAA cohort. Dislocation occurred following HLE in 18/88 PLA hips vs. 1/29 DAA hips ($p=0.049$). The one dislocation in the DAA cohort had no subsequent instability events, while 8 of the PLA cohort dislocated more than once (range, 2-4). There were 11 reoperations, all in the PLA cohort (12.5% vs. 0%, $p=0.061$). Indications for reoperations included recurrent instability ($n=7$), PJI ($n=2$), periprosthetic femur fracture ($n=1$), and wound dehiscence ($n=1$).

Notes

Arthroplasty for Femoral Neck Fracture Can Be Delayed for Treatment with an Arthroplasty Surgeon

Introduction: The modern treatment paradigm for displaced femoral neck fractures favors early arthroplasty for medically optimized patients. Typically, these injuries are managed by the on-call orthopedist regardless of subspecialty training to facilitate prompt care. The aims of this study were to compare outcomes for patients treated with arthroplasty for femoral neck fracture performed by adult reconstruction subspecialized surgeons to those performed by surgeons of other orthopaedic subspecialties and to determine if surgery can safely be delayed to accommodate subspecialized care.

Results: We identified 752 patients who underwent hemiarthroplasty and 509 who underwent THA for displaced femoral neck fracture. Almost all included THAs were performed by arthroplasty surgeons (98.4% vs. 1.57%). Greater rates of in-hospital complications were not observed when delaying care over 36 hours for surgeries performed by adult reconstruction surgeons compared to those treated by non-adult reconstruction specialized surgeons within 36 hours ($P = 0.174$). Hip-related readmission rates and 90-day mortality did not differ significantly among the four cohorts ($P = 0.611$ and $P = 0.257$). For the outcome of 90-day readmissions, 91% power was achieved.

Notes

State of the Art Management of Periprosthetic Fractures of the Femur

This symposium will provide the latest techniques on the management of complex pelvic bone defects in revision total hip arthroplasty (rTHA). Audience members will leave with an enhanced understanding of preoperative planning, available reconstructive options, and intraoperative pelvic reconstructive techniques using various surgical approaches in rTHA.

1. To understand the advantages, disadvantages and indications for use of modular or monoblock femoral revision stems.
2. To identify helpful fracture reduction techniques to rebuild the femoral isthmus before or after stem implantation.
3. To understand the indications and utility of the proximal femoral replacement in cases of significant bony compromise or an unsalvageable proximal femur.
4. To illustrate the indications and utility of an extended trochanteric osteotomy and indications for using supplemental fixation (i.e. plating) to augment fixation of the revision THA.

George J. Haidukewych, MD



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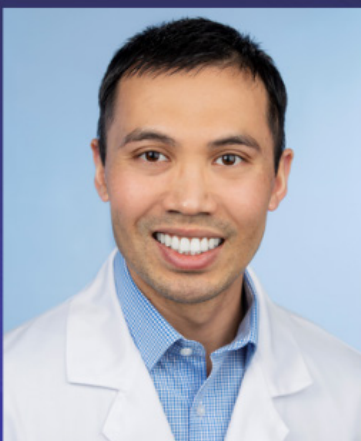
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