Meet Your Doctor

By Chris Motola / IN GOOD HEALTH / CNYHEALTH.COM

Tim Izant, M.D.

Orthopedic surgeon talks about new program at Crouse: 'Hip Today, Home Tomorrow' where patients go home a day after hip replacement

Q: Do you have a sub-specialty in your orthopedic practice?

A: I'm a sub-specialist in hip- and knee-replacement surgery.

Q: Are most of your patients older adults?

A: Actually, they vary in age. My patients range from 30 to 100. I've seen occasional urgent problems from people younger than that, down to kids.

Q: Have hip and knee replacement outcomes been improving?

A: Two of the operations that provide the most improvement of the quality of life for patients with medical problems are cardiac bypass surgery and hip and knee replacement. Most of the time the results are tremendous in restoring people's quality of life, improving their pain and getting them back on their feet. There's a small risk of complications, which there are for every specialty, but we enjoy some great improvements. In terms of technology, there are some advances every five years or so, but it's hard to make sudden changes without really knowing the long-term effects. So we're conservative about making advances without knowing how they'll function years from now.

Q: How about recovery time?

A: The new surgical approach to hip replacement allows for a much more rapid recovery from the surgery. The approach is called the "directly interior approach." That's been around for about 10 years. It was initially developed to try to do the surgery through a small incision. Early on they were using experimental implants and instruments that weren't very well developed. What's happened in the last five years is that instruments have been developed that allow us to better do the surgery through a small incision with standard implants.

Q: How much time are we talking about?

A: There's minimal muscle trauma, so the patient's initial recovery is incredibly fast. Even though I'm an experienced surgeon, it took several years of training to develop the skills. I've been doing it for a couple years now, and a whole bunch of my patients have been just flying out after surgery, leaving really fast. About a year ago, I noticed that a lot of my younger, healthier patients were going home the very next day. We were happy with that, so we rolled out a formal program where it was well-organized ahead of time to get the patients up, get them moving. Most of the patients that I anticipate going home the next day go home the next day.

I've partnered with Crouse to develop a formal program that we call Hip Today, Home Tomorrow. There are some places around the country that are even more aggressive and will try to do it as outpatient surgery, sending patients home the same day. We aren't interested in doing that. We think one night at the hospital allows us to have enough interactions with therapists and pain medications to allow us to safely send the patients home. After we send them home, we have a well-organized group of physical therapists and nurses who go to the patient's house and follow up on them.

Q: What are the factors that determine recovery time from surgery?

A: The size of the wound, the amount of muscle traumatized from the surgery. We aren't able to do [the low impact approach] for all patients. Patients that have difficult anatomy where we can't visualize everything through a small incision or have super tight ligaments or muscles I have to sometimes do the traditional approach for. It doesn't really matter what approach you use in terms of outcomes after three months. The advantage of the small incision is that it's a much quicker initial recovery.

Q: Are there similar procedures available for knee surgery?

A: There are less invasive procedures for knee replacement, but the exposure issue is more of a problem since you need to get a bigger device in there. There've been some issues where the small incision makes it harder to properly align the device, and there's not as significant an advantage in terms of recovery. There have been some advances with pain medication; knee replacement is a lot more painful and requires a lot more therapy. There are some places around the country trying outpatient knee surgery, but that's not really something on our radar.

Q: What are the typical causes of joint failure?

A: Arthritis, which is a breakdown of the cartilage, which is what we'll typically see in our over-60 patients. Some of my younger patients either have an abnormal hip from birth or childhood, or they've had injuries to the hip that have caused premature arthritis.

Q: In terms of upkeep, what do patients typically have to do post-surgery to keep the replacement in good shape?

A: I take only about 10 percent credit for my patients' results. The rest is due to my patients following through with physical therapy, particularly in the first three months. If they do that, they can expect good results. It takes a good year until you're 100 percent, mostly because it takes time to build the muscle back up.

Q: How did you become interested in surgery?

A: Being exposed to the operating room and general surgery in medical school. One of my rotations at the end of my third year was orthopedics, and I had the opportunity to assist the chairman of the department in taking care of a fractured forearm. I was just amazed by the beauty of the anatomy and the technology that allowed us to fix it by implanting plates and screws. You can take someone almost totally disabled and help them get back on their feet. And the surgery is actually a lot of fun to do. They call us "carpenters."

Q: Do you get an opportunity to get to know your patients prior to operating?

A: We get to know them briefly and intensely. If they haven't already received the conservative treatments from their primary, I'll initiate those. Once we've exhausted those, we'll discuss operative therapy. Some patients I get to know really well — I just saw a patient whose knee I replaced 25 years ago — some I'll be meeting for the first time to discuss the upcoming surgery. With the pressures of health care, we don't have that much time to spend with them, so I make use of some very talented physician's assistants. I couldn't keep up my quality of care without them.

Q: How long do the replacements last?

A: When we first started, we were telling patients they'd last 10 to 15 years. Now, with modern implants, I can safely say 20 to 25 years, if not longer.

Q: If they need a second replacement after a couple decades, is it easier to redo it?

A: No. From a surgical perspective it's actually a lot more difficult. From the patient's perspective, it's actually about the same or easier.

Lifelines

Hometown: *Cleveland*
Education: *Case Western Reserve University, Hospital University of Pennsylvania Affiliations: Crouse Hospital (chief of orthopedics), Syracuse Orthopedics Specialists*
Organizations: *American Academy of Orthopedic Surgeons, American Association of Hip and Knee Surgeons, American Medical Association*
Family: *Married (Lisa), four sons*
Hobbies: *Tennis, golf, photography, travel, family time*
Favorite Regional Attraction: *Green Lake*