INFECTION RISK ANALYSIS OF 101 SILVER-COATED ENDOPROSTHESSES

ANALIZA TVEGANJA ZA OKUŽBO PRI 101 POSREBRENIH ENDOPROTEZAH

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Our aim was to analyse the implant survival and infection rates of 101 consecutive silver-coated MUTARS® (= Modular Universal Tumour And Revision System) endoprostheses implanted at an independent orthopaedic tertiary hospital between April 1, 2011 and December 31, 2018 and to compare them with previous outcomes of the MUTARS® developmental hospitals. In addition, we tested the hypothesis that the infection-free survival rates of silver-coated implants depend on the patient’s age, gender, pre-operative diagnoses and anatomical localization of the reconstruction. The cohort included 47 sarcoma resections, 29 revision arthroplasties, 20 metastatic resections, 3 benign bone tumours and 2 primary arthroplasties. Endoprostheses was located in the distal femur (38 patients), proximal femur (29 patients), proximal humerus (12 patients), proximal tibia (10 patients), pelvis (6 patients), total femur (5 patients) and distal humerus (1 patient). The mean age at implantation was 49 (range 11–86) years and the mean follow-up 5.2 (range 0.1–7.7) years. Twenty-four patients required at least one subsequent revision operation and 15 endoprostheses had to be partially/totally removed. Patients’ age was an independent risk factor for postoperative infection regardless of other confounding factors (hazard ratio 1.05 for each year; p = 0.02). With the overall postoperative infection rate 12 % (4 % reinfection + 8 % newly acquired) and cumulative partial/total implant removal rate 25 % after 5 years, complications were comparable to the previous series of the MUTARS® developmental hospitals with high variability between preoperative diagnoses and anatomical localizations. Silver-coated implants show a consistent trend of preventing infections in high-risk body regions and enabling more successful treatment should infection occur, but 10–15 years of clinical follow-up is required for further assessment.

Keywords: bone defect, modular endoprostheses, silver coating

1 INTRODUCTION

In the past two decades the trend of bone defect reconstructions in limbs has shifted to the implantation of massive, large modular endoprostheses, with an inherent risk of periprosthetic infection, most likely by staphylococci. Endoprosthetic infections have been reported in up to 19 % of cases in proximal femur replacements, up to 11 % of cases in distal femur replacements, up to 23 % of cases in proximal tibia replacements and up to 43 % of previously infected endoprostheses. Manufacturers have been trying to reduce endoprosthetic infection rates with antimicrobial implant surfaces like antibiotic-based, antiseptic, photo-active-based or silver coatings. Antibiotic coatings have limited duration of drug elution and the risk of resistance, while effective antiseptic coatings (chlorhexidine, chloroxylenol) also exhibit toxicity. The nanostructured topography of the implants has also been tested in vitro for anti-bacterial properties, whereby mesenchymal and embryonic stem cells were unable to grow on surfaces with particular TiO2 nanotube dimen-
sions\(^\text{14}\). Metallic coating with silver has a low level of human toxicity and longer-lasting antimicrobial silver ion activity since the ions are only released into solution from the implant surface at negative pH values.\(^\text{15,16}\) The antimicrobial efficacy of silver-coated endoprostheses has not yet been confirmed in randomized controlled studies, but several retrospective studies analysed different implants.\(^\text{17,18}\) Among them the widely used MUT ARS® system (= Modular Universal Tumour And Revision System, Implantcast GmbH).\(^\text{1,4-6,19-24}\) These studies were either conducted by the main developmental hospital of this manufacturer (University Hospital Münster, Münster, Germany)\(^\text{1,3,6,15,21,24}\) or in smaller centres with patient series of 25–40 patients and < 2 years follow-up.\(^\text{1,5,20,22,23}\) So far no study has been published by an independent institution with the entire cohort of a hundred silver-coated MUT ARS® implants and over 3 years of mean follow-up.

The aim of the presented study was to analyse the infection rates and implant survival rates of the entire cohort of 101 consecutive silver-coated MUT ARS® modular endoprostheses implanted at an independent orthopaedic tertiary hospital with up to 7.7 years of follow-up and to compare them with previously published outcomes of the developmental hospital for this endoprosthetic system. In addition, we tested the hypothesis that the infection-free survival rates of silver-coated implants depend on the patient’s age, gender, pre-operative diagnoses and anatomical localization of the reconstructed bone defect.

### 2 MATERIALS AND METHODS

A retrospective observational study of prospectively collected data included an entire cohort of patients with silver-coated MUT ARS® endoprostheses implanted at a single orthopaedic oncolgical tertiary hospital between April 1, 2011 and December 31, 2018. Medical documentation was collected from the archives in order to obtain the data on: pre-operative diagnosis, patient’s age and gender at the time of surgery, localization of the bone defect to be reconstructed, implanted MUT ARS® endoprosthesis type, all recorded complications during implantation and in the course of the follow-up period, possible revision operations, the need for partial/total implant removal and infection-free implant survival until December 31, 2018 or possible death before the end of the observation period. None of the patients was excluded from the study or lost from the follow-up.

Statistical data analysis was performed with Office Excel 2016 (Microsoft Corp, Redmond, WA) and IBM SPSS Statistics 23.0 for Windows (IBM Corp, Armonk, NY). Cumulative incidences of partial/total implant removal for any reason were assessed after 1, 2 and 5 years of follow-up. The survival of silver-coated MUT ARS® implants until infection, until the first revision or until partial/total implant removal was assessed with the Cox regression models and covariables of age, gender, preoperative diagnoses (sarcoma resection, metastasis resection, revision of previously uninfected arthroplasty, revision of previous artificial joint infection) and anatomical localization (proximal and total femur, distal femur, proximal tibia, humerus, pelvis). Statistical significance was set at \(P \leq 0.05\).

### 3 RESULTS

The study cohort included 101 consecutive silver-coated MUT ARS® endoprostheses with 47 cases of primary sarcoma resection, 29 revision arthroplasties after previous reconstruction (18 previous joint arthroplasties and 11 previous sarcoma resections), 20 metastatic resections, 3 aggressive benign bone tumours and 2 complex primary total knee arthroplasties. The endoprosthesis was located in the distal femur in 38 patients, proximal femur in 29 patients, proximal humerus in 12 patients, proximal tibia in 10 patients, pelvis in 6 patients, total femur in 5 patients and distal humerus in 1 patient. The mean age at implantation was 49±20 years (range 11–86 years) and the mean follow-up of patients was 3.2 ± 2.2 years (range 0.1–7.7 years). We recorded 4 local tumour relapses and 20 patients died due to oncological disease.

Twenty-four patients (24 %) required at least one surgical revision of the silver-coated implant at a median 1.1 year after the initial implantation and 15 endoprostheses (15 %) had to be at least partially replaced or entirely removed. Nine patients in the cohort had previously been diagnosed/treated for artificial joint infection before the silver-coated MUT ARS® endoprosthesis was installed and therefrom 4 infections subsequently recurred; with an additional 8 cases of newly acquired deep infections after the silver-coated MUT ARS® endoprosthesis implantation the total deep infection rate was therefore 12 cases (12 %). In the subgroup of newly acquired infections, 1 case was in the proximal femur (3 % location-specific infection rate), 3 in the distal femur (8 % location-specific infection rate), 2 in the proximal tibia (20 % location-specific infection rate) and 2 in pelvis (33 % location-specific infection rate). Altogether, 6 silver-coated MUT ARS® implants had to be explanted eventually due to infection and 6 were retained with cured infection. Cumulative incidences of at least partial replacement or entire implant removal for any reason were 4 % after 1 year (1 % mechanical reasons / 3 % infection), 15 % after 2 years (9 % mechanical reasons / 5 % infection / 1 % tumour relapse) and 25 % after 5 or more years of follow-up (13 % mechanical reasons / 8 % infection / 3 % tumour relapse).

When the infection-free survival of silver-coated MUT ARS® implants was assessed with the Cox regression models and covariables of age, gender, preoperative diagnoses and anatomical localization (Table 1), it
turned out that a higher age at implantation was an independent risk factor for implant infection, regardless of all the other confounding factors (hazard ratio 1.05 for each year; \( p = 0.02 \)). There was also a trend of shorter infection-free survival rates in patients with previously diagnosed/treated infection (Figure 1) or pelvic resection (Figure 2), but the trend was not statistically significant. On the other hand, age, gender, preoperative diagnoses and anatomical localization had no statistically significant impact on Cox regression implant survival until the first revision or partial/total implant removal.

4 DISCUSSION

The limitations of the presented study include retrospective design, a high percentage of deceased patients for oncological reasons and consequently a high number of censored observations. Furthermore, the results in revision arthroplasty patients are difficult to analyse within or between different centres due to different diagnostic methods of infection (e.g., sonication), perioperative antibiotic regimens, number of previous surgical procedures and pre-existing infections. All these limitations were also present in all other recent studies of this topic1–6,19–24 where the infection-rate variability of silver-coated implants was larger between different patient populations (primary resection, metastases, revision, previous infection) and anatomical localizations than between different implant types (silver-coated vs. non-coated).2 However, within each selected patient population and anatomical localization, silver-coated implants have consistently shown lower infection rates in comparison to other implants18,25-26 and our results corroborate these findings in the setting of an independent institution with longer follow-up from previous smaller patient series.4,5,20,22,23 The overall 12 % infection rate of the presented study is almost identical to the previously

**Table 1:** Cox regression model of infection-free survival in the entire cohort of 101 silver-coated MUTARS® implants with covariables of age, gender, preoperative diagnose and anatomical localization (overall score Chi-square 24.2; \( p < 0.01 \)). Statistically significant P-values \( \leq 0.05 \) are marked with an asterisk (*).

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE</th>
<th>Exp(B)</th>
<th>95 % CI</th>
<th>P-value</th>
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<td>0.03</td>
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<td>0.00</td>
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B-regression line coefficient, SE-standard error, Exp(B)-hazard ratio, CI-confidence interval, [ref]-reference category
published series of mixed primary resections with revision arthroplasty where Glehr et al.\(^27\) reported an infection rate of 12.5 % among 32 patients who had been treated with MUTARS® silver-coated endoprostheses and Wafa et al.\(^28\) reported an overall postoperative infection rate of 11.8 % in the silver-coated group of 85 Agluna-Stanmore Implants. Likewise, Schmolders et al.\(^4\) had to perform revision operations due to infection in 10 % of their implanted silver-coated MUTARS® endoprostheses after a median follow-up of 24 months for primary or metastatic oncological patients. On the other hand, infection rates for silver-coated implants in primary tumour resections (i.e., unrevised and uninfected previously) of selected anatomical localizations (proximal and distal femur) were consistently lower: 3–8 % in the presented study and 4–7 % in the studies of the main MUTARS® developmental institution.\(^6\)

The presented study is the first one in the field of silver-coated implants to demonstrate patients’ age has as an independent risk factor of infection. This finding is not surprising as age-related higher complication rates have already been identified in the treatment of uncoated endoprosthetic infections,\(^29\) the osteosynthesis of long bones,\(^29\) and spinal fusion.\(^30\) Although the patients’ age itself is a non-modifiable factor, additional precautionary measures could be applied in elderly patients to reduce the implant infection risk, e.g., different perioperative antibiotic regimens, the use of local muscular flaps to ensure sufficient soft-tissue coverage or earlier aggressive drainage of haematoma.\(^31\) Not in the least, our findings indicate that age should be one of the factors when deciding upon the optimal radicality of the bone tumour resection or the complexity of the bone defect reconstruction in elderly patients.

5 CONCLUSIONS

This is the first study of a large MUTARS® silver-coated endoprosthetic cohort performed by an independent institution with up to 7.7 years of follow-up. With the cumulative partial/total implant removal rate of 25 % after 5 years and postoperative infection in 12 % of cohort patients, the complication rates were comparable to the previously published series of developmental hospitals with a high variability in results between different preoperative diagnoses and anatomical localizations. Patients’ age at implantation was identified as an independent risk factor for subsequent infection, regardless of all the other confounding factors.

Acknowledgment

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Ethics statement

The study protocol was reviewed and approved by the National Medical Ethics Committee of the Republic of Slovenia on September 19, 2017, case no.# 120-486/2017. All procedures performed in studies involving human participants were in accordance with the institutional/national ethical standards and with the Helsinki declaration and its later amendments.

Conflict of interest

The authors declare they have no conflict of interest.

6 REFERENCES


