

Australian Orthopaedic Association National Joint Replacement Registry

2025 SUPPLEMENTARY REPORT

Lay Summary: Hip, Knee and Shoulder Replacement



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National
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Lay Summary
Hip, Knee and Shoulder Replacement

2025 Supplementary Report

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National Joint Replacement Registry**

2025 Supplementary Report

**Lay Summary:
Hip, Knee and Shoulder Replacement**

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AOANJRR Data Snapshot 2024



2,285,453

Total number of joint replacement procedures reported by the Registry at the end of 2024



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Over a billion dollars of estimated benefit to the national health system accruing from AOANJRR activities

Joint replacement procedures performed in 2024

60,414

Hips

79,331

Knees

11,306

Shoulders



43

Hospital Audit Requests



1,173

Individual Surgeon Reports



33

Conference presentations



37

Journal Articles Published

National PROMs Data Collection

June 2025 Update

Participating Hospitals

244

Pre-Op PROMs

149,121

Post-Op PROMs

108,818

Pre-Op Completion Rate

74.1%

Post-Op Completion Rate

63.0%



Total Number of Hospitals Onboard per State / Territory:

- SA: **29**
- NSW: **66**
- NT: **3**
- QLD: **45**
- ACT: **6**
- VIC: **66**
- WA: **22**
- TAS: **7**

% patient-reported change following hip, knee, or shoulder joint replacement as "much better"

84.9%

% patient "very satisfied" or "satisfied" following hip, knee, or shoulder joint replacement

87.5%



162,434

Patient participation through AOANJRR patient dashboards



841

Total number of surgeons participating

Introduction

This summary is an explanation of the major findings of the Australian Orthopaedic Association National Joint Replacement Registry 2025 Annual Report for Hip, Knee and Shoulder Arthroplasty (replacement). This is the major clinical report produced by the Registry each year. The full version of the 2025 Annual Report on Hip, Knee and Shoulder Arthroplasty is available in the 'Publications' section of the Registry website

<https://aoanjrr.sahmri.com/annual-reports-2025>.

The Lay Summary is provided to ensure that a clear, concise, and easily understood explanation of the published findings are available to all those who may be interested. The Lay Summary also provides guidance for those who may wish to further review the full extent of the data published by the Registry in the Annual Report. The Australian Orthopaedic Association (AOA) believes this is especially important because of the high level of community interest in the Registry and the need to ensure that reports are accessible to all.

This year's report involved the analysis of 2,285,453 primary and revision procedures (972,256 hips, 1,205,616 knees and 107,581 shoulders).

This is the total number of hip, knee and shoulder replacement operations recorded by the Registry with a procedure date up to and including 31 December 2024. Some of the prosthesis designs reported since the Registry first began collecting data in 1999 are now no longer used.

Understandably, the performance of many of these older designs is not quite at the same standard as the currently used prostheses (described as 'modern prostheses'). To ensure that the relevance and currency of AOANJRR data are maintained, almost all analyses (unless specifically stated) have been limited in this year's report to modern hip, knee and shoulder prostheses, i.e. those prostheses that were still being used in 2024. Most of the operations that have been reported to the Registry over the years have used modern prostheses. The effect of not including prostheses that are no longer used is that overall outcomes reported for the different device classes are better, and a smaller number of individual prostheses/prosthesis combinations are listed in the report.

In addition to the Annual Report and this Lay Summary, there are a further 13 supplementary reports published by the Registry on the website: <https://aoanjrr.sahmri.com/annual-reports-2025/supplementary>.

A Brief History of the Registry Origins

The AOA started the National Joint Replacement Registry in 1999. It was initially for hip and knee replacement only. This was a complex system to set up, and therefore it took almost 3 years to fully implement the Registry across Australia. Since mid-2002, the Registry has received information on almost all hip and knee replacements undertaken in Australia. The Registry receives this information from over 300 hospitals.

In November 2007, the Registry commenced national data collection on a number of additional types of joint replacement. This included shoulder joint replacement procedures, the analysis of which is presented along with hip and knee replacement in the main report. The other additional types of joint replacement that the Registry collects information on include elbow, wrist, ankle, and spinal disc replacement. The analysis of these procedures is presented in the supplementary reports available on the Registry website.

In 2018, the Registry started collecting information directly from patients. These are known as patient-reported outcome measures (PROMs). The Registry collects this information from people happy to provide it, both before and 6 months after their operation. The purpose is to better understand the results of joint replacement by having good information from patients on the extent of problems that they have, not only with the joint being operated on, but also their general health and then how these change after the operation.

PROMs data are collected directly from patients invited by the Registry to answer a number of electronic survey questions. The questions are designed to provide an overview of a patient's general health, their ability to complete everyday activities and how much pain they are getting from the joint. By asking these questions before and after surgery, as well as additional questions about how happy they are with the joint replacement, the Registry is able to better understand the extent of problems that patients are having before their operation and then how much this has changed after it. This data provides really important new information that the Registry has not previously had, which is the patient's opinion on the benefit or otherwise of the joint replacement.

The Purpose of the Registry

The AOA started the Registry to improve the results of joint replacement surgery in Australia. Generally, this type of surgery is very successful but as with all areas of healthcare, there is always room for improvement. Since the Registry commenced data collection, there has been an improvement in the outcomes of this surgery.

One of the most serious consequences of a less than successful operation is the need to have a revision (redo) operation. The Registry provides information to assist surgeons to keep the number of these operations to a minimum. It does this by identifying those things that work best and highlighting what can be improved.

Supplementary Reports

The Registry publishes data in addition to that included in the Annual Report, in the following Supplementary Reports:

1. Partial Shoulder Arthroplasty

Detailed information on Partial Shoulder Replacement is available in this supplementary report. A summary of Partial Shoulders is provided in the main report.

2. Demographics of Hip, Knee and Shoulder Arthroplasty

This report details the age and gender profile of people receiving hip, knee or shoulder replacement and includes information on the reasons for undergoing replacement surgery.

3. Cement in Hip and Knee Arthroplasty

This report details the use of the different types of cement in hip and knee replacement surgery.

4. Mortality of Hip, Knee and Shoulder Arthroplasty

This report details the risk of dying following the different types of hip, knee and shoulder replacement surgery.

5. Shoulder Arthroplasty Comparative Analyses: No Difference Observed Supplementary Report

This report presents data from AOANJRR analyses of shoulder replacement. The comparisons show no significant difference.

6. Metal/Metal Bearing Surface in Total Conventional Hip Arthroplasty

This report details the outcome of metal/metal bearings when used with large (greater than 32mm) femoral heads.

Prior to establishing the Registry, Australian orthopaedic surgeons felt they had a lack of detailed information on the results of the many different procedures and types of joint replacement available. In particular, the surgeons required information to compare the impact of the many different factors known to influence the results for their patients.

Surgeons have a large choice of different types of artificial joints that they can use to replace damaged and painful joints. There are also different techniques that can be used to put these artificial joints in place. Surgeons know that there is variation in the results depending on the patient, the nature of the patient's problem, which joint is being replaced, the way the operation is performed, and the type of artificial joint replacement used.

The Registry is able to compare all of these different factors simultaneously. In doing so, it provides information to assist surgeons to decide the best type of artificial joint replacement to use in any particular situation. The Registry can detail the results for different classes (or categories) of artificial joints and different individual types of artificial joints in each of the classes. It can also determine if patient age, gender, weight, general health, and/or the reason a joint replacement is performed affect the result.

It is important to emphasise that this is not the only information that is used to determine what the best approach should be. When providing advice to patients, surgeons will also rely on their training and experience as well as information from medical journals, other registries elsewhere in the world, conferences, and courses they may attend, as well as learning from other surgeons.

The Registry provides information to assist in deciding the best type of artificial joint replacement to use in any particular situation.

When surgeons interpret information from the Registry, they use their knowledge and experience to put that information into context. The Registry does not decide or recommend the best joint replacement for a particular patient. This can only ever be decided by the surgeon in consultation with the patient. In this way, all factors relevant to each individual patient can be carefully taken into consideration.

Supplementary Reports

7. Demographics and Outcomes of Elbow and Wrist Arthroplasty

This report details the age and gender profile of people receiving elbow and wrist surgery. It includes reasons for undergoing these different types of joint replacement as well as some early information on the outcome of these operations.

8. Demographics and Outcomes of Ankle Arthroplasty

This report details the age and gender profile of people receiving ankle joint replacement and reasons for undergoing ankle replacement as well as some early information on the outcome of this operation.

9. Demographics of Spinal Disc Arthroplasty

This report details the age and gender profile of people receiving spinal disc replacement and reasons for undergoing this operation.

10. Shoulder Replacement in Australia

This report presents a broad overview of shoulder arthroplasty outcomes as reported to the AOANJRR.

How the Registry Works

The Registry collects a small amount of confidential information on each joint replacement operation undertaken in Australia, with the exception of those people who choose not to have their information collected by the Registry.

The information collected includes age, gender, weight, height, general health, the reason for the surgery, the joint type, and whether it was on the right or the left side. Information on the type of artificial joint and the components used in the operation are also collected.

Currently the Registry monitors and has information on over 2 million joint replacement operations.

As previously mentioned, if a problem occurs following a joint replacement one of the possible outcomes is that the operation is redone. This is referred to as a revision procedure. The Registry is notified about the revision, records this information and links it to the first (or primary) operation. The Registry can then determine how many primary procedures have been revised, the reason for the revision, how long after the original surgery, and can also record which of the components (if any) were replaced.

Who Funds the Registry?

The Commonwealth Government, through the Department of Health, Disability and Ageing, funds the Registry. The Government and the Department have been very supportive of the Registry. They provided the initial funding to establish the Registry and have maintained its core funding since the Registry commenced.

Supplementary Reports

11. Prosthesis Types with No or Minimal Use

This report details the outcomes of classes of hip and knee replacement that are no longer used or have minimal use and therefore do not appear in the main report.

12. Comparative Prosthesis Performance

This report provides summary data and outcomes for comparative prosthesis performance.

13. Patient Reported Outcome Measures (PROMs)

This report provides information on patient reported outcome measures (PROMs) which are surveys that assess dimensions of health from the perspective of the patient.

How the Registry Presents the Results

The fact that the Registry is a national database means it reports on the results of a very large number of operations, which improves the value and accuracy of the information. Currently, the Registry monitors and has information on almost 2 million joint replacement operations.

The Registry presents the results in different ways. The clearest and most important way is by graphs and tables. We know the time until the redo (revision) operation and so we can calculate the percent of procedures that have been revised at 1, 2, and 3 years after the original procedure. This is known as the cumulative percent revision. There are many things that can affect this i.e. make it lower or higher. The aim is to identify what things make the cumulative revision rate lower, which means that there is less chance of needing to have the operation again. This is done by comparing results of surgery undertaken in different types of patients (young vs older, male vs female, heavy vs normal weight, etc.), different types of joint replacement prostheses, and different techniques for implanting the device. Examples of different techniques include the use of different types of instruments, or robotic surgery, or the operative approach. By comparing these different groups, we are not only able to understand what works better in certain situations but also what does not work so well.

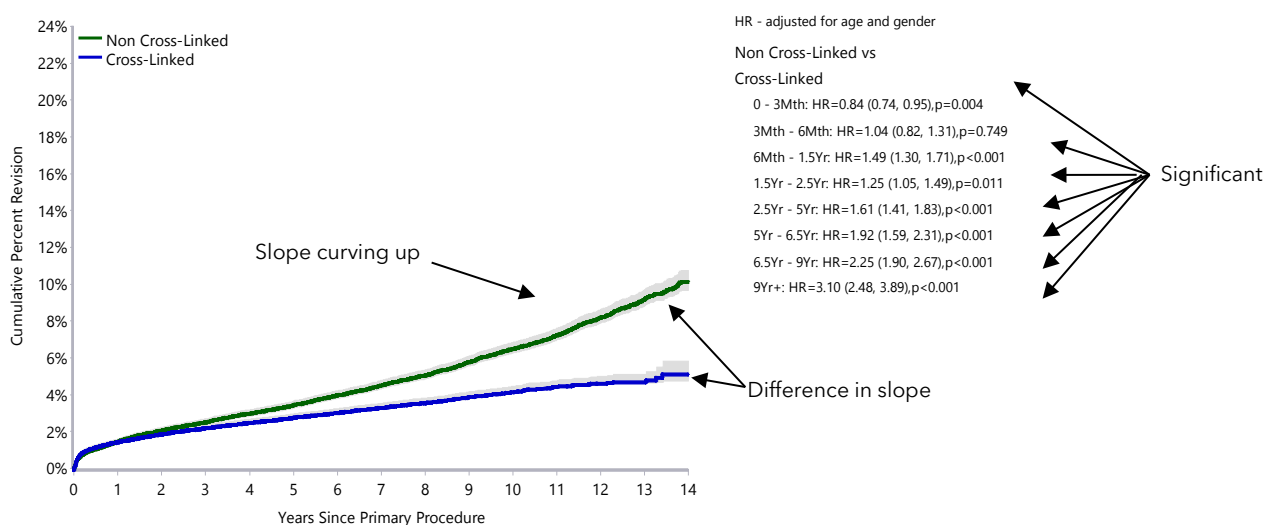
GRAPHS

To assist in the interpretation of any difference, the Registry often graphs the results. Figure L1 (below) is a typical example of a cumulative percent revision graph which is comparing two different types of plastic used in hip replacement. The cumulative percent revision which gets progressively greater as time progresses is plotted for each group at specific times since the original surgery. The time period scale is usually in years since the first operation.

The lines on the graph represent the results for the factors being compared. The more the lines slope upwards the greater the number of revision (redo) operations that have been done. In general, the greater the difference in the slope of the lines the more important the difference. This graph shows that there are more revisions when non cross-linked polyethylene (the green line) is used compared to cross-linked polyethylene (the blue line).

The information on the right-hand side of each of these graphs is important. This gives a measure of the amount of difference, how this is changing with time, and how confident you can be that the difference is real. The most important information is the HR (hazard ratio) and the p (probability) value. These are explained a little further down.

Example of a graph with Cumulative Percent Revision which compares the results of two different types of bearing surfaces commonly used in joint replacement surgery (cross-linked and non-cross-linked polyethylene)



TABLES

The Registry also reports data in cumulative percent revision tables (see below) which accompany these graphs. These tables give the number of revisions as a percentage of the number of operations at particular times, i.e. 1 year, 3 years, etc. The numbers are simply the values on the graph at these specific time points and are listed to provide the actual number for each year so that the number does not need to be guessed at by looking at the graph.

This table also shows some values in brackets after the main number i.e. at 10 years the main number is 5.3%, which means that at 10 years if you are still alive you have a 5.3% chance of having a revision. The reason that there are numbers in brackets afterward (in this case 5.2 and 5.4) is that 5.3% is not an exact number, it is an estimate based on the analysis of all the data. The numbers in the brackets represent the 95% confidence interval. This means that the estimate is 5.3% and there is 95% confidence that the actual or real number is somewhere between 5.2% and 5.4%. This is a small confidence interval which is usually when the number of operations is

large. When the confidence interval is small the estimate is likely to be accurate.

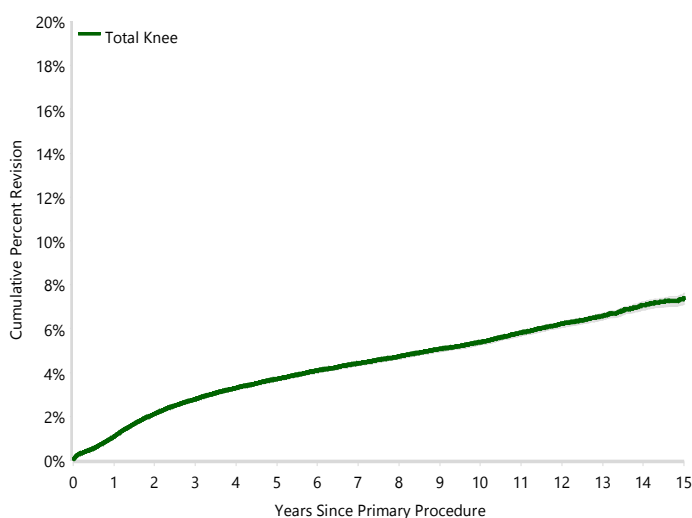
On occasion, the Registry provides only cumulative percent revision tables and does not provide the graphs. This is usually when the results of many different replacements in one category are being presented. The reason the graphs are not provided for each of the different replacements is simply a space issue. It would make the report too large.

When examining the tables, it can be seen that there is variation in the outcome of the different prostheses that are listed. It is important to understand that just because a prosthesis combination has a higher cumulative percent revision than other prosthesis combinations, it does not necessarily mean that the combination is not as good. It is possible that this difference in the number of revisions between the prostheses has occurred by chance rather than being a true difference. In reality, most but not all prostheses have equally good results.

Example of a table and corresponding graph

Figure KT12 Cumulative Percent Revision of Primary Total Knee Replacement (Primary Diagnosis OA) from the 2017 Registry Annual Report

Knee Class	N Revised	N Total	1 Yr	3 Yrs	5 Yrs	7 Yrs	10 Yrs	15 Yrs
Total Knee	17213	482373	1.0 (1.0, 1.1)	2.7 (2.7, 2.8)	3.6 (3.6, 3.7)	4.4 (4.3, 4.4)	5.3 (5.2, 5.4)	7.3 (7.1, 7.6)
TOTAL	17213	482373						



HAZARD RATIOS

Hazard Ratios (HR) are used to compare 2 different factors such as non cross-linked poly (non XLPE) compared to cross-linked poly (XLPE). The HR is an indication of the difference in the risk of revision for non XLPE compared to XLPE. For example, if the HR=3, this means that there is a three times greater risk of being revised. If the HR=1, then this means that there is no difference. If the HR=0.5 then this means that that risk of revision is half.

The p value is a measure of the likelihood that a difference observed between groups being compared is real, rather than occurring by chance. In statistical terms, this is called significance. The difference is regarded as significant (in other words likely to be true) if a p value is smaller than 0.05. A p value of 0.05 means that there is a 1 in 20 chance that the difference is not true. A p value of 0.001 means that there is only a 1 in 1,000 chance that the difference is not true. In other words, it is more certain that the difference is real.

Quite often different hazard ratios (HRs) are listed for different time periods as above. The time period is the number that is on the left. The values in the brackets after the HR number are the possible lower and upper limits of the HR. The reason that these numbers are given is that the HR number is an estimate just like the revision estimate and the numbers in the brackets indicate that there is a 95% degree of certainty that the actual HR falls within this range. Again, in the same manner as the revision estimate. For instance, the first entry in Figure L3 (below) referring to the 0-3 month period has a lower limit of 0.74 and an upper limit of 0.95. The HR value of 0.84 is the arithmetic mean (average) value of the upper and lower limit but because this is an

estimate there is a possibility that the actual HR is not this figure but there is a 95% likelihood that it falls within the range identified by the numbers in the brackets.

When the Registry compares two different factors, such as non cross-linked to cross-linked polyethylene, to see if there is a difference, it also tests whether that difference changes with time. That is why all the different time periods are listed. With this particular comparison, it can be clearly seen that the difference between the two different polyethylene types is increasing as the time after the original operation increases i.e., the HR is increasing with time after surgery.

The length of time after the initial operation, when differences become evident, is an important piece of information in helping to determine why there is a difference. Using Figure L3 as an example, the HRs have been divided into eight time periods, the time from the joint replacement to 3 months after the surgery, then 3 months following the surgery to 6 months, and so on. There are many reasons why some things may differ soon after surgery and these reasons often change as the time after surgery increases. What can also happen, as is the case in the example provided, is that the extent of difference can vary with time; sometimes the difference is greatest early, and other times the difference may increase as time progresses which is what has occurred with this example. In some graphs, the difference does not change with time but is the same from start to finish. When this occurs then instead of having a list of different time periods, only one HR will be given, and it will state that the HR is over the entire period.

Example of a hazard ratio from a Registry graph

HR adjusted for age and gender	
Non Cross-Linked vs Cross-Linked Polyethylene	
0-3Mth:	HR=0.84 (0.74, 0.95),p=0.004
3Mth-6Mth:	HR=1.04 (0.82, 1.31),p=0.749
6Mth-1.5Yr:	HR=1.49 (1.30, 1.71),p<0.001
1.5Yr-2.5Yr:	HR=1.25 (1.05, 1.49),p=0.011
2.5Yr - 5Yr:	HR=1.61 (1.41, 1.83),p<0.001
5Yr - 6.5Yr:	HR=1.92 (1.59, 2.31),p<0.001
6.5Yr - 9Yr:	HR=2.25 (1.90, 2.67),p<0.001
9Yr+:	HR=3.10 (2.48, 3.89),p<0.001

Revision Arthroplasty

Introduction

This chapter provides an updated analysis of outcomes following 1st revision of hip, knee, and shoulder replacement. The 2023 chapter focused on revision for infection, while the 2025 chapter examines aseptic revision arthroplasty. It builds on the 2015 and 2020 chapters and incorporates new findings on shoulder revision. The Registry regularly reviews this topic to monitor evolving techniques and indications for revision. For each joint, it reports reasons for revision and outcomes of major total, major partial, and minor revisions, as well as mortality following aseptic 1st revision.

Reasons for revision

A revision is required when the 1st joint replacement no longer functions effectively. Common causes include loosening, instability or dislocation, infection, and fracture. Some patients require multiple revisions over time.

Hip revision

The most frequent reasons for a 1st hip revision are loosening, instability, and fracture. Cementless fixation reduces the likelihood of further revision when the femoral component is revised for loosening. Dual mobility bearings lower the risk of subsequent dislocation after a 1st revision for instability. The use of metal with non-XLPE increases the risk of re-revision compared with metal or ceramic with XLPE. The posterior approach is most commonly employed, while the anterior approach is associated with a higher rate of 2nd revision. Mortality following the 1st hip revision is lowest when the indication is loosening and highest when the indication is fracture.

Knee revision

The most common indications for the 1st knee to be revised are instability/dislocation, loosening, infection, and instability. Patients with higher ASA scores and elevated BMI are at greater risk of early infection. Over time, the proportion of 1st revisions performed for loosening has decreased. Surgeons are increasingly using fully stabilised or hinged prostheses, with fewer minimally stabilised designs. Cemented fixation remains the most common approach. Minor revisions are performed most often. Major total revisions demonstrate greater longevity than major partial revisions and perform better than minor revisions in the short term, although this difference diminishes over time. The risk of further revision depends on the 1st indication, with patella-related cases showing the lowest risk and arthrofibrosis the highest. When the 1st revision is performed for loosening, the use

of fixation-supporting devices such as metaphyseal sleeves, cones, and stem extensions is associated with a reduced rate of 2nd revision. For patella-related cases, most 1st revisions involve the patella alone or with a tibial insert, and these knees often lacked a patella component at the primary operation. In cases of instability, many revisions involve either an insert-only procedure or a full knee revision. Fully stabilised components perform better than posterior stabilised designs in this context. Mortality after 1st knee revision is higher for infection and fracture, and lower for arthrofibrosis, when compared with loosening.

Shoulder 1st revision

Both primary anatomic and reverse shoulder replacements undertaken for all diagnoses are most frequently revised at aseptic 1st revision for instability/dislocation and loosening.

ANATOMIC SHOULDER REPLACEMENT

Most patients are female, with most having an ASA score of 2 or 3 and BMI within the pre-obese or class I obese range. The most common reasons for 2nd revision are instability or dislocation, followed by loosening. 2nd revisions typically involve replacement of both humeral and glenoid components, or the humeral component alone. Revision of an anatomic to a reverse shoulder replacement results in a lower risk of 2nd revision compared with a primary reverse revised to another reverse replacement. Platform prostheses allow retention of the humeral stem at the time of revision when implanted during the primary procedure, and stem retention does not alter 1st revision risk. Over the reporting period, minor revisions underwent 2nd revision more frequently than major total and major partial revisions, with major total revisions failing more often than major partial. Isolated head revision carries a higher risk than humeral revision. Glenoid or combined humeral-glenoid revision has a higher risk than humeral revision. Early 1st revisions, performed within two years, are associated with an increased risk of subsequent revision, although outcomes have improved in recent years. Younger patients have a higher risk than older patients, while ASA score and BMI do not significantly influence revision risk. Loosening and instability or dislocation are more likely to result in 2nd revision than rotator cuff insufficiency. Breakage of the glenoid insert increases risk beyond the early postoperative period. Short-term mortality following anatomic shoulder 1st revision is low.

REVERSE SHOULDER REPLACEMENT

1st revisions are slightly more common among males. Most patients have an ASA score of 2 or 3 and a BMI in the pre-obese range. The primary reasons for 2nd revision are instability or dislocation, infection, loosening, and fracture. A humeral component-only revision is the most common 2nd revision procedure. Retention of the humeral stem during the 1st revision does not affect 2nd revision risk. Minor revisions are the most frequent category, with outcomes broadly similar across classes. The typical 1st revision involves replacement of the humeral component, followed by cup or head exchange. Combined humeral-glenoid 1st revisions show a higher early risk compared with head or cup revisions, although this difference diminishes with time. Early 1st revisions, performed within two years, are associated with a higher very early risk, after which outcomes align with those of later revisions. Results are consistent across earlier and more recent time periods.

Younger females have a higher 1st revision risk than older females. Age has no significant impact on outcomes in males, whose results are comparable to females of the same age. ASA score and BMI do not affect the 1st revision risk. Compared with the 1st revision for fracture, the risk of 2nd revision is higher for loosening, instability/dislocation, or rotator cuff insufficiency at 1st revision. Long-term mortality following reverse shoulder replacement 1st revision is higher than that of an anatomic replacement 1st revision.

Conclusion

Revision arthroplasty remains complex, with outcomes influenced by joint type, indication for revision, surgical techniques, and patient health. Advances in prosthesis design and surgical methods have improved results, though significant challenges persist. Continued monitoring of these patterns supports improved patient care and guides future research.

Ten, Fifteen and Twenty Year Prosthesis Outcomes

This chapter provides information on hip and knee prostheses that have the longest follow-up in the Registry. It is very important to understand what the revision rates for different types of joint replacement are in the long term. The aim of joint replacement surgery is to relieve pain and restore function for as long as possible. Those prostheses with the lowest rates of revision over many years achieve this best.

Since the Registry commenced data collection, the risk of a revision operation has gone down. A major reason for this has been the improvement in the prostheses used. Since the Registry started collecting data over 20 years ago, many of the prostheses being used back then are no longer available. When considering which are the best prostheses to use, there is little point in considering the results of devices that are no longer available. It is for this reason that only procedures using prostheses that have been available and used in 2024 (described as modern prostheses) are included in these analyses.

Ten Year Outcomes

This year, the Registry is reporting on the outcome of 45 different modern hip prostheses (combinations of femoral and acetabular prostheses with at least 10 years of follow-up). Prostheses with 10 years of follow-up data account for 79.9% of all primary total conventional hip procedures being undertaken in Australia. The cumulative percent revision of primary total hip procedures that have 10 years of follow-up data varies from 2.5% to 8.0%. In this analysis, two groups of devices have been identified that have performed to a high standard, i.e. they are revised less often than other devices. There are prostheses with what is referred to as a 'superior benchmark' and then a second group which have been identified as having a 'non-inferior benchmark'.

All of these devices have proven low revision rates at 10 years. The superior benchmark devices have either a slightly lower revision rate than the non-inferior benchmark devices, or the certainty of the lower revision rate is higher. Both of these groups have what is regarded as low revision rates at 10 years. The Registry identified 11 hips with a superior benchmark and an additional 9 hips with a non-inferior benchmark. In other words, of the 45 different modern hip prosthesis combinations, 20 (44.4%) are identified as having low revision rates at 10 years. This is regarded as a very good result for these 20 different hip replacements.

It is important to appreciate that many factors contribute to the revision rates of different prostheses and many of the prostheses not identified as having a superior or non-inferior performance are likely to give excellent results. Surgeons are always happy to discuss the choice of prostheses with patients as it is a chance to alleviate any concerns around this.

A similar analysis was undertaken for primary total knee replacement. The Registry identified 37 modern total knee replacement combinations with data for 10 years or more. This group accounts for 89.2% of all the total knee procedures reported to the Registry. The percentage of knee replacement procedures that have 10 years of follow-up data and have been revised varies from 2.8% to 9.2%.

The Registry identified 8 knee prostheses with a superior benchmark and an additional 9 prostheses with a non-inferior benchmark. In other words, of the 37 different modern knee prostheses combinations, 17 (45.9%) are regarded as having a very good result.

This year, the Registry is reporting on 5 total stemmed anatomic shoulder replacement combinations that have been used to treat patients with osteoarthritis. These prosthesis combinations were used in 73.7% of all primary total stemmed anatomic shoulder replacement procedures performed for osteoarthritis. This group had revision rates at 10 years from 4.9% to 24.2%, with an average of 7.4%. One of the implants qualified for a superior result, but none were non-inferior.

There were 6 total stemmed reverse prostheses with 10 year outcomes representing 67.7% of modern implant combinations. The rate of revision ranged from 3.4% to 6.7% with a benchmark of 5.4%. Again, there was one superior outcome, and 2 prostheses combinations were non-inferior.

Fifteen Year Outcomes

The Registry also has information on currently used prostheses (26 hips and 19 knees) that extends out to 15 years. Many of the devices have performed well.

The percentage of hip procedures that have 15 years of follow-up data and have been revised varies between 4.4% and 17.8%. The Registry identified 7 hip prostheses with a superior benchmark and an additional 5 prostheses with a non-inferior benchmark. In other words, of the 26

different modern hip prosthesis combinations, 12 (46.2%) are identified as having low revision rates at 15 years.

For knee replacements, the percentage of procedures that have 15 years of data and have been revised varies between 4.0% to 11.4%. The Registry identified 4 knee prostheses with a superior benchmark and an additional 5 prostheses with a non-inferior benchmark.

In other words, of the 19 different modern knee prostheses combinations, 9 (47.4%) are regarded as having a very good result at 15 years.

Twenty Year Outcomes

The Registry can report 20 year outcome data for 12 hip and 6 knee combinations of prostheses that are currently being used. The hip prosthesis combinations have been used in 30.7% of all primary total conventional hip replacement procedures performed for osteoarthritis. The 20 year cumulative percent revision ranges from 5.4% to 16.3%.

The knee prosthesis combinations were used in 14.6% of all primary total knee replacement procedures performed for osteoarthritis. All 12 combinations were used in 2024. The 20 year cumulative percent revision ranges from 7.3% to 14.0%.

Hip Replacement

The Registry considers three different categories of hip replacement. These are primary partial, primary total and revision hip replacement. Each of these categories is divided into a number of different classes. These are described in the Annual Report at the start of the section on hip replacement.

There were 60,414 hip replacements undertaken in 2024. This is an increase of 62,206 procedures compared to the number reported in last year's annual report.

Primary partial hips account for 13.8% of all hip replacements reported to the Registry since it commenced data collection. Primary total hips account for 76.3% and revision hips 9.8%.

The proportion of hip replacement procedures that are undertaken each year that are revision operations is called the revision burden. The aim of any intervention to improve the outcome of joint replacement is to reduce the revision burden. The revision burden has declined since 2003, with the exception of 2011. In that year, the Registry reported an increase in the revision burden. This was largely due to the high revision rate of large head metal on metal hip replacements and, in particular, the ASR XL prostheses. In 2012, the revision burden again declined and has continued to decrease since that time. In 2011, the revision burden was 12.6%, in 2012 it was 11.9%, in 2013 it was 10.7%, and in 2024 it has decreased to 6.7%. This is the lowest revision burden for hip replacement ever reported by the Registry.

The Registry data continues to show that, in general, Australian surgeons have increasingly used approaches to hip replacement and hip replacement prostheses that the Registry has identified as being associated with an improved result. This is particularly evident in recent years with the increased use of prostheses known to have excellent outcomes over a long period and the decreased use of those that are known to have a less satisfactory result. It is anticipated that the effect of these changes will have a progressively beneficial impact on the revision burden in the coming years.

Primary Partial Hip Replacement

Most partial hip replacements are used to treat broken hips. Elderly patients with a broken hip involving a complete fracture at the base of the femoral head (ball of the hip joint), which is significantly displaced (moved out of position).

This is commonly referred to as a sub-capital fractured neck of femur.

The Registry has previously reported that the risk of further revision surgery following the treatment of broken hips with primary partial hip replacement is dependent on a number of factors. These include the age at the time of surgery, class of partial hip replacement, method of fixation, and the type of prosthesis used.

There are three main classes of partial hip replacement: unipolar monoblock prostheses, unipolar modular prostheses, and bipolar prostheses. Each has its place in the management of broken hips.

When the Registry first started collecting data, unipolar monoblock prostheses were the most common type of partial hip prostheses used. Of the three types of partial hip replacement, this has the highest rate of revision. The use of these devices, however, has continuously declined over the years, and they are now rarely used.

Bipolar prostheses are revised less frequently than unipolar modular prostheses when individuals are less than 75 years of age.

The use of cement fixation reduces the risk of revision by approximately half, regardless of the class of partial hip replacement. Consequently, in recent years, there has been a dramatic increase in the use of cement fixation when partial hips are used. However, the vast majority of partial hip replacements will do well, whether they are cemented or not.

Primary Total Hip Replacement

There are two main classes of primary total hip replacement. The first and most common is total conventional hip replacement, which involves replacing the femoral head (ball of the hip joint) as well as the acetabulum (socket of the hip joint). The second is a total resurfacing hip replacement. Although the socket is replaced in a similar way to a conventional hip, it differs in that only the surface of the femoral head is replaced, rather than the whole head.

Overall, resurfacing hip replacement has a higher rate of revision compared to primary total conventional hip replacement. In recent years, the use of total resurfacing hip replacement has continued to decline. Primary total resurfacing hip replacement represents 1.1% of all hip replacements performed in 2024. In 2024, the number of primary total resurfacing procedures is 5.7% more than in 2023.

Primary Total Resurfacing Hip Replacement

Factors that affect the outcome of primary total resurfacing hip replacement include the type of prostheses used, as well as the gender, age, and size of the patient. Women have a significantly higher rate of revision. This difference has resulted in this procedure now being done almost exclusively in males. Men have an age-related rate of revision. Males over the age of 65 years have a much higher rate of revision in the first 6 months after surgery and consequently, this surgery is almost never done in patients above this age.

It appears that there are a number of reasons for the difference in outcomes related to gender. The first relates to the size of the patient. Smaller femoral head sizes do not do as well in a resurfacing procedure and women on average have smaller femoral head sizes. It also appears that women still have a higher rate of revision following a resurfacing hip replacement when a larger head size is used, but the reason for this is not clear. Males with a smaller femoral head size also have an increased risk of revision when compared to males with larger femoral head sizes. The use of this type of hip replacement is now largely confined to men younger than 65 years who have larger femoral heads.

Primary Total Conventional Hip Replacement

The Registry has identified many factors that affect the outcome of primary total conventional hip replacement. These can be divided into patient and prosthesis factors.

Patient Factors

Patients with osteoarthritis have better outcomes compared to patients having a total hip replacement for a different reason. Generally, it can be said that women have a slightly lower risk of revision compared to men. In the long term, the rate of revision decreases as the age at the time of the initial surgery increases. This is more apparent in women than in men.

The Registry is again reporting on the impact of ASA score and BMI for all patients. The Registry only commenced collection of ASA data in 2012 and BMI data in 2015. The ASA score is a measure of general health. The score increases with the number of health problems. The higher the ASA score, the higher the risk of revision, this is due in part to an increased risk of revision for infection. This is because the general health of patients with a higher ASA score at the time of surgery is not as good. There are six categories of BMI, which include underweight, normal, pre-obese and then obese 1, 2, and 3. The revision rate is increased in

patients with a BMI that is categorised as obese 1, 2, or 3. The most common reason for the increased rate of revision is infection.

Surgical Approach

The Registry is again reporting on the effect of surgical approach. The Registry only commenced collecting data on approach in 2015. There are three main operative approaches used for hip replacement. They are posterior, lateral and anterior. The lateral approach and the posterior approach have a higher rate of revision compared to the anterior approach. The lateral approach also has a higher rate of revision compared to the posterior approach. However, there are differences in the reasons why a revision is undertaken. The anterior approach has a higher rate of revision for loosening and early fracture compared to the posterior and lateral approach and a lower rate of revision for infection and dislocation.

Fixation

As has been done in previous years, important prosthesis characteristics that influence outcomes have been highlighted in this year's report. These include the method of fixation, the type of bearing surface of the artificial hip joint, and some special design features of both the femoral and acetabular prostheses.

Primary total conventional hip replacements vary in the method used to fix the prosthesis to bone. There are three main types of fixation: cemented, cementless and hybrid fixation. Cemented fixation is when the femoral and acetabular prostheses are fixed to bone using a hard setting plastic called methyl methacrylate (bone cement). Cementless fixation is when the femoral and acetabular prostheses are fixed directly to bone without using cement. Initially, the fixation is achieved by fitting the device tightly into the bone. This tight fit then allows bone to grow into specially designed roughened surfaces on both the femoral and acetabular components to permanently fix the device in place. Prostheses are designed to be specifically used with cemented or cementless fixation. The other main approach to fixation is hybrid fixation. This involves cementing the femoral component and using a cementless acetabular component.

For many years, the Registry has reported that age has a major influence on the outcome of the different types of fixation. In general, older patients do better with hybrid or cement fixation and younger patients do better with hybrid or cementless fixation. The likely reason for this is that cementless fixation particularly of the femoral component does better when the quality of a patient's bone is good. It is known that bone

quality declines as we get older. With the analysis restricted to modern prostheses, there is little difference in outcomes based on fixation except for patients aged 75 years and older, where the revision rate is lower when either hybrid or cement fixation is used.

Bearing Surface

The Registry is again reporting on the outcomes related to the use of different bearing surfaces. The bearing surface is the articulating surface, i.e. the artificial ball and socket of the hip joint. It varies depending on the material used to make the femoral head and the acetabular socket. The socket may be plastic, ceramic, or metal. The type of plastic used is called polyethylene, it may be non cross-linked (non XLPE) or cross-linked (XLPE). XLPE means that an additional manufacturing process has been used that increases the bonding of the molecules within the polyethylene. It has been shown in laboratory testing that increasing the cross-linking reduces the wear of this material as the hip replacement moves. The femoral head (ball) may be made of metal, ceramic, or a third option called ceramicised metal, which is available mainly from one company. The bearing surface is made up of the combination of materials used to make both the ball and the socket. Consequently, there are a number of possible combinations that make up the different bearing surfaces. These include metal on polyethylene (non XLPE and XLPE), ceramic on polyethylene (non XLPE and XLPE) and ceramic on ceramic. Ceramicised metal femoral heads are only used with polyethylene (XLPE and non-XLPE). Metal on metal bearings were used in the past but this bearing is now largely confined to resurfacing hip replacements. The reason that metal on metal is not used in other types of hip replacements, is because it does not work as well as other available artificial joint surfaces.

In recent years, the type of polyethylene used has been almost entirely XLPE. The use of this material has been associated with a significant reduction in the rate of revision in primary total conventional hip replacement for dislocation, loosening, and lysis. The reduced rate of revision for dislocation is due to an increased use of larger head sizes (32mm or greater) in XLPE procedures. It is possible to use these larger head sizes because this type of polyethylene is more resistant to wear. When a larger head size is used, the hip replacement is more stable and so there is a lower rate of revision for dislocation. The reduced rate of revision for loosening and lysis is thought to be due to the reduced wear rate. Loosening and lysis are most often due to an inflammatory reaction, that occurs following the production of small wear particles. Theoretically, a

reduced wear rate means fewer particles and therefore less inflammation.

The lower rate of revision for XLPE compared to non XLPE occurs, regardless of whether a metal, ceramic or ceramicised metal femoral head is used. No matter what type of femoral head is combined with an XLPE socket the results are very similar.

The Registry has undertaken a detailed analysis of ceramic on ceramic bearings. Although the Registry has information on three different ceramics, only one of these ceramics (mixed ceramic) is in current use. It is the best of the three ceramics. The revision rate of mixed ceramic varies slightly with femoral head sizes less than 32mm having a slightly higher rate of revision. Compared to the different femoral heads used with XLPE the results are very much the same. On occasion in the main report, you may see that the Registry has referred to modern bearings, these include ceramic on ceramic bearings as well as metal, ceramic and ceramicised metal femoral heads combined with XLPE.

Exchangeable Neck Femoral Stems

The Registry also reports the results of several different types of hip replacements that have special features. These include mini femoral stems, as well as constrained and dual mobility acetabular components. The Registry is reporting on the results of these devices again this year.

Exchangeable neck femoral stems have a neck that is modular and includes different lengths and angles that can be fitted into the femoral stem. This differs from most other femoral stems where the neck and the stem are attached. The purpose of exchangeable necks was to give the surgeon greater choice to replicate the desired anatomy and the optimum position of the femoral component. Unfortunately, these devices generally do not work as well as fixed neck stems and they have largely been abandoned. Information on exchangeable necks is no longer provided in the main Annual Report. Detailed information on femoral stems with exchangeable necks is available in the supplementary report 'Prosthesis Types with No or Minimal Use' on the AOANJRR website:

<https://aoanjrr.sahmri.com/annual-reports-2025>.

Mini Stems

Mini stems are very short cementless femoral stems, where fixation to the bone is over a smaller area entirely in the top of the femur. This contrasts with the standard femoral stem that usually extends almost halfway down the length of the inside of the femur. Currently, mini femoral stems remain a relatively new technology and are not commonly used. They represent 2.2% of all

currently used prostheses for total conventional hip replacement. Mini stems have a reduced rate of revision from 1 to 1.5 years and after 2 years compared to standard femoral stems. There is a difference in the reasons for revision, with mini stems having a lower rate of revision for loosening after 1.5 years compared to the standard cementless stem, with no difference prior to this time. Mini stems have a higher rate of revision for fracture in the first 3 months after surgery and then they have a lower rate of revision. The rate of revision also varies depending on the type of mini stem used.

Constrained Acetabular Prostheses

A constrained acetabular prosthesis is a special prosthesis. Unlike normal acetabular prostheses, it has a mechanism to lock the femoral head inside the acetabular socket so that there is a reduced chance of dislocation but at the same time allowing almost normal movement of the hip joint. It is not surprising to find they are used in different types of clinical situations to usual acetabular prostheses. In particular, they have been used more commonly in situations known to have a higher risk of dislocation. Constrained acetabular prostheses compared to modern non-constrained acetabular prostheses when used to treat patients with osteoarthritis have a higher rate

of revision. When they are used to treat patients with a broken hip there is no difference.

Dual Mobility Acetabular Prostheses

Another type of special acetabular prosthesis is the dual mobility acetabular prosthesis. The reason it is called dual mobility is because the femoral head articulates with a polyethylene liner, but unlike the common situation where the polyethylene liner is fixed to the acetabular shell, in the dual mobility the liner is designed to move or articulate with the metal shell (i.e. there is dual mobility). The purpose of the dual mobility design is similar to the constrained acetabular prosthesis, in that it is designed to reduce the risk of dislocation. Similar to constrained acetabular prostheses, the proportion of dual mobility acetabular prostheses used for unusual reasons is high compared to standard acetabular prostheses. There has been increasing use of dual mobility devices in recent years. There is no difference in the revision rate of dual mobility acetabular prostheses compared to standard modern acetabular prostheses when the patient is being treated for osteoarthritis. However, revision specifically for dislocation is reduced when a dual mobility prosthesis is used. There is no difference between dual mobility and standard modern acetabular prostheses when used to treat a broken hip.

Knee Replacement

As with hips, the Registry considers three different categories of knee replacement: primary partial, primary total, and revision knee replacement. Each of these categories is further divided into a number of different classes. These are described in the Annual Report at the start of the section on knee replacement.

There were 79,331 knee replacements undertaken and reported to the Registry in 2024. This is an increase of 300 procedures (0.4%) compared to the number reported in 2023.

Primary partial knee replacement accounts for 7.0% of all knee replacements reported to the Registry since it commenced data collection. Primary total knees account for 85.2% and revision knees 7.8%. Almost all primary knee replacements, whether they are partial or total, are undertaken for osteoarthritis.

The proportion of knee procedures that are revision procedures has been decreasing since the Registry was implemented. The percentage of knee replacements that are revisions decreased from 8.8% in 2004 and 8.2% in 2019 to 6.9% in 2024.

Primary Partial Knee Replacement

A partial knee replacement is a replacement that only replaces part of the knee joint. The Registry identifies five classes of primary partial knee replacement. Most are used in small numbers and two are no longer used in Australia. The main report provides information on unicompartmental knee replacements and patella/trochlea partial knee replacements. The results of the two classes of partial knee replacement that are no longer used - unispacer and bicompartmental - are available in the supplementary report on the AOANJRR website called Prosthesis Types with No or Minimal or Use.

The most used partial knee replacement is the unicompartmental knee. This replaces the femoral and tibial joint surfaces on either the inner or outer side of the knee (most commonly the inner side of the knee). Its use accounts for 92.7% of all primary partial knees. Primary unicompartmental knee replacement has a higher rate of revision than primary total knee replacement. Age is a major factor affecting the outcome of unicompartmental knee replacement. The younger the patient, the more likely it is that the procedure will be revised early. At 20 years following a unicompartmental knee replacement,

26.7% have been revised. Almost 39.1% of patients less than 55 years of age at the time of their surgery have been revised within 20 years.

Unicompartmental knee replacement may be undertaken on the medial (inner), or lateral (outer) side of the knee. Medial unicompartmental knee replacement is much more common and accounts for 97.7% of all unicompartmental knee replacements. For the first three months, the lateral unicompartmental knee has a higher rate of revision compared to the medial unicompartmental knee replacement, but after 3 months, there is no difference. The revision rate of unicompartmental knee replacement varies depending on the type of prosthesis used. The Registry has been following and reporting on the outcomes of unicompartmental knee replacements that are placed in position using robotic surgery. The results of this type of surgery show no difference compared to when the surgery does not use any assistive tool.

Primary Total Knee Replacement

A primary total knee involves the removal and replacement of the joint surface of the femur and the tibia on both the medial (inner) and lateral (outer) sides. A single femoral prosthesis and a single tibial prosthesis are used. The tibial prosthesis may be one component, but it is more commonly two that are put together at the time of surgery. Usually, a metal tray fits over the cut surface of the tibia with a plastic insert (tibial insert) that fits inside the tray to make the tibial prosthesis. This then articulates with the single femoral replacement. A primary total knee replacement may or may not have the under-surface of the patella replaced.

Gender and Age

Primary total knee replacement has the lowest rate of revision compared to all other types of primary knee replacement. Men have a slightly higher rate of revision compared to women. The most important patient factor identified by the Registry that influences the rate of revision is age at the time of surgery, the younger the patient the higher the subsequent rate of revision. Patients less than 55 years of age at the time of surgery have a 15.8% chance of being revised at 20 years. However, the rate of revision is less for older patients.

Stability

An important difference between hip and knee replacement is what keeps the artificial joint surfaces from moving out of position. This is referred to as the stability of the joint. An unstable joint has additional unnatural movements between the joint articulating surfaces. The very extreme example of this is when the articulating surfaces come apart. This is referred to as dislocation which unlike hip replacement is very rare following knee replacement. There can also be lesser degrees of unnatural movement that can cause problems with the function of an artificial joint without the joint actually dislocating. In general, the stability of the joint is dependent on the shape of the joint as well as the soft tissues (muscles and ligaments) around the joint. If everything is working correctly, the combination of these factors allows normal movement and prevents unnatural movements (sideways or back and forward) between the joint surfaces. As the hip is a ball inside a socket joint, there is a lot of stability simply because of the shape. This is not the case with knee replacement where the tibial surface is relatively flat. The stability of the knee joint is much more dependent on surrounding soft tissues and in particular ligaments that hold these joint surfaces in place and in the correct alignment. Quite often in patients receiving a knee replacement, one or more of these ligaments may already be damaged. In order to address this issue, primary total knee replacement can vary depending on the additional built in stability that may be required. In certain circumstances, it is necessary to use a replacement that is designed to substitute for one or more of the damaged ligaments.

Most knee replacements used do not require any additional stabilising, other than substituting for the anterior cruciate ligament. These are referred to as minimally stabilised knee replacements. The next most common group is posterior stabilised. These have additional stability built into the knee replacement so that the prosthesis substitutes for both the posterior and anterior cruciate ligaments. The vast majority of knee replacements used are either minimally or posterior stabilised prostheses. Minimally stabilised prostheses have a slightly better outcome than posterior stabilised prostheses. However, there is some difficulty in being too definite about this, as posterior stabilised prostheses may be used more often in difficult cases. If a case is more difficult, it has more potential to be revised.

Fixation

There is only a small variation in the outcome of knee replacement related to the type of fixation used to hold the tibial and femoral components

tightly to bone. Hybrid fixation has the lowest rate of revision, but the difference is not major. Cemented fixation has a lower rate of revision compared to cementless fixation, but this varies depending on whether the total knee replacement is minimally or posterior stabilised. Minimally stabilised knees do best if at the very least the tibial component is cemented. Posterior stabilised knees do best when both the tibial and femoral components are cemented to the bone. However, after 1.5 years, cementless fixation has a lower rate of revision.

Other important ligaments around the knee are the medial and lateral collateral ligaments. These can also be substituted by what is often referred to as constrained knee replacements. These are not often required in primary operations. There is one final group of knee replacement when considering stability and these are hinged knees. These are used mostly when there is absolutely no ligament stability left in the knee. Their use is very rare for primary knee replacement.

Tibial Insert

Another general difference in the design of primary total knee replacement is the way the tibial insert is designed to move on the surface of the tibial tray. It may either be fixed to the tray (fixed insert) or designed to move slightly in one or more specific directions (mobile insert). Mobile inserts either rotate, slide or do both. For a number of years, the Registry has reported that in general, fixed inserts have a lower rate of revision. This year the Registry reports that after 6 years mobile inserts have a reduced rate of revision.

Bearing Surface

Unlike hip replacements, knee replacements only have two main types of bearings. They are a metal femoral component combined with polyethylene, either XLPE or non-XLPE. Comparing the outcome of XLPE to non XLPE across all knee replacements, there appears to be a benefit when XLPE is used. There is a lot of variation between the type of prostheses and the type of polyethylene used. As a consequence, any difference seen when comparing the overall result of XLPE to non XLPE may be in part due to the type of prosthesis, rather than the type of polyethylene. To try and overcome this problem, the Registry has undertaken analyses of specific designs of total knee replacement that have used both XLPE and non XLPE. There does not appear to be any situation where XLPE performs worse than non-XLPE. Sometimes it is better and sometimes it is the same.

Technology Assisted Surgery

The Registry has also carefully monitored the use and outcomes of computer navigation in primary total knee replacement. Computer navigation is computer-assisted surgery, which was first used over 20 years ago. It involves the use of intraoperative computer monitoring in an attempt to more accurately place the knee prosthesis. It is known that accurate positioning of the prosthesis is a very important factor in determining the result of the operation. The current information from the Registry suggests that there is no difference in revision rates when compared to procedures without technology assistance, regardless of age or other factors.

There are also other techniques that surgeons are using in an attempt to improve the positioning of

knee prostheses. Image derived instrumentation (IDI) is a technique that involves obtaining accurate images of the knee joint pre-operatively so that the instruments used to achieve the required alignment can be specifically made for that patient. In general, when IDI is used it is associated with a higher rate of revision compared to when no technology assistance is used.

In recent years, there has been an increase in the use of robotic surgery to aid with the accurate implantation of knee prostheses. Robotic assistance does not show any differences in revision rates or complications compared to procedures without technology assistance, regardless of age or other factors.

Shoulder Replacement

Shoulder replacement is also grouped into three different categories: primary partial, primary total, and revision shoulder replacement. Each of these categories is divided into a number of different classes. These are described in the Annual Report at the start of the section on shoulder replacement.

There were 11,795 additional shoulder replacements reported to the Registry in 2024. The number of shoulder procedures undertaken in 2024 increased by 730 (6.9%) compared to the number undertaken in 2023.

Primary total shoulders account for 83.4% of all shoulder replacements reported to the Registry since it commenced data collection. Primary partial shoulders account for 7.8% and revision shoulders 8.8%.

Due to the staged introduction of the Registry, the first full year that the Registry recorded complete national shoulder data was 2008. Since that time, the number of shoulder replacements reported to the Registry has increased each year. The number of shoulder replacements undertaken in 2024 was 328.9% more than undertaken in 2008.

However, there are differences in the rate of increase depending on the category of shoulder replacement. The number of primary partial shoulder replacements has decreased by 66.7% since 2008. The number of primary total shoulders has increased by 570.29% and revision shoulder replacement has increased by 226.6% during the same time. In 2023, the revision burden is 8.8%.

Primary Partial Shoulders

The Registry subcategorises primary partial shoulder replacement into four main classes. These are defined by the type of prostheses used. The main report provides information on the most used class of partial shoulder replacement: hemi stemmed anatomic. This replaces the humeral head with a prosthetic head mounted on a stem. Hemi stemmed anatomic accounts for 73.3% of all primary partial shoulder replacements.

The second most used partial shoulder replacement is hemi resurfacing anatomic that uses a humeral prosthesis to replace the humeral articular surface only, without replacing the humeral head. Hemi resurfacing anatomic accounts for 22.4% of all primary partial shoulder replacements.

Partial resurfacing anatomic involves the use of one or more button prostheses to replace part of the natural articulating surface on one or both sides of the shoulder joint. Partial resurfacing anatomic accounts for 2.8% of all primary partial procedures. Hemi stemless anatomic is the least used type of primary partial shoulder replacement, accounting for 1.5%. It involves the resection of the humeral head and replacement with a humeral head and a humeral stem prosthesis. A humeral stem prosthesis may have metaphyseal (former growth area of the bone) or diaphyseal (shaft) fixation.

Primary Total Shoulders

There are five types of primary total shoulder replacement: total resurfacing anatomic, total stemmed anatomic, total stemless anatomic, total stemmed reverse and total stemless reverse.

Total Stemmed Reverse Shoulder Replacement

Total stemmed reverse accounts for 74.4% of all primary total shoulder replacements. It involves glenoid replacement with a glenosphere prosthesis combined with resection of the humeral head and replacement with humeral cup and humeral stem prostheses. A humeral stem prosthesis may have metaphyseal or diaphyseal fixation. The results of shoulder replacement surgery with a total stemmed reverse prosthesis are affected by patient factors like age, gender, body weight (BMI) and overall health (ASA score). In addition, prosthesis factors, bearing surface and glenosphere size change the rate of revision. Implant sizing variations (modifications to prosthesis design range beyond simple size change) such as glenoid base plate augmentation and humeral stem length affected outcomes. This year we report the operative technique of rotator cuff repair reduced rates of total stemmed reverse replacements.

Total Stemmed Anatomic Shoulder Replacement

Total stemmed anatomic is the second largest group of primary total shoulder replacement, accounting for 18.9% of all primary shoulder procedures. This procedure involves glenoid replacement combined with resection of the humeral head and replacement with humeral head and humeral stem prostheses. A humeral stem prosthesis may have metaphyseal or diaphyseal fixation. Cement fixation of the glenoid component in total stemmed anatomic shoulder replacement has a lower rate of revision. The

implant configuration, including use of implant size variations (augmented polyethylene glenoid components, and humeral stem length) prostheses factors humeral head size, and the bearing surface, play a significant role in outcome.

Total Stemless Anatomic Shoulder Replacement

Overall, total stemless anatomic replacement has been used less frequently accounting for 6.6% of all primary total shoulder replacements but was the most common anatomic shoulder replacement undertaken in 2024. This procedure involves glenoid replacement combined with resection of the humeral head and replacement with a humeral head with an epiphyseal (base of the head) fixation prosthesis. Age, gender and glenoid component type rather than prostheses factors influence revision rates for stemless anatomic implants.

Surgeon Assistive Tools (SAT)

In total stemless and stemmed anatomic shoulder replacement the use of SAT (IDI) increases the rate of revision, while in total stemmed reverse an IDI reduces the revision rate in patients with osteoarthritis.

Total Stemmed Reverse with a standard baseplate compared to Total Stemmed Reverse with augmented baseplates, and Total Stemmed Reverse with custom baseplates.

Total stemmed reverse shoulder replacement with a custom baseplate has a higher rate of revision compared to total stemmed reverse shoulder replacement with a standard or augmented glenoid baseplate.

Total Stemmed Reverse Compared to Total Stemless Anatomic and Hemi stemmed anatomic with pyrocarbon heads.

Total stemmed reverse shoulder replacement has a higher rate of revision compared to Hemi stemmed anatomic with pyrocarbon heads for the first 6 months following surgery. After 6 months, there is no difference between these three classes of shoulder replacement.

Hip, Knee, Shoulder and Ankle Prostheses with a Higher than Anticipated Rate of Revision

The Registry reports on the results of individual prostheses in the different classes. There is variation in the revision rates for different types of prostheses in each class. Many of these differences are not statistically significant.

The Registry, however, does identify individual prostheses that have a statistically significant higher rate of revision. The threshold for that identification is that the revision rate is more than twice that of all other prostheses in the same class and the difference is statistically significant. In other words, the revision rate of these devices lies outside the expected norm. They are often referred to as outliers. These outliers are identified in the final chapter of the 2025 Annual Report.

This information highlights to surgeons, orthopaedic companies, and regulatory bodies worldwide, that something unexpected is happening with respect to the outcome of these prostheses. It enables consideration to be given as to the possible reasons for this difference and whether it is worthwhile or appropriate to continue to use these prostheses.

It is important to emphasise that there may be many reasons why the revision rate is twice that of other prostheses. Some of these may not necessarily be related or specific to the identified prostheses. The data relating to each of these prostheses have been carefully considered by an expert group of orthopaedic surgeons who have recommended these prostheses be identified and therefore be considered further as to whether or not they should continue to be used. When they undertake that consideration, all available data is reviewed and any subsequent investigation that they may request is undertaken and provided.

The consequence of this process is that not all outliers are recommended for identification. One of the main reasons that an outlier is not identified is because it is a non-standard prosthesis that is used in unusual or complex clinical situations associated with a higher risk of revision. In this situation, it is not fair to compare the results of

these special devices to those of standard prostheses used in standard clinical situations.

This year, the Registry has identified for the first time 6 prostheses or prosthesis combinations with a higher than anticipated rate of revision. These include 1 partial hip prosthesis, 1 total conventional hip prosthesis, 1 total knee prosthesis, 1 total stemmed reverse shoulder prosthesis, and 1 total ankle prosthesis.

Identified prostheses are listed in one of three groups. The first group are those that have a higher rate of revision that are being identified for the first time and are still in use in Australia.

The second group includes prostheses that are being re-identified but are also still used. This list identifies that the prosthesis continues to have a higher than anticipated rate of revision and it provides updated information on its continued use. Most prostheses that are identified for the first time or re-identified prostheses decline in use with time. This is usually evident only after the first year because almost a full year of use has occurred prior to the identification in a previous Annual Report.

The third group are prostheses that are identified but are no longer used in Australia. Most of these have been previously identified. However, occasionally there is a prosthesis in this group that is identified for the first time. These are prostheses that are no longer available for use in Australia, and as time progresses the Registry is able to identify that this device has a revision rate that is subsequently identified to be higher than anticipated.

The Registry identification of prostheses with a higher than anticipated rate of revision has resulted in many of these prostheses being withdrawn from national and international markets. Only summary information is provided in the Annual Report. However, the full detailed analysis for each of these prostheses is available from the Registry website (Investigations of Prostheses with Higher than Anticipated Rates of Revision).

Conclusion

The purpose of the AOANJRR is to provide high-quality independent data on the results of joint replacement in Australia. The Registry provides this information to surgeons, and all other stakeholders to assist them to make informed judgments on the best approach to joint replacement surgery.

It is hoped that the information presented in this report is useful to people who are seeking

additional information on joint replacement surgery, particularly those that are considering or have already undergone the operation. Registry information can be very complicated, as many factors interact to influence the outcome of the surgery. The intention of making this information available to everybody is to assist in promoting informed discussion about the outcome of joint replacement surgery, particularly between patients and their treating surgeons.



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