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Stephen S. Tower

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Arthroprosthetic Cobaltism: Neurological and Cardiac Manifestations in Two Patients with Metal-on-Metal Arthroplasty

A Case Report

By Stephen S. Tower, MD*

Investigation performed at the Anchorage Fracture and Orthopedic Clinic, Anchorage, and the Alaska WWAMI Biomedical Program, Anchorage, Alaska

Early failure of metal-on-metal hip arthroplasties is a current concern because tissue damage resulting from periprosthetic metallosis can compromise subsequent revision arthroplasty. The United Kingdom’s Medicines and Healthcare products Regulatory Agency has advised that patients with metal-on-metal implants who have pain, prosthetic malposition, or implants that are known to have excessive failure rates should be evaluated with the measurement of serum cobalt. A serum cobalt level of >7 µg/L indicates possible periprosthetic metallosis. A normal serum cobalt level is 0.19 µg/L, and 95% of those who are unexposed to cobalt have a value of <0.41 µg/L. A serum cobalt level of >1 µg/L indicates excessive cobalt exposure, and levels of >5 µg/L are considered toxic.

In excess, cobalt blocks cellular metabolism and can damage multiple organs. Cobalt poisoning (cobaltism) from beer additives, industrial exposure, or medicinal use is well known. Cobaltism can result in tinnitus, vertigo, deafness, blindness, optic nerve atrophy, convulsions, headaches, peripheral neuropathy, cardiomyopathy, and hypothyroidism. Including the two cases in the present report, there are at least six case reports of cobaltism related to arthroplasty implants (arthroprosthetic cobaltism). These four patients presented with combinations of deafness, blindness, cognitive decline, headaches, convulsions, fatigue, weakness, peripheral neuropathy, heart failure, and hypothyroidism. All of these patients had periprosthetic metallosis due to wear of steel femoral heads by ceramic, and all had a serum cobalt level of >60 µg/L. The two cases described in the present report were included in a summary paper by the author and are the first cases of arthroprosthetic cobaltism attributed to metal-on-metal implants that could be identified.

Case Reports

Both of the patients were fit, well, forty-nine-year-old men at the time of metal-on-metal arthroplasty with Articular Surface Replacement implants (ASR; DePuy, Warsaw, Indiana). In one of the patients (Case 1), the index hip arthroplasty was performed elsewhere and the revision arthroplasty was performed by one of the author’s partners. In the other patient, the index and revision arthroplasties were performed by the author. Both of these patients were briefly reported on in the State of Alaska Epidemiology Bulletin, and are included in a review paper by the author on arthroprosthetic cobaltism.

Case 1. Metal-on-metal hip replacement was performed for the treatment of osteoarthritis. The shell and femoral head diameters were 60 and 53 mm, respectively. Acetabular inclination measured 54° on a frontal hip radiograph, and anteversion appeared excessive on a lateral hip radiograph (Fig. 1-A). The patient demonstrated improvement initially but developed progressive hip pain with activity. At three months postoperatively, axillary rashes were noted, although skin patch testing and a lymphocyte transformation assay showed no reactivity to cobalt or chromium. Eleven months after surgery, dyspnea and progressive hip pain were noted, imaging studies showed a large periprosthetic fluid collection, and the serum cobalt level was 50 µg/L. At eighteen months, anxiety, headaches, irritability, fatigue, tinnitus, and hearing loss were noted; an audiogram demonstrated high-frequency hearing loss; and the serum cobalt level was 35 µg/L. At thirty months, pain at rest, hip creaking, hand tremor, incoordination, cognitive decline, and depression were noted. At thirty-six months, visual changes were noted, optic nerve atrophy was found, and the serum cobalt level was 122 µg/L.

Forty-three months after the initial arthroplasty, revision arthroplasty was done. Laboratory findings included a serum cobalt level of 83 µg/L, a cerebrospinal fluid cobalt level of 2.2 µg/L, and a joint fluid cobalt level of 3200 µg/L. Diastolic dysfunction was found on interval echocardiography. The pathologist noted metallosis, necrosis, and lymphocytic infiltrates.

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*EDITOR’S NOTE: It should be noted that one of the patients in the present study (Case 1) is the author of the report (S.S.T.).
Wear of the liner was estimated with use of several independent measures, including (1) the differential thickness of the liner rim at the worn and unworn quadrants as measured with use of a dial caliper (accuracy, ±0.001 in [0.025 mm]), (2) the use of image analysis software to evaluate three-dimensional digital images of the liner rim geometry at the worn and unworn quadrants, and (3) a roundness measurement based on a circular scan around the articular surface of the liner 1 mm down from the rim (6000 Geometry Gage; Mahr Federal, Providence, Rhode Island).

Estimates of the depth of wear at the most worn quadrant of the liner were 400 μm (on the basis of differential rim thickness), 306 μm (on the basis of analysis of the images of the rim), and 381 μm (on the basis of out-of-roundness excursion) (Fig. 1-B).

Sequential roundness scans down into the liner indicated maximum wear at the rim, with wear depth diminishing to nearly zero at approximately 20° down into the liner. The general shape of the wear area was depicted in a computer-aided design (CAD) model that was generated to geometrically model the head-to-liner placement that would create the observed wear zone and

**Figs. 1-A through 1-D** Case 1. **Fig. 1-A** Cross-table lateral radiograph of the hip, showing excessive acetabular shell anteversion. **Fig. 1-B** Three-dimensional digital image of the liner rim at an unworn quadrant (left) and the worn quadrant (right) (VHX 1000E; Keyence, Woodcliff Lake, New Jersey). The as-manufactured radius between the articular surface and the rim shelf is apparent in the unworn quadrant but is completely worn through in the worn quadrant, leaving a sharp rim edge. Image analysis demonstrated that the rim dimension indicated by the arrows was 2129 μm at the unworn quadrant and 1823 μm in the worn quadrant, a difference of 306 μm.
depth (Fig. 1-C). The wear zone shown in the figure is the volume of interference between the head and the liner generated by the head subluxating out of the liner by 1.0 mm and then translating laterally 0.3 mm.

The retrieved femoral head showed multiple burnished areas. The largest was in the peripolar area, was shaped like and sized proportionally to the polar ice cap, and, on magnified view, consisted primarily of fine parallel scratches (Fig. 1-D).

Eleven months after revision, the patient's hip pain, affect, cognition, hearing, exercise tolerance, tremor, and professional productivity were improved. His tinnitus and visual symptoms were stable. He had had five prosthetic dislocations, including one that was self-reduced, two that were reduced by family members, and two that were reduced under general anesthesia.

**Case 2.** Metal-on-metal hip replacement was performed for the treatment of a failed resurfacing of the femoral head. A 56-mm acetabular shell and a 49-mm femoral head were used, and an intraoperative radiograph confirmed the recommended implant position. One year after revision surgery, cognitive decline, vertigo, hearing loss, groin pain, rashes, and dyspnea were noted, and the serum cobalt level was 23 μg/L.

The hip was revised again forty months after the previous revision arthroplasty, at which time the serum cobalt level was...
23 μg/L and the joint fluid cobalt level was 3300 μg/L. Gross metallosis was noted on pathological examination, and the pseudocapsule was notably acellular (mature) fibrous tissue; no notable lymphocytic infiltrates could be identified. The acetabular shell showed scratching but no visible eccentricity. The femoral head had an equatorial wear scar. Seven months following the last revision arthroplasty, the patient demonstrated improvement but had required one hip reduction under sedation.

Discussion

The patients described in the current report, like those described in previous case reports on arthroprosthetic cobaltism, presented with hip pain resulting from periprosthetic metallosis as well as neurological and cardiac symptoms resulting from elevated serum cobalt. All patients demonstrated improvement after revision. One of the patients (Case 1) had a cerebrospinal fluid cobalt level that was seventeen times normal. Similarly elevated cerebrospinal fluid levels of cobalt were noted in two previously reported cases of neurological arthroprosthetic cobaltism.

The pattern of wear of the bearing in the first patient (Case 1) was consistent with edge loading due to prosthetic malposition. The annualized wear rate of 100 μm was 100-fold that of metal-on-metal bearings revised for reasons other than metallosis. The wear pattern of the bearing in the other patient (Case 2) suggested inadequate bearing clearance.

A serum cobalt level of >20 μg/L is common in patients with an ASR implant with prosthetic malposition or with a femoral head diameter of <50 mm. Patients with other types of metal-on-metal hips also can have a serum cobalt level of >20 μg/L. In a series of 214 patients with different hip resurfacing implants, ten patients had a serum cobalt level of ≥20 μg/L and one patient had a value of 111 μg/L.

In the patients described here, the revision arthroplasties were complicated by instability, a complication that has been reported to occur more frequently in hips that are revised because of metallosis.

Very high serum cobalt levels can occur in patients with well-positioned 28-mm metal-on-metal bearings if renal function is impaired. These patients might develop cobaltism without sentinel hip pain. Many patients with metal-on-metal hip implants may develop renal impairment with time. Coresh et al. reported that 43% of American adults between forty and fifty-nine years of age and 74% of those more than seventy years of age have acquired impaired renal function.

References