

# ABLE Advanced Anterior Approach

Smith+Nephew

ABLE<sup>◊</sup>  
Advanced Anterior Approach

Recent studies have shown upwards of 35-40% of surgeons who attempt to adopt Direct Anterior (DA) approach are unable to do so.<sup>1</sup> Barriers to adoption includes unfamiliar patient positioning and associated mechanics, retraining the OR staff, and investment in expensive table extensions.

The ABLE Approach is not a new technique. Over the years it has been referred to by many names, such as the Rottinger Approach and Modified Watson-Jones Approach with published clinical history dating back to 1854.<sup>2</sup>

The main difference between the ABLE and DA approach is the incision site. The incision site for the ABLE approach is one interval over from that of DA, between gluteus medius and tensor fascia lata (TFL). This incision site remains the same regardless whether the patient is in the lateral or supine position.

## The benefits of this Advanced Anterior Approach:

**Approach flexibility** – 2 patient positioning options – either Lateral or Supine

**BMI agnostic** – patient of any BMI can benefit from this surgery

**Little investment** – this procedure uses a peg board (in lateral approach), standard retractors and commonly available implants such as R3<sup>◊</sup>, ANTHOLOGY<sup>◊</sup>, AFIT<sup>◊</sup> and POLARSTEM<sup>◊</sup>

**Efficient recovery** – muscle sparing approach, minimizing blood loss thus allowing for quicker recovery<sup>3</sup>

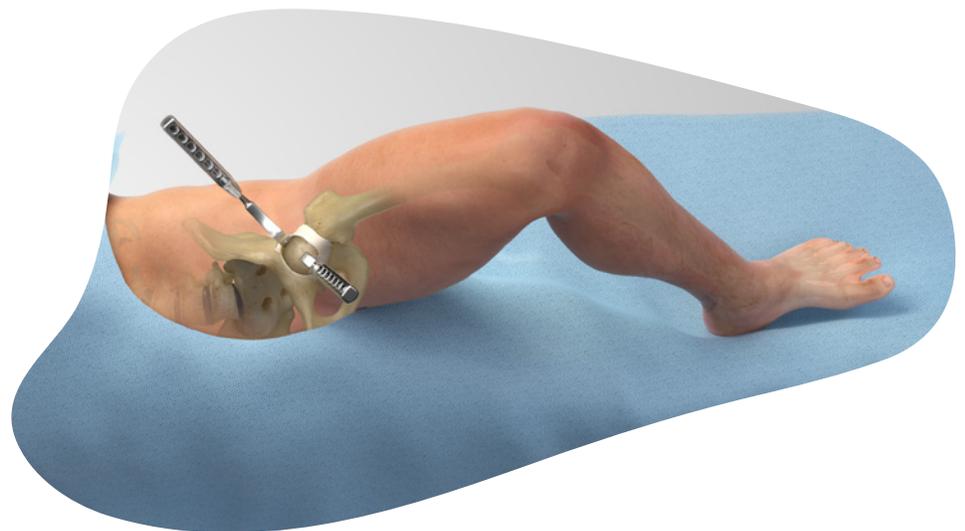
## With the ABLE Approach

### Surgeons are:

- ABLE to cater to all BMI patients
- ABLE to perform their surgeries with minimal changes to their current operating room technique

### Patients are:

- ABLE to reduce hospital stay<sup>3</sup>
- ABLE to recover faster<sup>3</sup>



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28412 V1 04/21

## References

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2. Sayre LA. Exsection of the head of the femur, and removal of the upper rim of the acetabulum, for morbus coxarius. New York: Holman, Gray & Co.; 1854.
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