We report the consensus of surgical opinions of an international faculty of expert metal-on-metal hip resurfacing surgeons, with a combined experience of over 18 000 cases, covering required experience, indications, surgical technique, rehabilitation and the management of problematic cases.

Required experience
The use of metal-on-metal bearings for THR and resurfacing presents a greater technical challenge than that of conventional metal-on-polyethylene bearings. The consensus (81%) was that an orthopaedic surgeon should have a minimum experience of 200 conventional THRs before starting to use a metal-on-metal hip resurfacing arthroplasty. Opinion varied on the number of these operations needed to overcome the learning curve, and ranged from 20 (36%), to 50 (28%) and more than 50 (30%).

Indications
The overall view (100%) was that the ideal candidate for a metal-on-metal hip resurfacing arthroplasty is a relatively young man with normal anatomy and primary osteoarthritis. Being female was not, by itself, a contra-indication (89%), but use of a small femoral head (<46 mm) was contra-indicated (70%). Being female and wanting to have children was a contra-indication (66%), as was being female and having a metal allergy (70%). Grossly abnormal anatomy, regardless of gender, was also agreed to be a contra-indication (83%). There was considerable debate about bone quality, the general view being that ‘good’ femoral bone is a prerequisite, but no agreement was reached on a working definition of acceptable quality.

Surgical technique
The majority opinion (56%) was that the best type of femoral placement guide is that which encircles the femoral neck. There was general agreement (63%) that the current acetabular placement jigs are inadequate. The overall preference (78%) was for cementing the femoral component with a thin cement mantle with fixation holes drilled in the femoral bone, use of pulsed lavage, and reduction of the hip in less than eight minutes from the start of mixing the cement.

Rehabilitation
Full weight-bearing can be allowed on the first post-operative day (73%) and patients should use crutches for as long as needed (57%). Six weeks is the optimal time to return to normal non-sporting daily activities (44%), and six months for returning to impact sports such as running or tennis (61%).
Managing problematic cases
It was difficult to achieve a consensus on this topic, and only the broad recommendations of the discussion are reported. It was generally agreed that these patients need to be followed up and those with symptoms investigated. There was no agreement on the diagnostic value of measurements of metal ions, but it was felt that ‘high’ concentrations of systematic metal ions indicated a problem with the articulation. Cross-sectional imaging and plain radiographs are required for the investigation of a symptomatic metal-on-metal bearing.

It is hoped that these consensus opinions will prove useful to orthopaedic surgeons and will lead to improved outcomes after surgery for hip replacement.