



Professor Munjed Al Muderis

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Hip Surgery

Specialisation in Muscle sparing and fast recovery based Direct Anterior approach for primary and complex revision hip replacement. Hip joint preservation surgeries including Hip arthroscopy.



Knee Surgery

Robotic and Computer Navigated Knee replacement In addition to anatomy preserving techniques in ligamentous injuries around the knee including ACL reconstructions.



Limb Deformity

Specialising in limb deformity correction, limb lengthening, limb deficiency, complex primary & revision joint replacement, bone & joint infection, complex foot & ankle, arthritic ankle joint replacement.



Osseointegration

Transcutaneous Osseointegration technology with *robotic artificial limbs* for amputees. This is designed to be as close to the human anatomy as possible to help the patient mobilise better.



Other Surgery

Leading management techniques of Fractures around the Hip, Knee, Ankle, Wrist, Elbow including Complex and neglected fractures.

Meet Professor Munjed Al Muderis

Munjed is a leading Hip Surgeon, Knee Surgeon, and Osseointegration Specialist in Australia. [Learn More](#)



Education

The more you know about your condition, the better you can deal with the challenges of surgery. [Learn More](#)



Patient Information

Learn what to expect before, during, and after surgery including the rehabilitation period. [Learn More](#)



The starting point

Hello and Welcome

Words matter. We know this; otherwise, you wouldn't be here reading this now. However, it is not just the RIGHT words that make the difference in accessibility, impact and inspiring people to take the action you want them to take; it's ensuring those words are also easy to find when needed most and packaged up in a way that resonates with your audience.

Professor Al Muderis is an extremely busy surgeon focused on his patients, so making time with him to sit down and go through something like web copy is almost impossible.

Therefore, I had to draw on multiple sources of information to ensure technical accuracy, while overlaying it with the knowledge I had gained spending time in operating theatres, with patients and in the clinic.

These factors not only helped support the copywriting process, but also gave me the opportunity to talk to patients and their families about their experiences and where any information gaps might be, and how best to present the information.

I then overlaid this with the

keyword and SEO data to ensure the copy I wrote was, first and foremost, patient friendly and the type of information they actually need, as well as supporting other aspects of the marketing strategy.

Following you will find examples of the source material and how I approached the re-write to ensure greater accessibility and resonance with the patient audience.

Please keep in mind that there is a lot of information to communicate to patients both in their research stage and once they've committed to surgery with Professor Munjed Al Muderis. The aim was to take the medical terminology heavy copy and re-write and rearrange it in a way that it became easier to read, understand and digest.

Original Copy

Over the past few years there has been a significant amount of debate over minimally invasive surgery hip. The results of surgeries using this technique have not necessarily proven to be better than the standard approaches and in fact some studies show an inferior outcome of MIS compared to the standard approach. The use of computer navigation in hip arthroplasty is another controversial subject since it hasn't shown any significant evidence of a better outcome than using standard approaches. However, each approach has pros and cons and their are advantages and disadvantages for each.

The common approaches to the hip joint for Hip Replacement are:

- The posterior approach: This approach accesses the joint through the back and taking the short external rotators off the femur. This approach gives excellent access to the acetabulum and preserves the hip abductors so the patient has less chance of a limp after surgery. Critics cite a higher dislocation rate, although repair of the capsule and the short external rotators negates this risk. Due to incisions through the posterior muscles recovery time can be slower.
- The lateral approach: This is also commonly used for hip replacement. This approach requires elevation of the hip abductors (gluteus medius and minimus muscles) in order to access the joint. The abductors may be lifted up by osteotomy of the greater

trochanter and reapplying it afterwards using wires. This approach has lesser chance of dislocation but the patients are more likely to develop a limp after surgery which could be permanent.

- The anterolateral approach: This develops the interval between the tensor fasciae latae and the gluteus medius. Recently the direct-anterior approach, which utilises an interval between the sartorius muscle and the tensor fascia latae has become more popular especially with the use of a specialised table that allows for hip extension. The advantage of this approach is a small incision and no cutting to any muscle. It is also associated with less pain and faster recovery times. However, it is more technically demanding and requires stringent patient selection since it is very difficult to use this approach on obese or very muscular patients.
- Anterior approach-The key defining feature of minimally invasive hip surgery compared with traditional hip surgery is the surgical approach taken. In minimally invasive hip surgery the surgeon does not have to cut muscles to access the hip. Anterior means to surgically approach from the front of the hip joint instead of lateral (side) or posterior (back). Muscles do not need to be cut or detached from the pelvis or femur. Recovery from Anterior Hip Replacement surgery is much quicker than recovery from traditional hip replacement surgery. Less post-operative pain than traditional hip replacement surgery. Return to daily activities faster compared to

traditional hip replacement surgery. Suitability to this approach is subjective.

Professor Al Muderis believes the best approach is the one that the surgeon is most comfortable with performing as long as optimal visualisation of the joint anatomy is obtained using as minimal soft tissue dissection as possible with efficient time utilisation. The best approach will vary from patient to patient depending on their individual situation and needs.

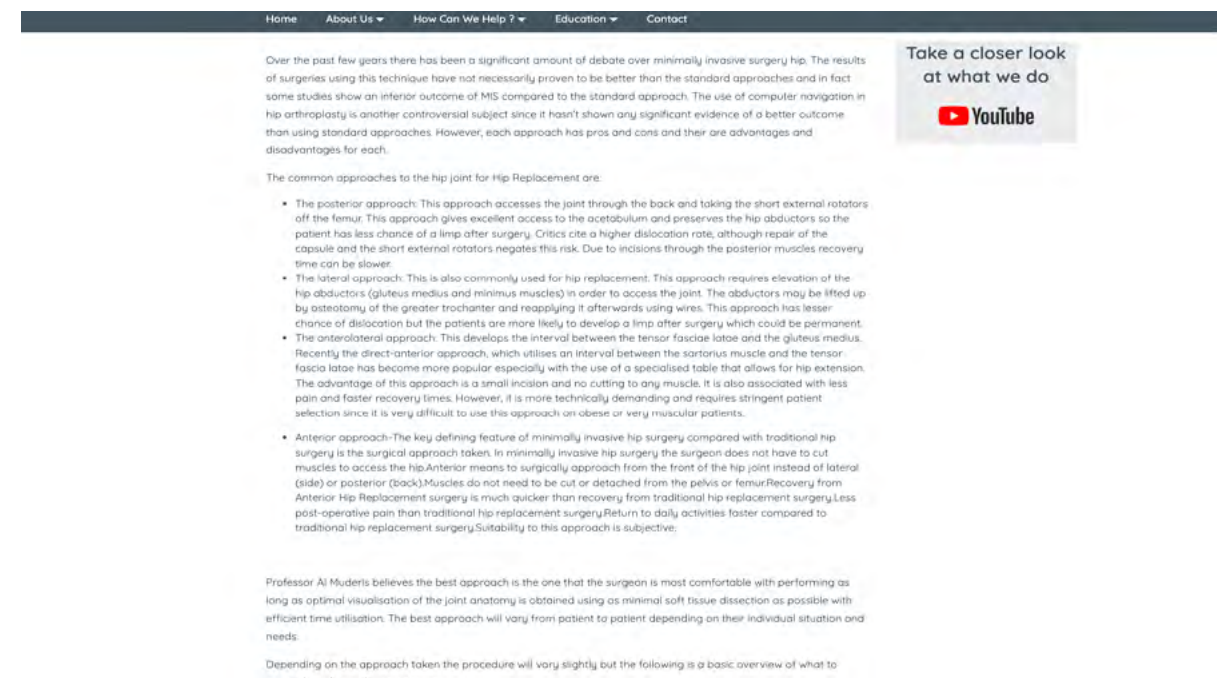
Depending on the approach taken the procedure will vary slightly but the following is a basic overview of what to expect from hip replacement surgery:

An incision is made over the hip to expose the hip joint. The acetabulum (socket) is prepared

using a instrument called a reamer. The acetabular component of the implant is then inserted into the socket. This can sometimes be reinforced with screws or occasionally cemented. The liner part of the prosthesis which is either made of plastic, metal or ceramic material is then placed inside the acetabular component.

The femur is then prepared. The arthritic femoral head is removed and the bone prepared to fit the new metal femoral component. The femoral component is then inserted into the femur. The femoral head component is then placed on the femoral stem. This can be made of metal or ceramic.

All components are fitted together and the muscles and soft tissues are carefully closed.



New Approach

01

Overview



Hip replacement (also known as hip arthroplasty) is a widely performed orthopaedic surgery that replaces the damaged hip joint with an artificial joint or implant to alleviate pain and increase a patient's flexibility, allowing them better mobility and quality of life.

Hip replacement surgery has profoundly changed the way of managing arthritic hips and is recognised as one of the most successful procedures of its time.

Since 2008 I have performed thousands of total hip replacements using the direct anterior hip approach. This approach uses a smaller incision on the front of the hip and does not require cutting of the muscles around the pelvis and thigh bone (femur). As a result, my patients experience a quicker recovery and less post-operative pain, enabling them to return to their normal activities sooner.

02

What does it involve?

Surgical approaches

The injured bone and surrounding soft tissues are cut and removed during hip replacement surgery. I almost exclusively use the direct anterior approach in my total hip replacements to give patients a faster, less painful recovery. However, here you will find more information about this approach, and others used in total hip replacement.

Anterior approach: The incision is made at the front of the hip. Rather than needing to cut or detach muscles from the pelvis or thigh bone (femur), this approach to hip replacement surgery offers much quicker recovery and far less post-operative pain than traditional hip replacement surgery. This in turn allows patients to return to their daily activities faster.

Posterior approach: The incision is made at the back of the hip close to the buttocks. By accessing the joint from the back, this technique helps to take the group of muscles found in the gluteal region (short external rotators) from the thigh bone (femur) and allows for better access to the hip socket (acetabulum). This procedure minimises the chance of a post-surgical limp by preserving the thigh muscles (hip abductors). Despite a higher chance of dislocation, this risk can be avoided by properly repairing the capsule and short external rotators. Nevertheless, this approach also extends the recovery time as the incisions cut through the posterior muscles.

Lateral approach: The incision is made on the side of the hip then. To perform the surgery, a part of the two major side-moving muscles - the gluteus medius and the gluteus minimus - is cut from the thigh bone (femur), and then the hip joint can be accessed. This approach has less chance of dislocation, but the patient is more likely to develop a limp after surgery which could be permanent.

Anterolateral approach: The incision is made on the side of the hip. This approach minimises surgical trauma to soft tissues by working between muscle groups with a small incision. There is no detachment or splitting of muscles, which is associated with less pain and faster recovery. However, it is more technically demanding and requires rigorous patient selection as it is very difficult to use this approach on obese or very muscular patients.

Continued...

02

What does it involve?

The surgery

I use the direct anterior approach routinely when performing all hip replacement surgeries, including:

- Primary hip replacement
- Hip resurfacing
- Complex hip replacement surgery
- Revision hip replacement surgery

The surgery involves removing the damaged cartilage and, depending on the best surgical treatment, replacing it with an artificial implant made from a metal shell inserted in the pelvis (called an acetabular component) and a metal stem inserted into the thigh bone (femur). These two components are connected with a ceramic liner and a ceramic femoral head to form the surface of the artificial hip joint. These are my preferred materials for a primary hip replacement.

03

How do I prepare myself for hip replacement surgery?

Several things need to be done to prepare for your hip replacement surgery. These include:

Skin

Your skin needs to be prepared, so the night before your surgery and the day of, please wash your leg, hip and pubic area with the sponge provided in the pre-admission clinic. Occasionally a skin test is required if there is suspicion of an allergy to antiseptic solutions.

Bowels

Please check with the hospital you're having your surgery regarding the necessary bowel preparation.

Medications

Below is a general guide regarding medications and their effects on your surgery. We strongly advise you take your GP's and surgeon's advice.

Medications - 30 days before surgery

Any herbal or complementary supplements recommended for the heart or joints generally cause blood thinning and bleeding. This includes krill oil, fish oil, green lip mussel extract and glucosamine. Please stop taking these a month before your surgery.

Medications - 10 days before surgery

Please cease aspirin or anti-inflammatory medications (e.g., Nurofen, Voltaren, Celebrex, ibuprofen) and any naturopathic or herbal medications.

Medications - 2 days before surgery

If you're taking any SGLT2i agents such as dapagliflozin (Forxiga), empagliflozin (Jardiance), or anything with metformin (Xigduo, Jardiamet), please cease taking these two days before surgery. Please do not take on the day of surgery.

Panadol, Panadol Osteo and Panadeine are ok to continue.

Medications - recommendation

We recommend that patients take vitamin D, magnesium, calcium and vitamin C supplements at least a month before their surgery to support preparation and recovery.

Physiotherapy assessment

You may be given pre, and post-operative exercises and instructions on gait training and you may be fitted and supplied with crutches to practice pre-operatively.

X-rays and scans

Please ensure you bring all your x-rays and scans to the hospital. This is essential. We suggest finding them ahead of time and ensuring they go in your hospital bag.

Pre-Surgery Information

The following is what can be expected prior to surgery:

- Skin preparation: Night prior to and morning of operation patient is required to wash leg, hip and pubic area to the midline with a sponge provided in the pre-admission clinic. Occasionally a Betadine Skin test is used if there is suspicion of an allergy to iodine.
- Bowel Prep: Glycerin suppositories will be provided at the pre-admission clinic. Patient to is required to administer the evening prior to surgery (instruction leaflet given at the pre-admission clinic).
- Patient education: Physiotherapy assessment will include: instruction of gait training, use of crutches and pre and postoperative exercises. Patient will be fitted for crutches to take home and practice preoperatively.
- Medications:
 - Cease aspirin or anti-inflammatory medications 10 days prior to surgery as well as any naturopathic or herbal medications.
 - Anti-inflammatory tablets: These need to be discontinued one week before the operation e.g., nurofen, voltaren, celebrex, ibuprofen
 - SGLT2i agents include dapagliflozin (Forxiga), empagliflozin (Jardiance), or a combination with metformin (Xigduo, Jardiamet). These drugs should be stopped the two days preoperatively and on the day of surgery.
 - Panadol, Panadol Osteo and Panadeine are ok to continue
 - Herbal or complimentary medicines: Any herbal or complimentary supplements which are recommended to be good for the heart or good for the joint generally cause thinning of the blood and therefore bleeding. Krill oil, fish oil, green lip mussel extract and glucosamine or the like fall into this category. We do ask you to cease these medications approximately one month before surgery or as soon as you book if your surgery is scheduled before this time.

- We do however recommend combined Vit D, magnesium and calcium supplement as well as vitamin C supplements.

- X-rays: We cannot stress enough the importance of taking ALL x-rays, scans and MRI's applicable to your operation to hospital with you when you are admitted.

Day of Surgery:

Surgical paperwork will be administered by the nurses and the anaesthetist will meet with you to ask a few questions.

A hospital gown will be given and the operation site will be shaved and cleaned.

The area to be prepared extends from the iliac crest (hip bone) laterally down the hip and thigh to the knee (i.e. side of leg only). The pubic/genital region is not touched.

Chlorhexidine skin prep will be applied to above area and wrapped.

All x-rays are to be sent with patient to theatre.



**Your job is not to write copy.
Your job is to know your
visitors, customers and
prospects so well, you
understand the situation they're
in right now, where they'd like
to be, and exactly how your
solution can and will get them
to their ideal self.”**

Quick Summary

The old v the new

The current website for Professor Al Muderis offers visitors information they can get from generic orthopaedic websites. To be effective, it needs to be written with the patient at the centre, far beyond the medical terminology used.

The current copy focuses on the medical condition and not on the person reading it, in that moment. Surgery is daunting for most people and to neglect this fact immediately puts Professor Al Muderis behind the eight ball when it comes to resonating with his audience.

People can't action what they don't understand.

By taking the time to learn about the patient experience and the type of information they need most at the moment they're searching for it, I have written 95,000 words of copy that takes the medical and makes it human. That makes it less daunting on the page and easier to find.

In addition to the copy itself, by revamping the format in which it's presented, from long pages of words to breaking it up into sections and FAQs (of which there are currently 237), the information is far more accessible, appealing and engaging.

This is just one of many examples of taking overly technical and wordy information, collaborating with the many stakeholders involved in its production and turning it into a robust, meaningful and accessible source of information that supports the marketing strategy and the commercial goals of the practice.

All while keeping the patient, and their experience, at the centre.

If you would like to see any more examples of this particular project, please let me know.

Otherwise, thank you for taking the time to go through this document and considering me for the opportunity to write for you.

Kindest

Kate Reddin.