



The
HIP AND KNEE
- SURGEONS -

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PATIENT INFORMATION

HIP REPLACEMENT AND RESURFACING

HIP REPLACEMENT AND HIP RESURFACING : PATIENT INFORMATION

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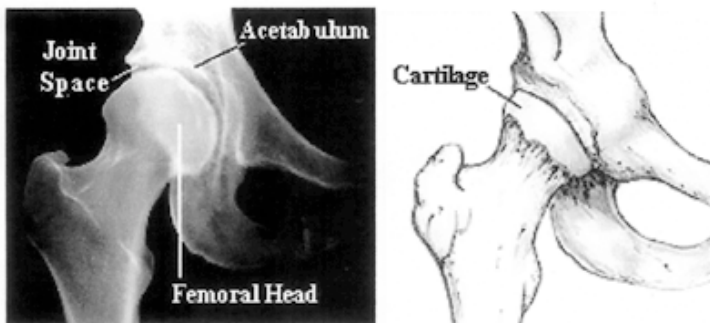


Hip replacements and resurfacings have enhanced the quality of life of millions of people by providing significant relief from pain and improvement in function.

This leaflet has been compiled to help you to prepare yourself for surgery, understand the procedure and the risks involved, the rehabilitation and the long-term precautions. It will assist you in knowing what to expect during your stay in hospital as well as answer some of the more commonly asked questions.

A joint is formed where two or more bones meet. The bone ends are covered with a smooth, shiny tissue called cartilage. This protects the bones from excessive force or pressure, and allows them to move easily without pain. The joint itself is enclosed in a capsule that has a viscous liquid called synovial fluid, which helps to reduce friction and wear of the joint. Ligaments connect the bones to one another, serving to keep the bones together and stabilize the joint. Crossing the joint are muscles and tendons which enable the joint to move. They also assist the ligaments in providing stability to the joint.

The Hip Joint



An X-ray and diagram of a normal hip joint

The hip joint is a ball and socket joint, between a cup shaped depression called the acetabulum in the pelvis, and the head of the femur, which is shaped like a ball and fits tightly into the acetabulum. This design allows for both mobility and stability, enabling the lower extremity to move in three planes. The hip joint provides an important shock absorption function to the torso and upper body, as well as stability during standing and other weight-bearing activities.

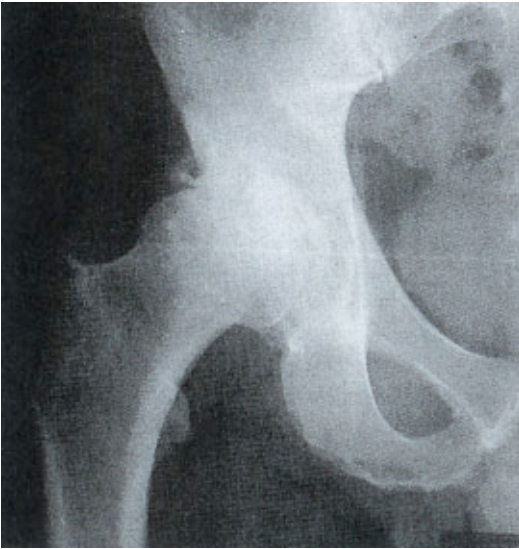
Both the head of the femur and the acetabulum are lined with articular cartilage, which cushions the bones during weight-bearing activities and allows the joint to rotate smoothly and freely in all planes of movement with minimal friction. A complex system of ligaments connect the femur to the pelvis and are essential for stability and keeping the hip from moving outside its normal planes of movement. The entire joint is enclosed in a membrane called a capsule, which produces a lubricating fluid called synovial fluid. This helps to reduce friction and wear and tear in the joint. Muscles and tendons cross the joint and work synergistically to provide the power for the hip



to move in all directions, as well as to stabilise the entire lower extremity during standing, walking or any other weight-bearing activities.

Arthritis of the Hip Joint

Arthritis of the hip occurs when the cartilage that covers the head of the femur and lines the acetabulum starts wearing away thus exposing the bare bone underneath. When this happens the joint becomes pitted, eroded and uneven, resulting in pain, stiffness and instability. Pain is often experienced in the groin, but may also be felt all the way down to the knee and sometimes into the lateral border of the calf. This may result in a limp and limited range of movement. The affected leg may look shortened and there may be muscle wasting which will cause the one leg to look thinner than the other.



An X-ray of an arthritic hip joint

Osteoarthritis

Osteoarthritis is the most common form of arthritis in the Western World. It can be found in all weight-bearing joints such as the spine, hips and knees and usually occurs over the age of 50 but can occur at any age, depending on predisposing factors. It is usually caused by wear and tear as a result of every day activities or sporting activities, but may occur earlier as a result of an injury, fractures or childhood abnormalities. Some experts believe that there may be a genetic predisposition in people who develop osteoarthritis of the hip joint.

In osteoarthritis the joint cartilage becomes worn and roughened and eventually the



bone becomes exposed. Some joints may become enlarged and swollen and develop bony spurs called osteophytes. The first symptom is pain, usually when weight bearing, in the groin, but it can refer further down the leg. The pain can also be experienced at night. People often compensate by limping which reduces the muscle forces across the hip joint, but which then increases the load on the spine and the other hip joint. The decreased range of motion in the hip joint results in difficulty with activities of daily living such as putting on your shoes and socks or cutting your toe nails.

Osteoarthritis can be treated with non-steroidal anti-inflammatories, analgesics and gentle exercise and modification of activities, but when the pain interferes excessively with daily activities surgery can be considered.

Rheumatoid Arthritis

Unlike osteoarthritis, which is a wear and tear phenomenon, rheumatoid arthritis is a chronic inflammatory disease, which affects mainly the joints but can have systemic effects on the body as well. In rheumatoid arthritis, when the synovial lining of the joint becomes inflamed and painful, the joint releases chemical substances that attack and gradually destroy the cartilaginous surfaces of the bone. This disease process leads to severe, and at times rapid degeneration of multiple joints, resulting in severe pain and loss of function. The exact cause of rheumatoid arthritis is unknown, some experts believing that a virus or bacteria may trigger the disease in people who have a genetic predisposition while others believe it may be an autoimmune disease in which the synovial tissue is attacked by the immune system.

The signs and symptoms of rheumatoid arthritis are similar to osteoarthritis in that there is painful swelling and loss of motion. However in rheumatoid arthritis there is seldom only one joint affected – usually multiple joints are involved including the small joints of the hands. The systemic symptoms include loss of appetite, fever, energy loss, anaemia, and rheumatoid nodules.

Rheumatologists using different medications, which will help to reduce the pain and slow down the process of degeneration, can treat rheumatoid arthritis.

Treatment options

Most people can be managed conservatively, i.e. with medication, physiotherapy and modification of the activities that cause pain. However if the joint pain or disability cannot be controlled conservatively there may be a need for surgery. Your orthopaedic surgeon will consider the impact of your condition on your social, domestic and professional life and whether it threatens your independence.

There are two objectives for having surgery, namely to:

- reduce pain; and
- improve function.



A total hip replacement or hip resurfacing is a surgical procedure in which your damaged hip joint is replaced by an artificial joint matching your own.

The purpose of your new joint is to relieve stiffness and pain and so improve your walking and ultimately your quality of life.

When is total hip replacement or resurfacing considered?

The most common reason to replace a hip is arthritis, resulting in pain, stiffness, deformity or instability which interferes with a person's lifestyle and cannot be controlled by more conservative measures such as medication or using a cane.

A normal hip joint has smooth cartilage surfaces, which glide across one another with almost no friction. In an arthritic hip the joint surfaces are rough and irregular, causing pain as the two uneven surfaces grind across one another.

In a hip replacement operation, the rough surfaces are replaced with smoothly articulating components. The operation is sometimes performed for other reasons such as a hip fracture or aseptic necrosis, a condition in which the bone of the hip ball dies. Most patients who have artificial hips are over 55 years of age, but the operation is occasionally performed on younger persons.

Although circumstances vary, patients are generally considered for total hip replacement if:

- the pain is severe enough to restrict not only work and recreation, but also the activities of daily living;
- the pain is not relieved by anti-inflammatory or arthritis medicine or the use of a cane, and restriction of activities;
- there is significant stiffness of the hip; or
- X-rays show advanced arthritis or other problems.

What is a total hip replacement?

A total hip replacement is a surgical procedure designed to replace a damaged hip joint. The hip is replaced by an artificial prosthesis, which is a replica of the patient's own.

The artificial prosthesis consists of a round head (ceramic or metal) and stem which is inserted into and down the centre of the thigh bone (femur) and held in place by cement. The stem with its round head fits into a metal cup, which is lined with plastic or ceramic and placed in the socket of the hip joint (acetabulum).





An example of a cemented (left) and uncemented (right) stem.

An alternative hip prosthesis that does not require cement has been developed. This artificial hip has the potential to allow bone to grow into it. In some cases, only one of the two components (socket or stem) may be fixed with cement and the other left without cement. This is known as a hybrid hip prosthesis. Your surgeon will decide which prosthesis will be best for your particular circumstances.



An example of a cup with a ceramic liner and head (left) and Oxinium head poly liner (right).

The artificial joint has a limited lifespan, the length of which will depend on how careful you are in protecting the hip from stressful activities.

With sensible use, the chance that your joint will last more than 10 years is greater than 95 percent.

If the components do loosen, they can be replaced in what is known as a revision operation. This is more complicated surgery and usually isn't as successful as the first total hip replacement.

Over the last 30 years, improved surgical techniques and new implant materials have been developed, making total joint replacement one of the most reliable and durable procedures in any area of medicine.



What is a Hip Resurfacing?

Hip resurfacing arthroplasty also covers the two surfaces of the hip joint. Instead of removing the head of the femur, it is shaped to accept an anatomically shaped metal sphere, which has a small metal spike that penetrates the head of the femur. Likewise, the acetabulum is lined with a metal cup, which is wedged directly into the bone. The components are made of cobalt chrome, which is finely machined to produce a high quality surface with a low friction finish.



An example of a Birmingham Hip Resurfacing (Left) and Birmingham Mid-Head Resection(Right) implant. The only difference is the stem.

The resurfacing arthroplasty has a 13-year 97% success rate in appropriate patients and is intended for use in people of a younger age who are active and require a hip replacement.

However not every patient is suitable and correct patient selection is imperative. Your surgeon will decide and advise you as to which is operation is the most suitable for you. The results of a hip resurfacing depend on having strong healthy bone present as it seats on a much smaller area of bone on the femoral side.



An Xray of a patient with a BHR in one side and BMHR on the other.

The main disadvantage of resurfacing arthroplasty is the lack of long term results. However the success of resurfacing after 13 years is better than those after

conventional hip replacement. Although the operation for hip resurfacing is similar to a conventional total hip replacement, in some ways it is a more demanding technique. The usual risks of dislocation after resurfacing apply but are much less, because the resurfaced hip is the normal physiological size. The risk of a leg length discrepancy is much reduced..

Possible Complications

There is a risk of developing complications during or after *any* surgical procedure. The complication rate following hip replacement or resurfacing is low and special precautions are taken to prevent these from occurring.

Anaesthetic complications can occur as well as surgical complications- the latter depend on the quality of the bone and muscle. After the operation there is a risk of dislocation and precautions need to be taken for six weeks post-operatively. Your physiotherapist in the pre-operative consultation will explain these precautions to you.

Other possible complications include problems with wound healing and infection. There is a high risk of blood clots forming but the compression stockings and sequential pumps that are applied to your legs help to prevent this. Of importance is early mobilisation after the operation.

Please see our procedure specific consent forms for a thorough breakdown of potential complications.

Preparation for Surgery

Each patient is assessed on an individual basis. There are two main reasons for surgery - to reduce pain and to improve function. Once the decision has been made that you require hip replacement or resurfacing then the following procedures take place:

To ensure that you are fit for surgery you will be required to consult a physician for a full medical examination. You can speak to your surgeon or physician about donating your own blood or having a family member donate blood for you, prior to the operation.

The following tests may be done prior to seeing the physician:

Blood tests

Chest x-ray

The following tests are usually done by the physician:

ECG (electrocardiogram)

Lung function test

If you wish to interact with the physiotherapist before your operation, you can set up



an appointment either at your home or at the physiotherapy practice by phone. The post-operative procedure can then be explained to you and you will be given advice with regard to the precautions whilst moving, and the adjustments that need to be made in your home. Research has demonstrated that those patients who see a physiotherapist pre-operatively have a reduced length of stay in hospital and are less anxious.

The physiotherapist is able to assess the height of your bed at home, and a good chair of a reasonable height to sit on. This is important because hip flexion is restricted to 70° for three weeks post-operatively. It will also be necessary to hire a raised toilet seat for six weeks after the operation, to avoid excessive hip flexion. It is also important that movements into adduction and internal rotation are avoided so the physiotherapist will show you how to get in and out of bed, get up and sit down from a chair, and how to get in and out of a car. Crutch walking and stair climbing is practised as well, so that when you get up for the first time on day one post-operatively these movements are familiar to you. The physiotherapist will also assess your shower and the ease with which you can get in and out of it, as well as the position of your toilet. You will be able to practice those things that prove to be most difficult.

It helps if the person who will be caring for you once you return home is present at the pre-operative consultation so that he or she is familiar with all the instructions and is aware of when you will need assistance e.g. you will require assistance with washing and drying your feet and putting your stockings or socks on.

Please complete a pre-admission form for the hospital which needs to be handed in a few days prior to admission. This can be done at hospital reception. You will also need to see the pre-admission sister at this time.

You will be admitted either the day before surgery or on the day of surgery, depending on the time of your operation. You should stop eating and drinking at least six hours before surgery. You will be required to wash with special soap which we will supply prior to coming in to hospital if you are admitted on the same day as your procedure.

You will be admitted by the nursing staff and visited by your anaesthetist. You will be measured for compression stockings that are worn to prevent a deep vein thrombosis.

What to bring to hospital

- All your usual chronic medication in its original packaging so that it can be dispensed by the nursing staff while you are in hospital.
- A nightie or pyjamas- if possible the nightie should only be knee length.
- Slippers that have rubber soles and a back, or slip-on shoes also with an enclosed back.
- Dressing gowns should only be knee length.



- Toiletries should include body cream that the staff can use to rub your back when doing pressure care.
- Shower gel as picking up dropped soap can be difficult after your hip surgery.
- You can include shampoo if required because you will be able to shower before being discharged.
- Crutches can be brought with you or can be hired from Medlend on the eighth floor of the Claremont Hospital.
- You will need a raised toilet for when you are discharged home. This can be hired from Medlend or bought at Wynberg Pharmacy.

The day of surgery

Before surgery

The morning of your surgery you will need to shower with antiseptic soap.

A nurse will ensure you are prepared for theatre. You will be given a theatre gown to wear. Your leg and hip will be painted with special antiseptic solution and wrapped in a green theatre sheet. You will be asked to put items you might need in high care in a toiletry bag and this will be marked with your name and accompany you with all your notes from the ward.

The anaesthetist will visit you to explain the protocol that will be followed in theatre prior to your operation and pre-assess you to ensure that it is safe for you to have the anaesthetic. They may prescribe a tablet, which will help you to relax.

Your family will be allowed to see you on the day of the operation before going to theatre if they wish.

You will be taken to theatre on your bed accompanied by a staff member, where you will be handed over to the theatre sister who will take care of you until you have recovered sufficiently to leave the theatre complex.

During surgery

Depending on your general health, the anaesthetist will decide whether you will be given a general, epidural or spinal anaesthetic. The operation is performed in a special ultra-clean theatre. In routine cases, the surgery lasts about one and a half hours.

During the surgery and immediately afterwards you will be given antibiotics to prevent infection occurring in the new joint. You may or may not require a blood transfusion. You will remain in the theatre recovery room for a period of close observation.



After surgery

A ward staff member will transfer you from theatre to high care as a normal precaution and for extra pain control. You may remain in this area for 12 to 24 hours until you are ready to be moved back to the orthopaedic ward. Once you awaken you may find-

A mask for oxygen.

A drip- this replaces the fluids that may have been lost during the operation.

A cuff around your arm. This records your blood pressure.

A drain - there may be a tube next to the incision site that drains any excessive blood or fluid within the tissues. It helps the wound to heal more quickly by reducing the amount of bruising.

A gutter cushion or pillow - this will be placed under the operated leg to support the hip in the correct position. This will help to prevent unwanted harmful movements that cause undue stress to your hip. Movement of your operated leg, as instructed by the physiotherapist, is however an important part of the programme.

Sequential pumps - these will be placed around the calf muscles to promote better circulation of the lower limbs while in bed.

You must assist the nursing staff to move in bed by using the unoperated limbs. In particular lifting your buttocks off the bed is important for relieving pressure and the use of bedpans initially. You will be allowed to sit up to an angle of 70° for meals.

Your family can visit you in high care at specified times. Only two visitors may visit at a time.

Rehabilitation after hip replacement or resurfacing.

Bed exercises:

You will be instructed by your physiotherapist how to perform simple exercises. These consist of:

Breathing exercises including alternate side lying and coughing to keep your lungs clear

Leg exercises for both legs to:

- minimise the risk of blood clot formation.

- strengthen muscles and keep joints mobile.

- prepare your operated leg for improved walking technique.

The leg exercises are particularly important because the leg muscles on the affected side are often weak and tight as pain and stiffness in the arthritic hip has limited normal movement. Exercises will also help recovery by developing good strong muscles around the "new" hip.



On the morning after the operation, a physiotherapist will come to see you in the High Care Unit. She will treat your chest by rolling you into alternate side lying and instruct you in deep breathing exercises whilst shaking and percussing your chest. This is done to loosen any secretions and to encourage full expansion into the base of the lungs.

Exercises with the operated leg:

Ankle exercises

Pull feet up and push down.

Repeat 10 times every hour.



Static Gluts

Squeeze buttocks together.

Hold the contraction for 5 counts. Repeat ten times, three times per day.



Quad sets / Knee extension

Lie on your back with leg straight.

Tighten the muscle on top of your thigh and press the back of your knee downward into the bed.

Hold for 5 seconds.

Repeat 10 times, three times per day.

**Short arc quad/Extension**

Lie on your back with a towel under your knee.

Raise the heel off bed until knee is straight.

Hold for 5 seconds and slowly lower.

Relax.

Repeat 10 times, three times per day



Hip and Knee bending

Lie on your back.

Gently bend hip and knee upwards keeping heel on bed.

Bend knee to approximately 50° then slowly straighten. (Do not bend hip greater than 70°)

Keep the small of your back pressed into the bed.



NB. Always keep operated hip LESS than 70° to AVOID DISLOCATION

Hip Abduction

Keep leg straight and on bed.

Move leg slowly out to the side (small movement), and back.

NB. Only move to neutral, don't cross the midline.

Repeat 10 times, three times per day.



Bridging

Lie on your back with your knees bent.

Lift your buttocks up off the bed keeping your pelvis level.

Repeat 10 times



NB. Always keep operated hip LESS than 70° to AVOID DISLOCATION

Standing hip flexion, Abduction, Extension



NB. Always keep operated hip LESS than 70° to AVOID DISLOCATION

Hamstring Curls



Getting in and out of bed

Always bear in mind that your legs should be kept apart at all times. Whilst in bed do not lean forward beyond 70° at the hip joint, as you may cause it to dislocate. Get into and out of bed on the same side.

Getting out of bed:

- Move to the edge of the bed on the side of the operated leg.
- Come up onto your hands taking care not to bend your operated hip more than 70 degrees.
- Swing both legs round and onto the floor at the same time as pushing up into a sitting position on the edge of the bed. Assist the operated leg with the “good “ one.
- The unoperated leg should touch the floor first and take your weight.
- Push up into standing using your arms and unoperated leg into a standing position
- When standing, reach for your crutches and position them ready for walking



Getting into bed:

- Move to the same side of the bed as your operated leg.
- Stand with your good leg against the bed and the operated leg placed forward
- Put down your crutches and sit on the edge of the bed with your legs wide apart allowing the operated leg to slide forwards.
- Lean backwards with your upper body, press on your hands and move the unoperated hip further onto the bed so that you are sitting at an angle.
- Swing the operated leg onto the bed whilst lying back onto your elbows. If necessary assist it with the other leg.

Do not attempt to get up and down from a sitting position using your crutches as you may lose your balance and fall.



Sitting down and getting up from a chair

The chair should be approximately 60cm high and should have a firm cushion.

You will need to use a raised toilet seat for 6 weeks to avoid sitting too low.

After the first 3 weeks you may sit in a chair allowing the hip to bend to 90°.

You may not sit on a couch or “lazy-boy” and must continue to use the raised toilet seat until 6 weeks.



Sitting down on a chair with arms

- Position yourself so that your legs are right up against the chair.
- Place the crutches next to you taking most of your weight through the unoperated leg.
- Reach back for the arms of the chair one hand at a time.
- Slide your operated leg out in front, keeping your knee straight.
- Sit down on the chair.
- Reverse this process when getting up.
- Always make sure the crutches are within easy reach.
- Use the same procedure when using the toilet with the assistance of the raised toilet seat- at no time should you sit with the operated leg bent to 90° for the first 3 weeks.

DO NOT LEAN FORWARD WHILST SITTING THUS INCREASING THE ANGLE AT THE HIP FROM ABOVE .

Always make sure that your knee is lower than your hip when sitting.



Walking with crutches

You will be assisted into sitting on the edge of the bed. You will then walk as far as you are able with crutches or a walking frame and the assistance of the physiotherapist.

The sequence is always:

Crutches first

Then place the operated leg between the crutches.

Walk through with the other leg, pushing down hard on your hands to take the weight off your operated leg.

It is preferable that women wear a shorter nightie and dressing gown so that there is no risk of tripping over longer attire. Footwear should be "slip on" with backs and non-slip soles.

If you have had a bilateral hip arthroplasty, you will begin walking with a walking frame and progress to crutches when you are coping well on the frame.

Turning around - you should always try and turn with your operated leg on the outside. Your feet must be picked up at each step to prevent twisting or pivoting on your new hip. You will be assisted to get out of bed until you are able to do it independently.

Both crutches will be used for the first three weeks after your operation. After 3 weeks you may walk with one crutch. Start by using one crutch for short distances at home and gradually progress. Always use the crutch on the opposite side to your operated leg. Example: Right hip operation, the crutch will be held in your left hand.



Stairs

You will be taught to negotiate stairs by your physiotherapist before discharge. BOTH CRUTCHES will be used for 6 weeks after the operation when going up or down stairs. You may walk with one crutch after 3 weeks but you must use both crutches when negotiating stairs.

ASCENDING

First -	unoperated leg
Second -	operated leg
Third -	crutches

DESCENDING

First -	crutches
Second -	operated leg
Third -	unoperated leg

Just remember – good leg goes to heaven, bad leg goes to hell....



Bending

If you need to pick something up off the floor or lean over the basin, stretch the operated leg behind you, bend your unoperated leg and hold onto a firm surface



NB. Always keep operated hip LESS than 70° to AVOID DISLOCATION

Getting into and out of a car

Get into the back seat of the car, on the opposite side to that of your operated leg. Sit on the seat with your operated leg stretched forwards.

Leaning backwards gradually shift backwards along the seat using your arms and unoperated leg to propel you.

Leave the operated leg resting on the floor.

Lean against the opposite door with a pillow supporting your back.

Place a black dustbin bag onto the back seat to make sliding easier.



Dressing your lower half

You must not bend forward excessively to reach the foot of your operated leg, nor lift your operated foot up too far. You must make use of a long handled shoehorn to assist with putting your shoes on. You can also use a pair of long handled braai tongs to help you get pants or trousers over the foot of your operated leg.

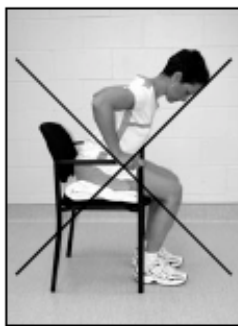
Precautions

The precautions are in order to prevent the danger of dislocation until healing is complete. There are four basic movements which must be avoided for six weeks after the operation. These precautions apply in all situations including sitting and whilst moving into and out of a bed or chair.

DO NOT CROSS YOUR LEGS. The operated leg must always be held out to the side away from the mid-line of the body.



DO NOT BEND THE OPERATED LEG EXCESSIVELY i.e. not more than 70° by sitting completely upright, or by bending the same knee too high towards the chest or by leaning forward whilst sitting. At three weeks post-operatively you may sit on an ordinary chair with your hip bent to 90°.



DO NOT TWIST THE OPERATED LEG IN OR OUT or twist your body on your leg i.e. reaching too far across your body. When walking or turning you should always keep your toes and kneecap, pointing straight ahead.



DO NOT LIE ON YOUR SIDE WITHOUT A PILLOW BETWEEN YOUR LEGS
You should avoid lying on the unoperated leg side unless you have placed a pillow between your knees and feet, which will support your hip. Your legs may not lie crossed.



Helpful hints on discharge

Go for short essential walks - do not take long walks for exercise

Your wound will be checked approximately 14 days after surgery and all dressings removed.

Use two crutches for up to 3 weeks after the operation. You may then progress to one crutch, but it must be held in the opposite hand to your “new” hip.

Start cycling at three weeks post-operatively

You may walk and exercise in water once the wound has healed- usually two to three weeks post operatively.

Your physiotherapist will increase the exercises that you should be practicing at 10 days, and again at 3-4 weeks post-operatively.

Medication

You will be sent home with prescribed medication to prevent blood clots. Your doctor will determine whether you should take aspirin or Xarelto until 35 days after surgery. If injections are necessary, your doctor will discuss it with you, and the nursing staff will teach you or a family member how to administer these.

You will be sent home with prescribed medication to control pain. Plan to take your pain medication 30 minutes before exercising. Preventing pain is easier than chasing pain. If pain control continues to be a problem, call your doctor.

Incision

Your stitches or staples will be removed on day 14 or after.

You should not take a tub bath until your stitches or staples are removed, but may shower if your dressing has been waterproofed.

Follow-up appointments

You will have a wound check after 2 weeks.

Thereafter a six-week follow-up appointment will be made for you to see your surgeon, who will then evaluate your progress.

Precautions for the rest of your life

If you develop an infection in any part of your body, the germs may spread through the bloodstream and infect your artificial joint. Please consult your home doctor immediately if you develop any of the following infections, so that antibiotics can be



prescribed: tooth abscess or extraction, boils, infected cuts and sores, bladder infections. If you should undergo any other operation, you must inform your doctor that you have an artificial hip so that appropriate antibiotics can be given to you.

All sports put more stress on your artificial hip than normal walking, but recreational sports such as golf, bowls or exercise bikes are relatively safe. Avoid contact and high impact sports. Please consult your surgeon before you embark on an exercise programme.

Being overweight places abnormal stress on your joint. Always guard against this as it can reduce the lifespan of your new joint.

Rather bend at the knees than the hips to pick up an object from the floor. When bending down to reach something on the ground, you may kneel on the leg on the un-operated side.

Conclusion

As you start using your new hip you should see continued improvement in your strength and endurance for up to a year after surgery. Total hip replacement is rated as one of the most successful orthopaedic procedures and should enable you to return to your work and cope normally with activities of daily living. Remember to keep your follow-up appointments.

Walk tall and enjoy your new hip....



Frequently asked questions

Will I have a lot of pain after surgery and, if so, what will be done to relieve it?

You will have pain following the surgery, but this will be relieved initially by the spinal anaesthetic or a local nerve block and later by strong pain killing injections into your drip. After some time this will be changed to tablets, and we recommend that you take these regularly for a couple of days.

Will I still experience pain after discharge?

Yes, you may experience pain occasionally as well as stiffness for some time after your surgery, as the muscles heal and your body adapts to the new joint.

Will I be able to shower once I am home?

Yes, you can shower but may need assistance with washing and drying your feet as well as putting on and taking off your stockings. Your dressing will be waterproofed so that showering is possible.

Is swelling of my knee and ankles normal after surgery?

Yes, to a degree. You can expect some swelling for a few months after surgery. This may be worse at the end of the day. However the swelling should have reduced by the morning or after you have been lying down. If it does not go down or there is pain associated with the swelling you should contact your surgeon immediately.

Will I need additional physiotherapy after my discharge?

You will be given an exercise programme to follow and you need to do this twice a day. This, together with regular walking, will be sufficient until your follow-up visit. It is advisable to see the physio at least at 14 days and 6 weeks. These appointments can be scheduled for the same day as you see your surgeon for follow-up.

How do I know if I am exercising too much or too little?

Let your body guide you. If you find that you are stiff one day, you have probably overdone it the day before. Just cut back and build up again slowly on your existing exercises but do not add any extra exercises.

How do I know if I am doing well or not?

There is no such thing as doing badly. Everyone works at their own pace and achieves goals in their own time. Never feel that you are progressing slower than someone else. There are no set time frames to achieve goals and if you work hard you will get there.

Can I go out in the first six weeks or should I stay at home?

There is no reason why you cannot go out. You will probably find that you are quite tired the first couple of weeks after discharge and don't really feel like going too far afield.

Is it normal to feel tired and washed out after my discharge?

Yes, don't forget that you have had a big operation and that your body needs time



and rest to recover. Take things easy and structure your daily activities. Also try and rest on your bed after lunch, mainly so that your legs are raised as this will help reduce swelling.

When can I start driving?

Every patient is different. Usually patients are able to drive at about 4-6 weeks. It is vital that you are able to perform an emergency stop without hesitating due to your hip. Left hip replacements using automatic vehicles can often drive sooner. Remember not to bend more than 70 degrees at the hip for the first 3 weeks and 90 degrees for the first 6 weeks.

Who do I contact if I have any problems or queries?

The team is always available to assist you if you have queries or problems. You are welcome to contact us at any time.





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