TOTAL HIP REPLACEMENT SURGERY

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Total hip replacement is an excellent procedure for relieving pain and improving function in an arthritic hip. Most people are very happy with their hip replacement and have very little pain after it has healed. Often, a mild stiff feeling and occasionally some discomfort when one first gets up out of a chair is present. A small percentage of patients have enough pain to be somewhat bothersome but usually this is mild compared to preoperative pain. It usually takes about 2 years for the hip to heal completely after surgery.

Post-operative range of motion of the hip is often improved somewhat after surgery. Improving range of motion, however, is not a good reason to pursue hip replacement. The improvement is variable, with most patients getting mild improvement.

Questions do arise as to the best operative approach for hip replacement surgery. Some large studies have been done and have shown that most of the common surgical approaches for hip replacement are equivalent in the time required for return to function. Most of the studies showed that the best indicator of successful outcome is the surgical approach that is most familiar to your surgeon. The approach that I use is the posterior approach. I have done over 5000 hip replacements using this approach. The anterior approach, which has historically been a very uncommon approach, has recently been touted as the best approach for quick return to function. This has not been shown to be true in most of the studies that have been performed. Furthermore, it requires longer operative times and usually results in significantly higher blood loss than the posterior approach. There is also a higher complication rate, including fractures of the femur, loosening of the femoral component, and infection.

The most common risk associated with hip replacement is the development of blood clots in the legs. This occurs in about 20-40% of patients if no prophylaxis for the blood clots is given. There are several agents which are used to help prevent blood clots after knee replacement. The most common, in patients with no prior history of blood clots is aspirin is aspirin twice daily for 1 month after the surgery In some patients, other blood thinners are used including Xarelto, Elliquis, Lovenox, and Coumadin. In general, these reduce the chance of getting a blood clot to about 2-3%. In most instances, the blood clots remain in the legs and are not life-threatening. Sometimes, however they can break off and go to the lungs and cause problems with breathing. Very rarely (in about 1 in 10,000 patients) these clots in the lungs are severe enough to cause death.

Infection is another complication of the hip replacement surgery. It is very uncommon, occurring in about 1 in 500-600 patients. It can occur around the time of surgery or can occur many years after

surgery. If it does occur, it usually requires further surgeries and IV antibiotics for treatment. Some infections are very difficult to eradicate.

Antibiotics have been prescribed to use prior to dental procedures after joint replacement. There is not good evidence to support or disprove this practice. In general, if one tolerates antibiotics well and is not prone to allergic reactions, I recommend taking them when dental cleaning or other dental work is necessary. On the other hand, if one is allergic to multiple antibiotics or has significant gastrointestinal issues when taking antibiotics, I recommend trying to use the antibiotics for the first 2 years after surgery and then discontinuing their use. During the first 1-2 years after surgery, while inflammation is still present, there is a higher risk of the knee becoming infected.

Another issue that can occur with hip replacement is dislocation of the prosthetic joint. This occurs in about 1-2% of patients. Most of these dislocations occur in the first 2-3 months. It is important to take care to avoid flexing the hip more than 90°. This is mostly a concern when getting up out of a chair or bending over. The precautions for this are relatively simple and consist of turning the leg outward or placing the leg behind your body slightly when bending over. When bending over while seated (such as when putting on shoes and socks), simply turning the knee outward and making sure to reach inside of your knee towards your foot is all that is necessary.

Finally, although uncommon, leg length discrepancies are a possibility after hip replacement surgery. Preoperative templating is performed to estimate the sizes of the prosthetic components that will be needed and their relative positions in the bone. There are, however, no definitive bony landmarks around the hip that can be used to verify the exact length of the limb. Furthermore, differences in the bone quality and shape can alter the final position of the prostheses and therefore have unexpected effects on the leg length. Postoperative measurement of leg length is also very difficult and variable. Several different landmarks can be used for measuring leg lengths and these often give several different results. Often, immediately after the surgery, the operated leg may feel longer. This is usually due to scarring and tightness in the ligaments and tissues around the hip which cause a tilt in the pelvis. Gradually, after 3-6 months these tissues stretch out and the leg lengths feel equal.

In general, most hip replacements (about 90%) should last your lifetime. Occasionally the hips can fail by coming loose from the bone or wear of the plastic. Also, sometimes injuries can damage the hip, although this is unusual. Infection is another reason that the hip might require reoperation. Also, if a hip dislocation occurs early in the postoperative period, the hip has a much higher likelihood of dislocating again. If recurrent dislocations do occur, it is often necessary to re-operate on the hip and alter the configuration or position of the components to prevent further dislocation.

Once the decision has been made to pursue knee replacement surgery, scheduling is done. Dr. Junick will have you see your primary care physician to get preoperative clearance for surgery. Bill, his

Physician's Assistant, will generally see you in the office about 2 weeks prior to surgery for history and physical exam. Please be sure to bring any notes and clearance from your primary care provider with you. This will save you considerable time at this appointment. During this visit home physical therapy arrangements will be made. It is very important to follow through on arranging this prior to your surgery date. It is often difficult or impossible to schedule the therapy in a timely fashion after your surgery. After seeing Bill, you will also need to go to the preop screening unit at the hospital (PASS Unit). The Preop nurses and anesthesiologist will review your chart and physical exam. At the pre-operative screening bacterial cultures will be done of your nasal passages to see if you are a carrier of Staphylococcus. If these are positive, we will have you treat your nasal passages with an antibiotic ointment to decrease the risk of contamination of your knee replacement with these bacteria.

On the day of surgery, we typically use a spinal anesthetic and some sedation. The spinal anesthesia does decrease the chances of getting a blood clot and allows the pain to have a more gradual onset so that it can be controlled more efficiently. Generally, you will be in the hospital overnight. Weightbearing as tolerated is allowed with a walker and you can progress as fast as comfortable. Most people will use a walker for 3-4 weeks. By about 1 month most people are walking reasonably well. By 2-3 months most people are reasonably comfortable. However, intermittent moderate to severe swelling and nighttime pain are both common during this time. Usually, around 3-4 months the hip does improve significantly and most of the swelling and nighttime pain decrease significantly. The hip usually becomes consistently comfortable with good function sometime between 3 and 6 months. It does take up to 2 years for complete healing of the hip to occur. In most people, swelling will dissipate completely over this time but some people will still have some swelling in the limb occasionally. It is not uncommon to develop pain over the outside(lateral) of the hip around 3-6 months after surgery. This is usually bursitis and is caused by the swelling of the IT band from surgery coupled with an increase activity around this time. This pain will typically (80-90% of the time) subside by one year post-op. It can, however persist, as trochanteric bursitis is a very common occurrence whether or not you have had a hip replacement.

When you are discharged from the hospital, you will have an occlusive dressing on your hip. This should be left in place for 7-10 days and then removed. All sutures are under the skin so there is no need for suture or staple removal. You will also follow-up with physical therapy. If you do not have adequate help at home or require more extensive rehab prior to returning home, skilled nursing facilities are available. Insurances are somewhat variable in their willingness to cover the cost of these facilities so occasionally alternate plans must be made. Follow-ups are generally at 5-6 weeks and then 3 months, 6 months, and 1 year postoperatively. After that we usually like to see you back every 3 years or so to re-x-ray the knee and make sure that no problems are developing.

After surgery, you will have an Aqua Cell dressing on the hip. As long as the edges of the dressing do not peel off of the skin, it is waterproof and will allow you to shower. It is also antimicrobial and can be left on 10-14 days. We recommend that the dressing be removed around 7-10 days post-op. There are no staples or external sutures. The sutures are all underneath the skin and will dissolve over 4-6 weeks. Steri-Strips are applied to the skin at the time of surgery and can be removed when the dressing is removed or, if you prefer, can be left on for another week or so.

You will be sent home wearing TEDS hose on both lower extremities to help prevent blood clots and swelling. They should be worn while you are up during the day and can be taken off at night when you are in bed. Prescriptions for a muscle relaxant and narcotic pain medication will be given to upon discharge from the hospital. These can be used as needed for muscle spasms and pain associated with the surgery. Every attempt should be made to wean off of these medications as quickly as tolerated as they do have side effects such as nausea, constipation and drowsiness. You should not drive for at least 6 weeks postoperatively. When you do drive, you should not be taking the muscle relaxers or narcotic pain medications. Tylenol and anti-inflammatory medications such as Aleve or Advil can be used at this time.

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