TOTAL KNEE REPLACEMENT SURGERY

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Total knee replacement is an excellent procedure for relieving pain and improving function in an arthritic knee. Most people are very happy with their knee 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. Most knees will get close to full extension and will bend about 120-130°. Kneeling on the knee will not feel particularly comfortable, but it can be done without any injury to the knee—generally after about 3 to 6 months after surgery. There is usually a small to moderate sized numb area just to the outside of the kneecap which is the result of some of the small skin nerves being severed when making the initial incision. This area may be fairly large soon after surgery, but shrinks significantly as time progresses. It usually takes about 2 years for the knee to heal completely after surgery.

The most common risk associated with knee 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 twice daily for 1 month after the surgery. In some patients, other blood thinners are used including Xarelto, Eliquis, Lovenox, and Coumadin. In general, these reduce the chance of getting a blood clot to about 2-3%. Most of the blood clots do 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 knee 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 surgery 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.

Arthrofibrosis, or stiffness in the joint, does happen in about 2-4% of patients. It does vary in degree. Some patients have some mild stiffness and loss of motion while others have a very stiff swollen painful knee that does not seem to improve. Nobody knows exactly why this occurs. It does seem to be associated with overactive nerves around the knee and with anxiety.

In general, most knee replacements (about 90%) should last your lifetime. Occasionally the knees can fail by coming loose from the bone or by wear of the polyethylene which is part of the joint surface. Also, sometimes injuries can damage the knees although this is unusual. Infection is another reason that the knee might need further surgery.

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 you will be given a prescription for physical therapy and/or scheduled for the therapy. It is very important to follow through on arranging this prior to you 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 with 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. A local nerve block in the thigh will also be performed by the anesthesiologist and this usually lasts anywhere from 12-24 hours postoperatively. All these modalities used together have been very helpful in minimizing post-operative pain and hastening the recovery process. Generally, you will be in the hospital overnight with discharge home usually occurring the following afternoon. Weightbearing as tolerated is allowed with your walker and you can progress as fast as you feel comfortable. Most people will use a walker for 3-4 weeks. Often, about 2 weeks after surgery, the knee will look very red and swollen, and feel somewhat more painful. This is not uncommon and usually resolves over about another week. By about 1 month most people are walking reasonably well. By 2-3 months most people are reasonably comfortable. Moderate to severe intermittent swelling and nighttime pain are both common during this time. Usually, around 3-4 months the knee does improve significantly and most of the swelling and nighttime pain decreased significantly.

The knee usually becomes consistently comfortable sometime between 3 and 6 months. It does take up to 2 years for complete healing of the knee to occur. In most people, swelling will dissipate completely by 2 years, but some people will still have some swelling in the knee occasionally.

When you are discharged from the hospital you will 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.

You will be sent home wearing TEDS hose on the leg opposite from your knee surgery to help prevent blood clots and swelling. Your operative knee will have a large, bulky dressing. Leave this dressing in place for 72 hours. The bulky dressing should then be removed, leaving a plastic, occlusive dressing in place if it is in good condition. The second TEDS hose, which should be given to you at discharge, should then be applied to the operative leg over the occlusive dressing. The TEDS hose should be worn while you are up during the day and can be taken off at night when you are in bed. As long as the edges of the occlusive 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. Typically, your physical therapist or home health care personnel will remove the dressing and remove your staples between postoperative days 10 and 14. If there is any problem having this done, contact Danielle at 505-724-4346 to arrange for staple removal in the office.

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 drive, you should not be taking 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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