

## Total Hip Replacement

### Introduction

This guide has been written to give you an understanding of your hip replacement surgery, please use this only as a guide and keep in mind that individuals differ therefore progress may vary. A total hip replacement replaces a worn out hip joint usually damaged by arthritis. With wear and tear the cartilage in this joint can wear away exposing the underlying bone. The joint then becomes very painful with restriction in movement.

There are many different hip components in use, but the principles of the procedure are all similar. There are two components, one to replace the worn socket, an acetabular cup, and another to replace the worn ball of the femur, a stem. The acetabular cup is made of a high-density plastic and the stem is made of metal. Most hip replacements are held in place with special bone cement.

### Preparation for surgery

No major surgery should be entered into lightly, therefore, your pain should be severe, your walking distance restricted and simple painkillers affording you no relief. You may also be using a stick.

Following your clinic appointment arrangements will be made for you to visit the Outpatients Department where the nurse practitioner will take a blood test, a urine test, an electrical recording of your heart and arrange a chest Xray and possibly a hip Xray.

The physiotherapist will also see you at this time to discuss your exercise regime and also devices, which will help you after the operation, such as crutches, a toilet seat raise, a long shoe horn etc. If you are on non-steroidal anti-inflammatory drugs such as Aspirin, Brufen, Nurofen (and Ibuprofen) Voltarol (Diclofenac) and Naprosyn (Naproxen) these affect your blood clotting factors. Please see your GP, inform him of the date for surgery and use alternative painkillers for at least 10 days before surgery.

If you are a smoker your postoperative recovery is greatly enhanced if you stop smoking two weeks before surgery. Smoking makes anaesthesia difficult and leaves you prone to chest infection or circulatory problems after surgery. Upon admission for surgery your consultant will again discuss the details of the operation with you and will ask you to sign a consent form. The anaesthetist will also visit you prior to surgery.

### The operation

The anaesthetist will prescribe medication to help you feel sleepy and relaxed before you go to theatre. Surgery is performed under a general anaesthetic. You may also have a spinal injection to numb the legs and help with pain relief. The operation itself usually takes a couple of hours, but you will not be back in your room for at least three to four hours as you will spend some time in the recovery room next to theatres.

### After the operation

When you awake you will probably have an oxygen mask on and a triangular pillow between your legs. This keeps the hip in position. You will have a tube (intravenous drip) in one arm to give you fluid and antibiotics. Additional pain relief or a blood transfusion can also be given through this drip. You

will also have tubes (drains) coming from your wound. These are attached to a bottle and collect fluid which seeps from the operating site for a few hours after surgery. Some patients also have a urinary catheter (tube into the bladder) for a while.

You will be wearing "anti-embolism stockings" which reduce the risk of blood clotting in the legs by improving circulation. Initially, you will have some pain, but this will be controlled either through the drip, with injections or tablets once you are able to eat and drink. The wound is covered with a clear plastic or white absorbent dressing. Sometimes fluid accumulates under this dressing, which can be readily drained. Stitches underneath the skin are normally used. These do not need to be removed.

The day after surgery some of the tubes will be removed. The Physiotherapist will visit you and get you to stand, and possibly, walk on your new hip. On the second day the Physiotherapist will get you walking with crutches. You will soon be able to sit out in a high chair and use the toilet with a raised seat. You must not sit on a low chair. This is because it would allow your hip to bend too far and could dislocate the hip. You should keep the triangular pillow between your legs when in bed whilst in hospital. You will be encouraged to be as independent as possible with the help of the nurses and physiotherapists until you are ready for discharge home.

### **Going Home**

Most patients can go home about 6 – 9 days after surgery. Prior to this arrangements can be made for the private hire or purchase of certain aids, including a

toilet seat raise, a shower chair, walking frame, crutches, walking sticks and a gadget to help you put on your stockings, socks and shoes. If you have stairs then the physiotherapist will teach you to climb these before you leave hospital.

If you live alone it is advisable to have a friend or relative staying with you for at least a week when you are home. You will also need help with shopping and domestic work in your home for about four weeks following discharge.

Once home you must continue with the exercise regime you discussed with the Physiotherapist. Always try to get out of bed on the same side as your operation for the first eight weeks. Have a half-hour lie down on your bed twice a day as this will help stretch your hip and sleep with a pillow between your legs for the first six weeks. Lie on your back for the first six weeks.

When you are sitting never let your knee be higher than your hip. Likewise, when you get up out of a chair, push up from the arms without leaning too far forward. It is common for your leg and ankle to become swollen after surgery. This may take several weeks, or even months, to resolve.

It is advisable to go for regular daily walks. As the days go by you will be able to walk greater distances. For the first four to six weeks you should expect to walk with two and subsequently one crutch for support. Thereafter you may use a stick.

### **As you progress**

Try general household activities – spread chores over the day and avoid long periods of standing.

The most rapid improvement is in the first six weeks, but your range of movement will improve and your confidence grows.

Many patients report progressive improvement for twelve months after the operation. You should soon be able to enjoy a normal sexual relationship. You must remember not to bend your hip further than a right angle or 90°, but it is usually safe to let your knees roll out. At first it is best to be on your back, but as time goes by you can be more adventurous. You will be seen after about 6 weeks in the Outpatient Clinic when you will be able to discuss your progress.

Unless you have specific problems you can usually restart hobbies such as gardening, bowling, gentle dancing, golf and swimming three months after surgery. It is best to avoid breaststroke.

### **Some useful advice**

- **Don't** cross your legs, knees or ankles.
- **Don't** allow yourself to become overtired
- **Don't** sit on armless chairs. You will need arms to help you push in to a standing position.
- **Don't** jump, even low distances.
- **Don't** lift heavy objects.
- **Do** the gentle exercises that you have been taught.
- **Do** increase your waling distance gently. Make sure you have somewhere to rest if you get tired.
- **Do** watch your weight.

### **Remember**

It usually takes:

- Two weeks for the skin to heal;
- Six weeks for the ligaments and capsule to heal;
- A further six weeks for them to strengthen; and
- Up to six months for the bone to fully heal and strengthen.

### **Driving**

You can start driving when you have adequate control of your leg, which is usually between 6 – 12 weeks. You must, however, inform your Insurance Company that the operation has taken place.

### **Risks**

A hip replacement is usually a very successful operation. Over 90% of patients come into hospital, have the operation, go home again and have no problem. Surgery should not be taken lightly, however, and there are some risks. The most common of which are:

Infection (1% risk). Even with careful surgical techniques and antibiotics infection is a rare complication. It is, however, serious and on a few occasions the artificial joint replacement needs to be removed.

- Blood clotting. Blood can clot in the legs following surgery. You are given special stockings to wear (TEDS) to help combat this. Occasionally a blood clot can break off and go to the lungs, causing severe breathing problems.
- Chest & Urinary tract infections are common risks to all surgical procedures.

- Dislocation (2-3%). This is most common in the early stages following surgery. On rare occasions the hip may need to be revised to control this problem.
- Leg length. We try and give equal leg length following surgery but some variation is common. This is usually not noticeable, but occasionally heel or sole raises may be need.
- Nerve damage. The major nerves around your hip can occasionally be stretched and damaged, leading to weakness and loss of feeling in your foot or leg.
- Stroke & major chest problems. These are very occasional, but catastrophic consequences of any major surgery.
- Loosening and wear. All hip replacements wear in time. Failure is usually caused by loosening. Components rarely break. 10% of hip replacements fail in 10 years, but around 80% are still functioning well after 15 years.
- Anaesthesia. This carries its own risks. These are small, but can be significant, and the anaesthetist will discuss these with you.

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