

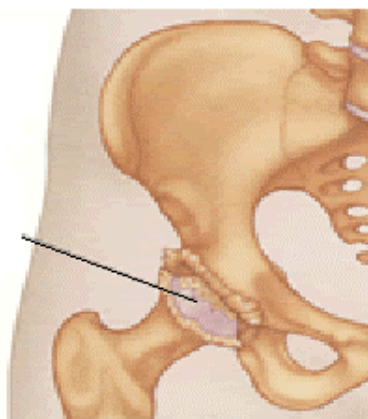
## Patient Information Sheet : Total Hip Replacement

### What Is It?

Total hip replacement means removing the damaged joint surfaces and replacing them with a mixture of metal and plastic implants (prosthesis). Usually the operation involves a cut down the outside of the hip joint, splitting of the deep muscles so that the old hip joint is dislocated and the joint surfaces are removed. On the pelvic side of the hip joint there is a socket which is scraped out and replaced by a new socket, usually of plastic but occasionally of metal. This can either be cemented into place or occasionally can be screwed or hammered into place using uncemented techniques. Likewise, the other side of the hip joint, the head of the femur, is cut away and replaced by a new ball, (again usually metal, but occasionally made of ceramic or other material). This is fixed into the thigh bone by a stem which goes down into the shaft of the bone and can either be cemented into place or left uncemented with various coatings of the implant to encourage fixation of the implant directly to the surrounding bone. Once the new prosthesis has been put into place the hip is then relocated and tested for range of movement and stability on the operating table before the surgeon sews up the tissue layers. Normally the skin wound is closed with either nylon stitches or metal clips.

Diseased Hip

Roughened ball and socket joint

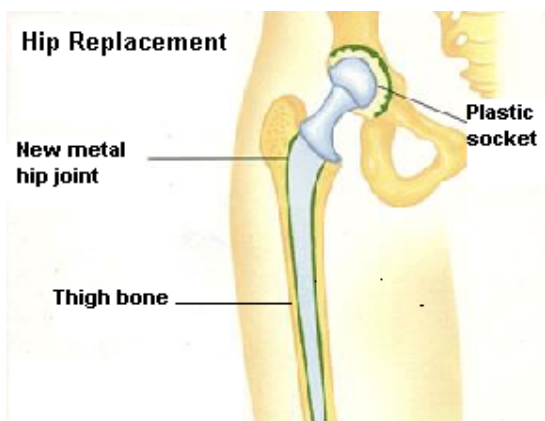


Hip Replacement

New metal hip joint

Thigh bone

Plastic socket



### Why Do We Do It?

Hip replacement is usually required as a result of damage to the joint surfaces as a result of :

- 1. Wear and tear arthritis (osteo arthritis).** This occurs in us all but occurs at different rates depending on our activity level, weight, family history and any associated diseases such as neurological (nerve) problems
- 2. Inflammatory arthritis.** The most common of these is rheumatoid arthritis and this involves damage to the joint surface due to inflamed or swollen joint lining which encroaches upon and erodes the joint surfaces. The resultant damage can cause deformity and pain much earlier than one would normally see in osteo arthritis. Even though the inflammatory condition may "burn out", the damage done to the joint will accelerate the ongoing wear and tear process. Other conditions associated with inflammation of the joint lining are gout, psoriasis, pigmented villonodular synovitis, and pseudo-gout (chondrocalcinosis). All, apart from rheumatoid arthritis, are really quite rare
- 3. Post traumatic arthritis.** This refers to a condition in which a normal joint has been damaged as a result of injury or deformity in the past, such as hip dysplasia, fractures involving the hip joint or complications from previous surgery such as infections.

Replacement of the hip joint is a very good operation and in fact has been shown statistically to be the most successful operation devised by modern day surgeons. This is when measured against other operations in terms of improvement in quality of life, function and the length of time the improvement lasts for. It is a very common procedure nowadays in most countries and has a success rate in the order of 95%. However, hip replacement is a major operation and it is only with the advance of operative techniques over the last 50 years that the operation has become so successful.

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### **What Are The Risks?**

The fact that 95% are successful means that 1 in 20 operations are **not** successful. If things go wrong the complications can be disastrous. Around 1 in 100 patients develop one of the significant complications such as **deep infection** (when infection gets deep into the new hip joint) and sometimes, even with antibiotics the infection cannot be brought under control until the new hip has been removed, the infection has settled down and then the operation has to be redone. 1 in 100 patients get significant **pulmonary embolus** (blood clot travelling from the veins in the leg or pelvis and passing through the heart and lodging in the lung). This blood clot blocks the blood flow to the lungs and causes chest pain and occasionally even death if the blood clot is large enough to block the blood flow through the heart and lungs to the extent where the body is starved of oxygenated blood. The pulmonary emboli arise from blood clots in the legs (DVT or deep venous thrombosis). **Deaths** from blood clots thankfully are very rare (said to be 1 in 1000 patients).

Around 1 in 100 patients who have a hip replacement develop **fractures** of the bones around the new hip replacement (prosthesis) i.e. femoral or thigh bone fractures or pelvic bone fractures. Again this can cause major complications and necessitate either more extensive surgery to stabilise the fracture or prolonged bed rest to allow the fracture to heal naturally. Sometimes the new joint fails to work together properly and the hip joint **dislocates** where the ball of the femur separates from the socket of the pelvis. If this happens it normally does so within the first few weeks of surgery and can require either wearing of a brace to hold the hip in position for anything up to 6-12 weeks or even re-operation to re-align the new hip joint. Thankfully each of the above complications is rare but when the major complications are added together, this is why 1 in 20 patients do not do well.

### **How Long Will My New Hip Last?**

No matter how well the new hip replacement operation is undertaken eventually the new hip will wear out and the plastic socket or the metal ball breaks free from the surrounding bone and becomes loose (**aseptic loosening**) and requires replacement. Also eventually the plastic socket will wear out and will require replacement and these factors usually occur between 10-20 years following joint replacement. This is why we try not to undertake these operations in patients under the age of 60. In order to try and prolong the life of the new hip various surgeons have tried other materials beyond the standard metal ball and plastic socket devised by Charnley in the 1960s. However, these other implants (metal on metal, ceramic, and others) are in early development and really should only be undertaken in regional centres where there are full audit facilities for monitoring the progress of these new types of operation. Recent evidence suggest that in the younger active patient, the hip replacement should be modified in order to allow full range of movement without increased risk of dislocation. Also the acetabular socket appears to last longer in these younger patients if it is of the uncemented type. Therefore, in my own practice I use a so-called "hybrid" hip using an uncemented socket into the pelvis and a large headed cemented stem into the femur. In the less active patients older than 70, the standard Charnley hip replacement using cemented socket and stem is proven, at the moment, to be the most effective implant.

### **Summary**

Despite these risks, the fact is that 95% of patients do very well following hip replacement and return to normal activities for their age following successful surgery and therefore the potential benefits far outweigh the potential risks. Also wear and tear damage to the hip is progressive and the hip joint will only get more worn and usually more painful, and make any subsequent hip replacement more difficult the longer it is left. For this reason hip replacement is rightly recommended when it is felt that the patient and I feel that the quality of life has been sufficiently impaired to justify the risks involved.

### **What Happens In Hospital?**

#### **On Admission**

Most patients undergoing hip replacement will be admitted on the day of surgery and will be seen by the anaesthetist to discuss the anaesthesia involved and then also by myself. The anaesthetist will discuss the types of anaesthetic to involve general anaesthetic usually, or regional anaesthetic such as nerve blocks or spinal block. When seen by myself I will go through the operation again with you, discuss any queries or points you may raise. Once you understand the procedure and the various risks and benefits have been explained to you, I will place a mark on your leg with a marker pen to indicate the site and type of operation to be undertaken. After the operation you will be given an injection of heparin, which is a drug used to slow down the clotting mechanism and is useful in helping to prevent deep vein thrombosis following surgery. These injections will continue for three weeks following discharge from hospital. You will be clerked in by the nursing staff and you should

remember to bring in with you suitable clothing for a 6-7 day stay, any medication which you are taking prior to coming into hospital and any notes and xrays which you may have in your possession (particularly with regard to your hip). You will also be seen by the physiotherapists and instructed in the use of exercises and aids, such as crutches. The operation will usually be undertaken mid morning and can last 1½-2 hours. You will wake in recovery (an area in theatre where monitoring of blood pressure and breathing will take place) until you are stabilised and then returned to your own bed. Occasionally patients may need to go to an area of more intensive monitoring, called the High Dependency Unit, usually for just one night. This is normally the case for patients who have significant medical problems such as heart or lung conditions which need closer monitoring than is usual.

### **After Surgery**

Once back on the ward, you will be encouraged to move around as much as comfort allows. This is true for both your legs and you should try and move your feet and ankles, as well as your hip, within the limits of the dressings, etc. You will notice that you have a drain or tube coming out of the hip area to take away any excess bleeding. This drain will normally be left in place for 24 hours. You will also notice that there is a small plastic needle in the veins in the back of your hand, (an intravenous cannula) which is left in place in case you need drugs or fluid. Once a decision has been made regarding any requirement for intravenous fluids or blood, then the fluids will be taken down but the needle is left in place for another day or two in case further fluids are required. Apart from moving your operated leg you should also try to move around in bed to avoid pressure sores on your bottom and heels, and also practice deep breathing exercises to encourage good lung function. You will be able to sit up in bed and begin taking fluids and food within three-four hours of the operation. Normally, patients who have had a hip replacement are in hospital for five-seven days in total and begin getting out of bed within 24 hours of surgery. You should be independently mobile, getting in and out of chairs, getting in and out of bed, and walking around the ward within a few days. Prior to leaving hospital you will be asked to ascend and descend stairs just to ensure that you are capable of doing this comfortably and safely. When you leave hospital you will still be using your crutches but will be encouraged to put as much weight through your operated leg as possible.

### **Post Operative Progress**

On discharge from hospital you will be given a note to keep at home which summarises your hospital treatment in case you have any requirement for emergency GP visits over the first two-three days. A separate letter will be sent by the hospital to your GP and a more detailed letter will be sent by myself summarising your hospital stay and post operative progress. However, this often takes a few days before it arrives. Your wound will normally be covered by a wound dressing and underneath will be a series of metal clips or staples which will need to be removed 12-14 days after surgery. This will be arranged by the hospital for you to either come back to the hospital or preferably in liaison with your GP where the district nurse will come and see you at home. Once home you can shower or bathe and get the wound wet, even with the clips in, but you should not let the wound soak until the clips have been removed.

You should be given any medication which you brought in to the hospital, to continue using at home, as directed by myself and the nursing staff. Also, any extra drugs such as pain killers or anti inflammatories which you require, will be given to you to ensure an adequate supply over the next few days before you can get repeat prescriptions from your GP or before these drugs are no longer required.

### **How Mobile Will I Be After Discharge?**

Before you are allowed to leave the hospital you should be independently mobile with your crutches and be safe, even walking up and down stairs. For this reason some patients need to stay somewhat longer than normal. The average hospital stay for a hip replacement patient is around seven days, but it can vary between five days and up to two weeks. Although you will be encouraged to get outdoors for short periods, for most of the first six weeks you should be indoors. Walking would be encouraged outside but you should be using your crutches at all times, and in non crowded areas unless you are with friends or family.

### **When Can I Drive?**

Normally patients are advised to refrain from driving completely for at least six weeks, i.e. until the first clinic review with myself. After that time, once you are able to walk without your crutches, you are considered safe enough to drive but this would normally involve short journeys only for the first couple

of weeks, before progressing to normal driving. If the operated leg is your right side it is often harder to recover sufficient strength and confidence to allow safe operation of the brake. Therefore it could be 9 or 10 weeks before you are safe to drive following a right sided hip replacement. As a general rule, once you are able to walk without crutches and sticks without a limp you are able to drive.

### **When Can I Return To Work?**

Most patients will be off work for around three months. If your work is sedentary or supervisory you can return to work in a part time capacity and/or on light duties from around six weeks following surgery. However, this would only be if you have a degree of control over your working environment. Normally, return to work will be discussed more formally at the six weeks post operative clinic visit.

### **What Drugs Will I Need Following Discharge?**

As mentioned above you will be given the medication which you brought into hospital to take home with you. If you are on medication for medical conditions such as diabetes, asthma, blood pressure treatments, etc. these should be continued up to coming into hospital and then re-commenced on discharge from hospital. Specifically with regard to the hip operation, you may require a few weeks supply of pain killers or anti inflammatory and this supply will be given by the hospital. You will also be instructed in the use of Heparin (a drug used to reduce the risk of thrombosis) such that you can give yourself injections of the medication once a day for up to four weeks following the operation, i.e. around three weeks after discharge from hospital. Beyond the medication provided by the hospital, simple analgesics such as Paracetamol, Nurofen (a mixture of Panadol and Ibuprofen) or stronger pain killers such as Distalgesics, Co-dydramol, etc. can be used. However, more prolonged excessive use of these medications would suggest a review by your GP or myself is required to ensure there is no complication.

### **What Exercise Should I Do?**

Prior to discharge from hospital you will be seen by the physiotherapists and given an exercise programme to follow. This is important, first of all to get your hip working properly following the operation and secondly to help recover any muscle loss which has occurred as a result of the prolonged wear and tear process which led to the necessity for a hip replacement. Usually the physiotherapist will arrange for you to be reviewed either by the physiotherapists at the hospital or a more local physiotherapy unit. On average this would be once per week during the first few weeks following discharge from hospital. This will allow the physiotherapist to monitor progress and give further advice and encouragement as required. The amount of physiotherapy will be dependent on individual circumstances.

### **What Does It Cost Privately?**

Most insurance policies fully cover the cost of surgery and I do not charge over the recommended medical insurance guidelines. If you are not insured, the Fitzwilliam Hospital has a Fixed Price Package for most procedures, including total hip replacement. This price includes all surgeons fees, anaesthetists fees, theatre fees, etc. Total hip replacement surgery usually costs in the order of £8,500.00 - £9,000.00 at the present time.

### **What Happens If Things Go Wrong?**

Should you be unfortunate enough to develop a complication either as an in patient or following discharge from hospital this will be dealt with either by your own GP or myself. If the problem develops at home you can phone the hospital ward and speak to the nursing staff on duty for advice. They would normally be able to deal with most queries or suggest suitable alternatives such as phoning your GP, attending the local accident and emergency department or returning to hospital depending on the circumstances.