Hampshire Hospitals NHS
NHS Foundation Trust

Department of Trauma & Orthopaedic Surgery

HIP REPLACEMENT

CONTENTS

INTRODUCTION

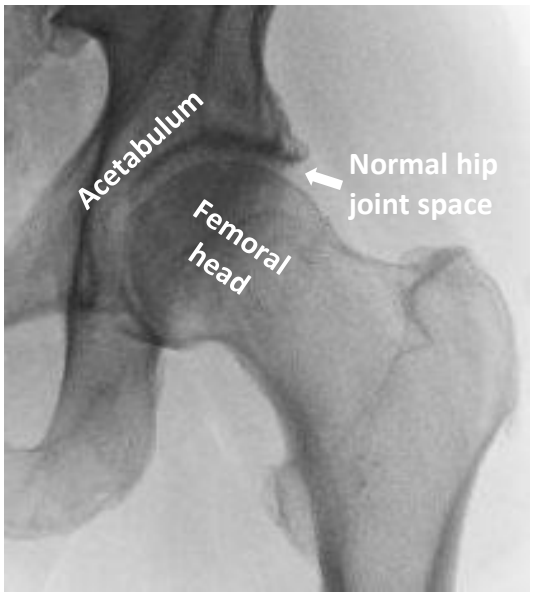
About the hip

The hip is a ball and socket joint that allows your leg to move forwards, backwards and sideways as well as rotating. Both the ball and socket are lined with an extremely smooth substance called articular cartilage that provides an almost friction free articulation.

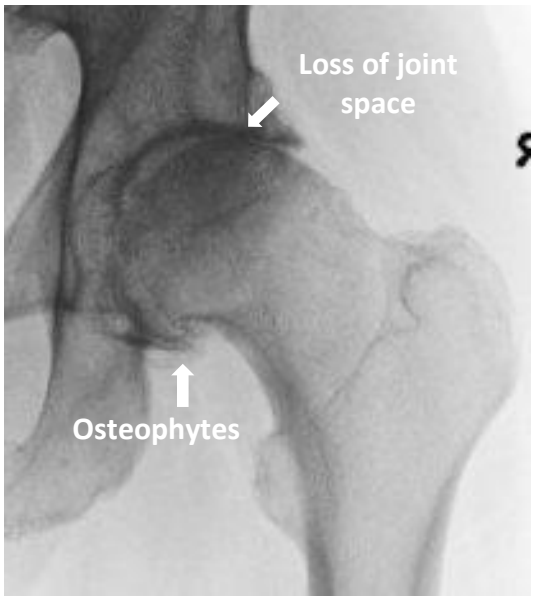
Arthritis is a process in which the articular cartilage is destroyed; once cartilage is damaged or destroyed it's gone for good. Arthritis can develop over years or fairly rapidly and can follow a serious injury. Injury, wear & tear and a family history of arthritis all seem to play a part.

As the cartilage wears away the joint becomes increasingly stiff, painful and difficult to move. Stiffness is very often the first sign, then pain on activity and finally pain at rest or at night. Your surgeon may offer you a total hip replacement when pain and disability are having a serious effect on your daily activities.

A hip replacement is very effective in relieving pain and stiffness and will allow you to return to near normal activities, with only a few minor restrictions.



Normal Hip



Arthritic Hip

What is a hip replacement?

Hip replacement surgery is extremely successful. The first total hip replacement was performed over 50 years ago and since then millions of people have undergone replacement surgery. In the UK alone almost 50,000 replacements are performed every year.

The procedure uses biocompatible (body friendly) implants to replace and resurface the bones of the joint, recreating the smooth gliding surfaces of the joint. Total hip replacements are typically made from a combination of metal alloys such as titanium or cobalt chromium, medical grade polyethylene (a durable plastic) or ceramic. They may be implanted with or without bone cement.

For more information please read the section entitled 'Types of Hip Replacements and Bearing Surfaces' found later in this booklet.

What are the potential risks and complications?

INTRODUCTION

A hip replacement is an extremely successful operation. At least 95% of patients are satisfied with their new hip. It is very effective in getting rid of the pain experienced from the osteoarthritis or other degenerative hip problems. It also improves the range of hip movement and allows you to return to a nearly normal level of activity.

As with anything in life there is always a possibility of problems or unexpected events occurring. For example, even crossing the road or a car journey has inherent risks, but this should not deter you travelling providing you take reasonable precautions. This is also true of any major operation such as hip replacement.

The list of risks provided here is not intended to frighten you, but is for your information. It covers both major and minor risks but it is not comprehensive.

2. ANAESTHETIC AND MEDICAL

The type of anaesthetic needed for a joint replacement may be either a general anaesthetic, an epidural or spinal anaesthetic (an injection into or around the spinal canal) and / or a nerve block (to numb the nerves around the hip).

For further information on this please read the section entitled 'Types of Anaesthesia' found later in this booklet.

Any anaesthetic and major operation carries a very small increased risk of being complicated by the following medical conditions:-

1. Heart Attack
2. Stroke
3. Chest Infection - After any general anaesthetic there is a very small chance of developing a chest infection. This is usually treated with antibiotics and breathing exercises
4. Deep Vein Thrombosis (DVT) - a blood clot in the veins of your leg
5. Pulmonary Embolus (PE) - a blood clot in the lungs

The risk of having a DVT or PE is increased in certain circumstances. We always assess your risk before the operation. It is very important to tell us if you have ever had a DVT or PE or if any family member has ever had one.

Measures are always used to help prevent thrombosis and these may be mechanical, such as pumps for your feet and getting you up as soon as possible after your operation, or with blood thinning injections or tablets (these can however lead to an increased risk of bleeding and bruising). We will discuss this with you and tailor the best regime to suit you.

We will make sure you are medically fit for your operation and measures will be used to reduce the risk of any medical complications.

You may require extra tests before your operation if we have any concerns.

3. BLOOD TRANSFUSION

During and after the operation you will lose some blood. The blood you lose will usually be made up by your own body in the weeks after surgery.

A blood transfusion is rarely necessary these days. Blood needed for a transfusion is always tested and matched to your own but still carries very small risks associated with it such as :-

1. Rejection and reaction to the donor blood
2. Transmission of infection

5. INFECTION

An infection can occur after any operation but it is particularly important that you understand its consequences when undergoing a joint replacement.

There are two types of infection:-

1. Superficial Wound Infection
   This is an infection of the healing wound where it is red and may have a small discharge. It is usually treated with a course of antibiotics but occasionally it may require a further small operation to help clear it.

2. Deep Infection
   There is a risk of an infection with bacteria getting around the hip replacement at the time it is inserted or during wound healing. The risk of a deep Infection is about 1% (i.e. 1 in every 100 cases).

   This is a very serious complication. If a deep infection occurs it may necessitate the hip replacement being removed so that the antibiotics can then work more effectively. This can mean a prolonged period in hospital before a further hip replacement can be reinserted.

   Very occasionally a further hip replacement is not possible and we have to leave the patient without a hip replacement. These patients can normally walk short distances often without the use of crutches but a pronounced limp is inevitable. This is called a "Girdlestone Procedure" and used to be the treatment for severe pain and arthritis before hip replacements were invented.

Precautions are taken before the operation to prevent an infection. These include the taking of nasal and skin swabs (to make sure you are not carrying MRSA bacteria in your nose or on your skin) and ensuring that there is no damage to your skin such as cuts, wounds or infections.

Prophylactic antibiotics (to reduce the risk of infection at the time of the surgery) are always used.

6. WOUND AND LEG PROBLEMS

1. Haematoma
   Bruising can develop around the wound and this can track down towards the knee. This is common and is usually not a problem resolving over a few weeks.
   Occasionally a more significant bruise (haematoma) occurs under the wound and this can delay the healing. A small operation may be required to release this blood collection.
   This is more likely to happen if you are taking Aspirin, Warfarin or anti-inflammatory medications (such as Ibuprofen or Voltarol). Please inform us at the Pre-assessment consultation if you are taking this type of medication. Usually stopping it for a specified period

of time before your operation reduces the risk; you will be advised about this in the Pre-Assessment Clinic.

2. Tender Scar and Trochanteric Bursitis

Some people have discomfort around their scar. Very occasionally it persists and is called trochanteric bursitis. Usually measures such as physiotherapy and time will help settle this problem.

3. Leg Swelling

Leg swelling is quite common after the operation. It tends to improve over night with rest and leg elevation. Usually there is no underlying problem. The vast majority of this swelling settles over a 2 to 3 month period and does not cause any long-term problems. If it is worsening or becomes painful then you should seek advice as one of the causes of this swelling can be a deep vein thrombosis.

4. Groin Aches and Thigh Discomfort

Minor aches and pains are usual. It must be remembered that the painful arthritic joint has not been used properly for a long time and your muscles can therefore be weak prior to the surgery. You will be exercising your new joint and most people experience some aches and pains for a few months while their muscle strength is building up again.

In patients who have an uncemented hip replacement, occasional thigh pain is felt until the bone grows onto the metal component and stabilises it.

5. Limp

This is common initially as your muscles recover from the surgery but improves and usually disappears once the muscles have regained their strength.

Very occasionally a nerve is bruised or damaged and the limp will be permanent. The risk is dependent on the type of approach your surgeon makes to replace your hip but can be at least 1% (1 in 100 cases).

6. Leg Length Difference

Almost everybody, even if they do not have hip problems, has a slight difference in their leg lengths. Although we try and ensure that your leg lengths are the same during the operation occasionally, for technical reasons, this is not possible.

Contractures of the hip joint caused by the arthritis are released at surgery, thereby restoring the leg back to its normal length but making it feel tight initially

Most people will initially feel that one leg is longer or shorter than the other after the operation. That feeling usually settles within a few weeks.

Even if there is a measurable leg length difference, most people will not notice a difference of up to ½ inch. If after a period of a few months it is still noticeable, occasionally a small shoe raise is helpful.

7. Referred Pain

If you have a back problem or a knee problem as well as your hip problem, then pain from these two areas can be felt as if it is in the groin area. If you do experience any discomfort or pain in your hip or groin after the operation you should inform your surgeon or GP so that the cause of it can be investigated.

7. DISLOCATION

Risk of dislocation is about 2-3% (2 to 3 in every 100 cases).

A dislocation is when the ball of a hip replacement pops out of its joint. The risk can be dependent on the type of approach your surgeon makes to replace your hip and the size of the head of the femoral component.

A dislocation can occur at any time after your hip replacement but is most likely to occur during the first 6 weeks while all the muscles and tissues are healing. After the first 6 weeks the risk of dislocation is less likely.

You will be given very specific instructions on how to prevent dislocation. You will need to learn slightly different techniques of how to pick things up off the ground or reach your feet. The things you will not be able to do are squat down or bring your knees up to your chest. You need to follow these instructions very carefully especially during the first 6 weeks after your operation. This is unlikely to restrict your activities significantly. In general you will be able to undertake all normal activities.

Women have to be generally more careful because socially they sit and pick things up in a slightly different way from men. They have to learn a different way of doing these activities.

If you follow the advice and guidelines given to you then a dislocation is unlikely to occur.

8. OTHER COMPLICATIONS

1. Allergies

   If you are allergic to anything (causing swelling, a rash or difficulty breathing) please let us know at the pre-assessment consultation.

   Occasionally people have allergies to some of the medications (e.g. antibiotics) and materials (e.g. metal) we use for the hip replacements. We test people for the common allergies such as iodine or Elastoplast.

2. Urinary Retention

   Some patients find they are unable to pass urine for several hours after having major surgery. If this occurs causing stretching of the bladder or pain, then you may require the insertion of a catheter. In most cases we can then remove the catheter a day or two later once you are up and about.

This is rarely a problem in ladies. It is more common in men who have developed an enlarged prostate. If you feel you have symptoms such as having difficulty in passing water, especially having to get up frequently at night, please let us know before your operation. If necessary a referral to see an urologist will be arranged.

3. Fracture

Very occasionally during the operation the bone may break. The break will normally be fixed at the time of your surgery. Postoperatively you may be able to mobilize normally but you may be asked to use crutches for a period of time. Very rarely the fracture may be treated with a period of bed rest.

4. Nerve and Artery Damage

Damage to a major nerve or artery can occur at the time of surgery but is extremely rare.

9. REVISION SURGERY

Hip replacements do not last forever. Research shows that up to 95% of hip replacements are lasting 10 years without problems and may last even longer. They do have the potential to loosen or wear out as does any piece of mechanical machinery. If your hip replacement does wear out or becomes loose and painful it can be revised in the vast majority of cases. This is called a revision hip replacement and is a much bigger and more difficult operation than the first hip replacement.

There are many different types of hip replacement. For further information on this please read the section entitled 'Types of Hip Replacements and Bearing Surfaces' found later in this booklet.

CONCLUSION

This is for your information to help you understand more about a hip replacement. It is certainly not intended to put you off having surgery or to unnecessarily worry or frighten you. In general a total hip replacement is an extremely successful pain-relieving, mobility restoring procedure. Many people who have total hip replacements return to a near normal life with very few restrictions. Sports including swimming, cycling, walking and doubles tennis are possible again.

Patients need to be aware that occasionally things do not go quite as planned. In making up your mind that you wish to have the operation you must be aware of the risks so that you balance them against the benefits of the operation. The time for a hip replacement is when you feel the benefits of the pain relief and improved mobility outweigh the potential risks. This information booklet does not list all problems that might be encountered following a total hip replacement but covers the vast majority.

How long will my hip replacement last?

Fact
95% of hip replacements will last for 10 years

All hip replacements have a limited life expectancy dependent on an individual's age, weight, level of activity and medical condition.
Hip replacement longevity will vary in every patient. It is important to remember that a hip replacement is a mechanical device and can wear out. While it is important to follow your surgeon's advice after surgery there is no guarantee that your particular implant will last for a specific length of time.

Why do implants fail?

The most common reason for failure in a hip replacement is that the components become loose and / or wear out. Old components can usually be replaced with new ones but this is a much bigger operation than the first hip replacement.

Will I have restrictions after surgery?

You will be advised not to participate in high impact activities such as running, squash, singles tennis and from playing contact sports.
You will also be restricted from crossing your legs. Six weeks after your surgery you will be instructed how to bend safely past a 90° angle. You will be advised by your consultant if other restrictions need to be applied depending on the type of hip replacement you have received.

What sporting and recreational activities will I be able to participate in after my recovery?

You are encouraged to participate in low impact activities such as dancing, golf, swimming, cycling, gardening and gym work (after instruction). Other activities may be possible but please ask about them.

Will I notice anything different about my hip?

You may notice some numbness around your scar. The area around your scar may feel warm. You may also notice some clicking as you move your hip as a result of the artificial surfaces coming together.

When will I be able to return to work?

We recommend that most people will need at least six weeks off from work. Patients with more sedentary jobs may be able to return to work sooner. The timing of your return to work will depend very much on the physical requirements of your job.

When will I be able to drive?

Getting back to driving will depend on your individual speed of recovery. Generally it will take between two to six weeks. You will be assessed approximately two weeks following surgery and advised when you will be able to recommence driving.

RAPID RECOVERY FOLLOWING TOTAL HIP REPLACEMENT

The field of orthopaedics is constantly researching new techniques to help make joint replacement surgery less painful and to help patients recover more quickly. Here are some areas that have been shown to help your recovery.

1. A better understanding of your operation. Fear of the unknown is often the greatest barrier to recovery. We believe that it is most important that you fully understand the recovery process before you have your surgery. In this way you will be able to help yourself. The rest of this booklet explains in detail each step of hip replacement, from preparation for surgery to full recovery.
2. A smaller incision. The operation will be performed through a small incision where possible. The reduced trauma of this smaller incision can aid a rapid recovery. However, not all patients are suitable for this type of 'mini' surgery as obesity and extensive joint damage may necessitate a longer incision. It is important to realise that a longer incision does not necessarily mean a more protracted recovery.
3. Your care after surgery. Although this is a big operation doing the following things can significantly aid your recovery:
    a) Drinking plenty of fluids rather than having an intravenous infusion 'drip'.
    b) Getting up quickly after your operation.
    c) Avoiding very strong pain killers if possible as these can make you nauseous and sleepy.

The Rapid Recovery Process

In the Rapid Recovery Programme you mobilise at your own individual rate; there are no fixed rules as has traditionally been the case. You will be assessed throughout your recovery and advised when you may resume activities. Most people will be able drive between 2 and 6 weeks, garden after four weeks and play golf about six weeks following surgery. Every person's recovery time will vary but in most cases it will take about half as long as a traditional recovery programme. It is a patient based programme and will depend upon you.

ADVICE WHILE YOU ARE WAITING FOR YOUR HIP REPLACEMENT

While you are waiting for your hip replacement there are a few things you can do that may help speed your recovery.

General Exercise

General exercise is always beneficial and continues to be so whilst you are on the waiting list. It will also help to speed your recovery.
If exercise results in excessive pain in your hip joint you will need to modify the exercise to suit you. Please follow the pre-operative exercise programme.
Gentle exercise such as cycling, swimming or walking all helps. It is better to take pain killers and do the exercise than not to exercise at all.

General Health

Keep yourself as fit and healthy as possible whilst you await your operation as it will help with your recovery.
If your general health deteriorates it is important to see your GP so that any problems can be dealt with before your operation.
In particular it is very beneficial to stop or at least dramatically reduce smoking.
Alcohol in moderation is not a problem.
If you have a weight problem, losing weight will help reduce the load taken through the hip joint. This will be of benefit before and after your operation. It will also help the surgeon make a smaller incision for your operation. If you require help with this you may consider asking your GP for a referral to a dietician.

Pain Relief

If you are experiencing pain in your hip joint and are not taking any pain medication or the medication you are taking is not effective, your GP may be able to prescribe something to help relieve this.

Load Reduction – using a stick

Reducing the load taken through your hip joint may help to reduce your pain.
You may wish to use a walking stick (held in the opposite hand to the affected joint). It will help reduce the load whilst you are walking.
Adequate rest periods and avoidance of unnecessary strain also help to reduce the load on your hip joint.

Foot Care

It is very important to pay particular attention to foot hygiene as minor wounds, sores or infections may result in your operation being cancelled.
Be careful when visiting the chiropodist; tell them you are going to have an operation.
If you have any concerns seek advice from your GP.

Skin Care

If you have any cuts, abrasions, rashes or skin conditions please see your GP as this may also delay your surgery if left untreated.

Dental Care

It is advisable to visit your dentist to ensure that your teeth are in good order prior to your operation, as any dental infection may spread to your hip joint.

WHAT HAPPENS BEFORE THE OPERATION?

Hip School

You will be given an appointment to attend Hip School.
Here you will be assessed by a Physiotherapist or Specialist Nurse and given a specific exercise plan to help strengthen the muscles that support your hip.
At Hip School you will be given a talk about hip replacement surgery. This is to ensure you understand exactly what is going to happen throughout the process of having a hip replacement, and what you can do to make your operation and recovery as quick and successful as possible.
You will also be shown how to use crutches and practice climbing stairs.
You will have the opportunity to ask any questions you may have.
You will be seen by a member of the Occupational Therapy Team who will talk to you about your home environment and any equipment you may require to help you after discharge from hospital. They will discuss any issues and help you to make plans for your discharge. They will also demonstrate the gadgets available to help you dress independently.
You should have been given a DVD to watch. Please watch this as it complements this booklet. If you have not been given one please ask us. You may copy it if you wish but please return it to the department at your 6 week post-operative check-up.

Pre-Assessment Clinic

Before your operation you will be asked to attend the Pre-Assessment Clinic where a thorough physical assessment will be carried out by the nurses to make sure that you are medically fit enough for surgery.
At this clinic routine pre-operative tests including urine, blood, ECG (heart trace) and X-rays if required, will be carried out.

Skin swabs will be taken to screen for MRSA (Methicillin Resistant Staphylococcus Aureus - a normally harmless bacteria that can, on occasions, cause wound infections).
We will confirm with you the plans that you have made for your discharge.
This appointment will also provide you with an opportunity to speak to your Consultant and / or their Registrar. You will also be asked to sign a consent form.

You can be in the clinic for 3 to 4 hours.

Prior to your admission

- Ensure that you assess your home for ease of movement with crutches or a walking frame. Remove any loose rugs, which may cause you to trip.
- Put objects that you use regularly in easy reach so that you do not have to bend or stretch.
- Identify people who will help do your shopping, laundry and cleaning.
- All discharge arrangements and plans must be made before you come into hospital. If you feel there may be a problem please tell us and we can help.
- Arrange transport in and out of hospital.
- Please make sure you have a supply of your normal medication for when you go home.

What to bring with you

In addition to your personal belongings you will need to bring the following:

- Any regular medication you are taking (in its original boxes / containers).
- Appropriate foot wear e.g. trainers or well-fitting shoes NOT mules or 'flip flops.'
- Loose comfortable clothing (you will be expected to dress the day following your operation).
- Nightwear.
- Please bring your dressing aids as advised by the OT in hip school.
- Towels and toiletry bag including hand wipes.

Please leave valuables at home.

YOUR STAY ON THE ORTHOPAEDIC WARD

ADMISSION

You will be admitted on the day of your surgery.

Nursing Assessment

You will be welcomed to the ward. A nurse will check your details and complete the nursing assessment.

Do feel free to ask any questions.

You will be provided with:

- Foot Pumps (Intermittent Pneumatic Compression (IPC) boots) - inflatable boots to help your circulation, reduce leg swelling and protect you against Deep Vein Thrombosis.
- A wedge to help maintain the correct position of your hip following surgery.

Your temperature, pulse, respiration, oxygen saturation and blood pressure will be recorded.

The nursing staff will administer any pre-medication as prescribed by the anaesthetist.

Physiotherapy

A physiotherapist will instruct you in deep breathing and circulatory exercises and check you are using your crutches correctly.

Anaesthesia

The anaesthetist will visit and examine you to ensure you are fit for surgery. They will discuss the type of anaesthesia that will be used, the methods of pain control available, and prescribe any medication to be taken prior to surgery.

Surgical Team

Your Consultant, or a member of the surgical team, will mark the operative limb and ask you to confirm your consent form.

Going to Theatre

You will be assisted into a theatre gown and your bed prepared.

Theatre staff will collect you from the ward and take you to the operating theatre.

POST SURGERY

Following surgery the inflatable foot pump boots, wedge and a dressing will be present. You may also have an intravenous infusion 'drip', an oxygen mask and very occasionally a wound drain.

Nerve blocks inserted by the anaesthetist in the operating theatre may leave your leg temporarily feeling weak and numb when you wake up.

You will remain in the recovery area until your condition is stable and your pain is well controlled.

On return to the ward the nursing staff will take regular observations of your temperature, pulse, respiration, oxygen saturation and blood pressure. They will monitor pain control and give you pain relief as appropriate.

You will be encouraged to drink fluids straight away, and will gradually be allowed to recommence a normal diet.

You will be assisted with all your hygiene needs.

We will encourage you to sit out of bed once you feel well enough.

YOUR RECOVERY AFTER SURGERY

During this time you will begin physiotherapy for your new hip.

It is important to start moving your new hip as soon as possible after your operation to promote good blood flow, to regain movement and muscle strength, and to help the recovery process.

You should be out of bed and walking as soon as possible with a Zimmer (walking) frame or crutches, definitely within 24 hours of your operation.

It is very important that you wear your foot pump boots whenever you are not walking. You must remind the staff to reattach your foot pump boots after you have been walking.

During your stay you will practise how to get in and out of bed safely, how to get into and out of a seated position, and how to climb and descend stairs.

You will need an X-ray and a blood test before you go home.

You can go home as soon as you are ready but it is likely to between 2-4 days after your surgery.

Prior to discharge you will be seen by a member of the occupational therapy team who will discuss and practise everyday activities with you in the OT assessment flat. You will also practise getting in and out of a car.

Before discharge the physiotherapist will review the exercises you were practising before your surgery. These are specifically designed to help you to regain mobility and strength in your new hip. You should perform these exercises regularly in your own home as instructed by the physiotherapist.

You will be required to attend follow up appointments at 2 weeks and 6 weeks after your surgery where your hip movements and strength will be assessed. If necessary you may be asked to attend outpatient physiotherapy or hydrotherapy.

DISCHARGE FROM HOSPITAL

When leaving the hospital you should:

- Be safely transferring from sitting to standing
- Be walking safely with your walking aid and have practised going up and down stairs
- Understand your home exercise programme (see the pictures and instructions at the end of this booklet)

On discharge the nursing staff will give you:

- Medication as appropriate
- A copy of your discharge letter
- A sick certificate if required
- Instructions regarding follow up care for your wound and further appointments
- A joint replacement card (which you should carry with you at all times)

Do's and Don'ts

Do's

Do continue to take pain medication regularly.

Do the exercises as instructed by your physiotherapist.

Do try to take regular daily walks increasing the distance each day (however walking does not replace your exercise programme).

Do keep your wound clean and dry.

Do take a rest on your bed for at least an hour every morning and afternoon.

Do rest on your bed for short periods with your feet above horizontal if you have persistent swelling of your leg.

Do use a pillow between your legs when you are sleeping.

Do contact Orthopaedic Education and Follow up Clinic (01256 313580) if there are any problems with your wound, or if you have increased pain in the calf, associated with swelling.

Do resume normal sexual activity as soon as you feel able, but do take care not to force your hip into an uncomfortable position. Initially it is best for you to be on your back with your partner on top. Remember that you must not bend your hip further than a 90° angle.

Do avoid bending or twisting, either when sitting or standing, until seen in the follow up clinic.

Don’ts

Don’t twist, swivel or pivot on your operated leg. When turning, always make sure your feet are facing the same way as the top half of your body.

Don’t bend your hip further than a 90° angle until seen in the follow up clinic.

Don’t sit for too long. You may become stiff and find it difficult getting up and going again.

Don’t drive until you have been seen and assessed in the follow up clinic.

Don’t cross your legs.

Don’t walk without using your walking aids until advised.

Don’t stand still for too long.

Don’t get your wound wet. Keep your wound dry until it has healed.

Don’t overdo it.

TYPES OF HIP REPLACEMENTS AND BEARING SURFACES

Hip replacement is a highly successful procedure in the majority of cases, but the artificial joint can wear out and fail. There are two main modes of mechanical failure of a hip replacement:

1. Loss of fixation between the artificial joint and your bone (often called aseptic loosening).
2. Wear of the bearing surfaces which may cause debris that, in turn, may precipitate loosening of the replacement and damage to the bone or soft tissues around the bones. It can also lead to dislocation of the joint.

Research is continuing to help minimise these risks and has led to a number of different types of replacement being available.

There are advantages and disadvantages to each type of replacement. No single type of replacement is better than another in all circumstances, and not all replacements are suitable for all patients. The decision as to which replacement is best for you is complex and dependent on a number of factors - your surgeon will discuss this with you.

Currently there are three main types of replacement, categorised by the way the replacement is fixed to bone. These types may be further categorised by the bearing surfaces that they employ.

TYPES OF HIP REPLACEMENTS

(1) Cemented Hip Replacements

This is the type of hip replacement that first came into common clinical use in the 1960s; they are the most tried and tested with the longest clinical results. The arthritic head of the femur (the 'ball' of the hip joint) is removed and replaced by a metal ball that is fixed by means of a stem inserted into the shaft of the femur. The socket of the hip is lined by a polyethylene cup. Both components are held in place by a plastic cement called polymethylmethacrylate (PMMA).

An example of a Cemented Hip Replacement

The Metal Stem and Plastic Socket

An X-ray showing it in place

There are a number of such cemented hip replacement designs that have clinical results of over 20 years; Exeter, Charnley and Stanmore are just some of the designs you may have heard about.

How long do they last?

It is impossible to guarantee how long an individual's replacement will last, but many studies have shown that in older people:

95% will last 10 years
70-75% will last 20 years
60-70% will last 20-25 years

Thus it is unlikely that older people will require any further surgery. However in younger people, who tend to be more active, there is a greater chance that their hip replacements will wear out; sometimes even before 10 years.

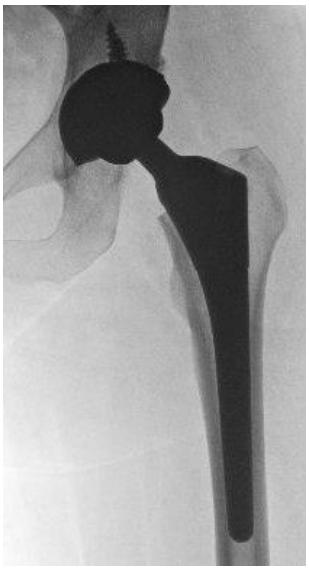
It was initially thought that the polymethylmethacrylate cement was the problem and so uncemented hip replacements were designed.

(2) Uncemented Hip Replacements

The design of these replacements is similar to that of cemented replacements, with the exception that no cement is used. A special coating is applied to the stem that encourages bone to grow onto the replacement and hold it in place. A metal cup that also has a special coating is used for the socket, and a plastic or ceramic socket fits into this to form the bearing surface.

An example of an Uncemented Hip Replacement

The metal stem with coating



An X-ray showing it in place

There is now good long-term follow up data on these types of replacement. Results up to 10 years are almost equivalent to cemented replacements, and there are suggestions that they may be giving better results up to 15 years. Very long-term results over 20 years however, are not yet available.

Despite these good results this type of replacement may not be suitable for all patients. Because they depend on bone ingrowth they may not be indicated in all patients, especially those who have osteoporosis or have rheumatoid arthritis. In these patients a cemented replacement may be more appropriate.
In some people their bone does not grow onto the metal. The hip can become loose at an early stage and would therefore have to be revised.

(3) Hip Resurfacing Replacements

This type of hip replacement uses a metal socket like an uncemented hip replacement socket, but with no plastic liner. Instead of cutting off the femoral head (the 'ball' of the hip) the surface is milled and covered with a metal cap that fits over the head.

The use of this type of prosthesis has declined significantly following problems with allergic reactions to metal in some patients. They may still be used in special circumstances in a selected group of young male patients.

BEARING SURFACES

The ideal bearing for an artificial hip would have the following qualities:

1. It would have a diameter similar to that of the normal hip thereby reducing the risk of dislocation
2. It would have minimal friction
3. It would show no wear with time

Unfortunately there is no manmade bearing that meets all these criteria and compromises have to be made. The available options are as follows:

1. Metal Head / Polyethylene Socket. The traditional hip bearing is a metal ball with a plastic socket. To reduce the effect of wear in the socket the ball needs to be made quite small but this increases the chance of the hip dislocating. Furthermore, even with a reduced head diameter there is significant wear of the plastic cup after 10 years. This will cause debris which may lead to a tissue reaction which damages the bone and causes loosening of the hip. Dislocation is more likely in a worn hip.
   This has prompted the search for better bearing surfaces.

2. Altered Polyethylene Socket. The plastic cup may be made stronger by using 'highly cross-linked polyethylene.' Laboratory studies have shown promising results but long term clinical outcomes are awaited.

3. Ceramic Head / Polyethylene Socket. The artificial ball may be made of ceramic which reduces both friction and wear when tested in the laboratory. This theoretical advantage has yet to be shown in long term clinical studies. Early models of ceramic head occasionally shattered but new generation ceramic is stronger and does not appear to be prone to this form of failure.

4. Ceramic Head / Ceramic Socket. With the ceramic ball and sockets there is very little, if any, debris produced. This means that in theory the joint will not wear out or cause a tissue reaction and so last for a very long time. There is a very rare risk of the ball or liner fracturing leading to immediate hip failure. There is also a small risk of the joint squeaking.

5. Metal Head / Metal Socket. This has been used until recently but, because of unexplained reactions / allergy to the metal in some people, it is no longer used.

CONCLUSION

Research continues to try and find an artificial hip that will allow normal activity and will last a lifetime. No available hip replacement is perfect but they all should allow almost normal activity and are likely to last in excess of 10 years. It is hoped that modern replacements will last even longer. However it is unlikely that a hip replacement will ever be quite the same as a normal natural hip joint and it is sensible to take some simple precautions.

Activities that you would be expected to be able to do after hip replacements are:-

(1) Walking
(2) Swimming
(3) Cycling - exercise bike or normal bicycle
(4) Golf
(5) Visiting the gym

But …….. patients should avoid impact activities such as running and any high impact aerobics (although aqua-aerobics is acceptable). We do not advise badminton or squash, although gentle 'doubles' tennis is possible. People who are experienced skiers can consider skiing again. The use of most gym machines is safe. In fact exercising in a non-impact way is very important.

TYPES OF ANAESTHESIA

All patients are assessed pre-operatively to establish the safest and most appropriate anaesthetic technique for each individual. Your anaesthetist will discuss the clinical benefits of any techniques with you before you go to theatre.
There are two main types of anaesthesia that can be used for a total hip replacement: general anaesthesia and regional anaesthesia.

1. General Anaesthesia

Advantages:

1. The patient is completely unconscious for the operative period. They will not remember anything between the period in the anaesthetic room and arrival in recovery after the operation is completed.
2. The surgeon is able to operate on a completely still patient.
3. In certain patients, especially those with some types of heart disease, it is safer for the operative period.

Disadvantages:

1. All the risks of general anaesthesia.
2. Damage to teeth or crowns.
3. Nausea.
4. Sore throat.
5. Allergy problems.
6. Detrimental effects on the cardiovascular and respiratory systems.
7. Pain in the recovery room on regaining consciousness.

2. Regional Anaesthesia - Spinal or Epidural Anaesthesia

Advantages:

1. Good pain relief immediately post-operatively.
2. Low blood pressure during the procedure and no surges of blood pressure.
3. Better for patients with lung disease.
4. No sore throat or airway problems.
5. Reduced incidence of venous thrombosis.
6. Better for frail, elderly patients with memory problems as there is less post-operative confusion.

Disadvantages:

1. The patient may be aware of aspects of the procedure. However, it is possible to combine a regional anaesthetic with sedation.
2. Sometimes it is unsafe in heart disease.
3. An awake patient can be distracting to the surgeon if they are a bit restless and try to move. However, the patient can be sedated.
4. There is a risk of urinary retention.

5. If the patient is muscular, is having a resurfacing, or is having revision surgery; muscle relaxants cannot be used, which can make the operation more difficult.
6. Some patients may not be able to lie flat or still for the procedure. These patients may need a general anaesthetic.
7. Patients who have had back surgery may not be suitable for these techniques.

Find more information about anaesthesia at

The Royal College of Anaesthetists
http://www.rcoa.ac.uk/

Hampshire Hospitals NHS Foundation Trust
http://www.hampshirehospitals.nhs.uk/

PAIN

Pain is common immediately after joint replacement surgery and may even be moderate or severe at times. Therefore good pain relief is an important part of your recovery. We will aim at all times to try to minimise and treat any pain.

All strong pain killers have side effects including dizziness, nausea, vomiting, itching, difficulty in passing urine, constipation and hallucinations. By giving you the right combination of pain killers we can reduce side effects to a minimum while controlling your pain. We will also give you medication to try to prevent or treat any side effects.

The following plans are in place to minimise your pain after surgery:

Before surgery

We may give you a pre-med, which often consists of a very strong slow release pain killer, an anti-sickness medicine and a drug which makes the pain killer work better. This means that you should be comfortable immediately after surgery.

During surgery

During the operation the anaesthetist will give you additional pain killers. The surgeon will inject local anaesthetic around the operated area to help reduce pain after surgery.

After surgery

We will give you pain killers and anti-sickness medicine regularly. It is important that you take these even if you are not in pain or feeling sick as they will prevent pain and sickness when you are doing your exercises.
You may also be given a very strong pain killer and an anti-sickness medicine to take at night. This will help control your pain and ensure that you are rested for your physiotherapy the next day.
Your physiotherapist will help you to stand and walk as soon as possible after surgery. While this may be painful initially, moving around will speed up healing and aid recovery. It will also improve circulation and reduce swelling.

If you do not feel your pain is being managed adequately, please speak to one of the doctors or a nurse.

Total Hip Replacement – Occupational Therapy Advice for Safe Discharge

How you can help prepare for surgery:

Bring in the following items:

- A long handled shoehorn, and an aid for reaching (grabber or helping hand).
- Comfortable slip-on shoes and slippers with backs that can be easily put on using a shoehorn.
- A bag which can be worn across you so that you can carry things while your hands are occupied with walking aids.
- Your hip booklet.

Points to consider at home:

- Measure the height of your furniture as requested in the environmental sheet sent out with your Hip School information. For the first few weeks it is important to maintain a right angle at the hip when seated. Your bed also needs to be of suitable height – your Occupational Therapist (OT) will be able to advise accordingly at Hip School. You may need to adapt your chair by adding extra cushions or use a chair of more suitable height for short-term use.

- Personal care. It may be useful to have a stool or chair next to the basin so you can sit down to have a strip wash in the short term. **The wound must be kept dry until healed.**

- Shower cubicle. Consider where you may place a balancing hand or whether you could hold the side of the shower frame when stepping into the cubicle. Practise prior to admission stepping into the shower tray with the unaffected leg and stepping out with the operated leg.

- Over bath shower. Access to this will be discussed and potentially practised at follow up clinic 2 weeks after surgery.

- Bathing. Dry practise will be completed in the OT flat at either 2 weeks or 6 weeks after surgery.

- Household tasks. Think about where you might get help with changing of bed linen, laundry, vacuuming and shopping whilst you are walking with walking aids. Perhaps family, friends or neighbours can help. Some neighbourhoods have voluntary agencies who may assist you. But ask now; don't leave it until you go home after your operation.

- Caring for your pet. Feeding bowls will be reached more easily if they are positioned on a box or biscuit tin near to a bench or table, which can be used for support.

- Car use as a passenger following surgery. Ask the driver to move the front passenger seat back as far as possible, putting a plastic cover on the seat assists with sliding across. Turn with your walking aids until the back of your legs are touching the car, then hand your walking aids to the

driver. Lower yourself down onto the car seat, holding onto the doorframe if necessary. Slide your bottom across the passenger seat towards the handbrake then bring in your legs. Full instructions are found later on within this booklet. Please read and practise before admission.

Points to consider in the kitchen:

1. Stock up the freezer with basic supplies such as ready-made meals, milk and bread. Stock up cupboards with tinned and packet foods.

2. If you are alone during the day consider where you can eat. You will be unable to carry plated meals whilst walking with walking aids. The OT may provide a trolley if it is not possible to eat in the kitchen. Consider buying a flask or insulated beaker, which can be carried in a neck or shoulder bag, for hot drinks or soup.

3. If you have a stool of suitable height, it would be possible to sit facing the work surface, with the under bench cupboard door open to allow room for your knees.

4. If you have a table in the kitchen, move it to be within easy reach of the work surface. Check the height of the chair or stool to be used. This will need to be practised during your assessment.

5. Arrange commonly used items in accessible groups to avoid excessive reaching, bending or walking about.
   - Position your kettle close to the sink and fill using a plastic jug. Move tea, coffee, sugar, mugs and cutlery nearby.
   - Rearrange your fridge freezer with regularly used items on the top shelf for easy access. Avoid large containers of milk.

6. Use one crutch in the kitchen and take support through the other arm by placing your hand on the worktop. While standing still, move the item forward, then use the crutch and work surface as support to walk towards it.

7. To reach down into low cupboards, or your fridge or freezer, extend your operated leg out behind you and take your weight through your good leg. Place your crutch in the door hinge or onto the bench to prevent it falling. Keep one hand on the work surface for support.

8. When reaching into high cupboards, take support from the surface in front of you. Ensure your feet are apart to provide a stable posture and stand in front of the object you are lifting down (do not lean over to the side).

9. Sit down where possible e.g. to do ironing or prepare vegetables.

The Occupational Therapy team will be available to discuss any particular concerns relating to everyday activities both on the ward and at follow up clinic. You will also practice activities in our assessment flat, a few days after surgery.

Getting in and out of the car
following a Total Hip Replacement

Preparation

Always use the front seat. Before you start, ask someone to move the passenger seat back as far as possible, and if you are tall, move the driver's seat back in line with the passenger seat. Reclining the back of the passenger seat will give you more room.
Avoid getting in or out of a car parked against a kerb. The driver must leave adequate space for you to step onto the road.
If you place a plastic bag on the passenger seat it will help you slide back and into position more easily. Remember to remove it from under you before you start your journey.

Getting In

1. Turn with your walking aids and feel the car sill with the back of your legs. Hand your walking aids to the driver.

2. Place your right hand on the dashboard and your left hand on the back of the passenger seat.

3. Place the operated leg out in front of you and sit down slowly.

4. Move your bottom right back towards the driver's seat. If you have long legs you may need to actually go onto the driver's seat.

5. Now lift your legs around and into the car with as little twisting as possible, but keep your operated leg out straight and your toes pointing upwards until you are in your seat.

6. Lift your bottom across into the passenger seat and get yourself comfortable. Remove the plastic sheet at this point. Remember to reach for the seat belt with your left hand.
   [Note: If there is a raised armrest or other obstruction between the two front seats, which would prevent you from sliding across the seats, use the following method:
   Recline the front passenger seat fully; it will now be possible to slide up and backwards along the seat and its back, bringing the extended legs into the car at that point.]

Getting Out

1. Move your bottom back across the driver's seat.

2. Lift your legs out of the car and slide forward to the edge of the passenger seat.

3. Place your left hand on the back of the seat and your right hand on the dashboard (not the car door), and push yourself up to stand.

4. Then take your walking aids from the driver.

PRE-OPERATIVE EXERCISES

1. Hip abduction exercise in standing

- Keep your body straight throughout the exercise. Stand holding onto a firm surface.
- With your knee straight, take your affected leg out to the side keeping your foot pointing forward.
- Hold for a count of 3.
- Slowly return until your foot is on the floor.

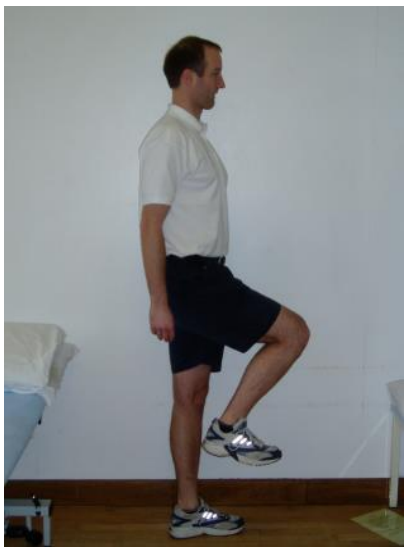
Repeat 10 times, 1-2 times per day.

2. Buttock contractions and bridging

- Lie on your back.
- Bend both knees until your feet are flat on the bed.
- Squeeze your buttocks and lift them off the bed as far as you can.
- Try to keep your pelvis level throughout the movement and hold for 5 seconds at the top.
- Slowly lower back down.

Repeat 10 times, 1-2 times per day.

3. Hip flexion in standing



- Keeping your body upright throughout the movement and hold onto a firm surface.
- Bring your knee up to the same level as your affected hip.
- Hold for 2-3 seconds.
- Slowly lower back down.

Repeat 10 times, 1-2 times per day.

4. Supine hip abduction exercise (lying)

- Lie flat on your back.
- Keeping your toes pointing up towards the ceiling and your heel on the bed, take your affected leg out to the side as far as possible.
- Hold for 2-3 seconds.
- Return slowly.

Repeat 10 times, 1-2 times per day.

5. Hip extension in standing

- Keeping your body upright throughout the movement and holding onto a firm surface.
- Take your affected leg backwards slowly, as far as possible, so your foot is off the floor.
- Hold for 5 seconds.
- Return slowly back to the floor.

Repeat 10 times, 1-2 times per day.

POST-OPERATIVE EXERCISES - Weeks 1 to 2

1. Hip abduction exercise in standing

- Keep your body straight throughout the exercise. Stand holding onto a firm surface.
- With your knee straight, take your operated leg out to the side keeping your foot pointing forward.
- Hold for a count of 3.
- Slowly return until your foot is on the floor.

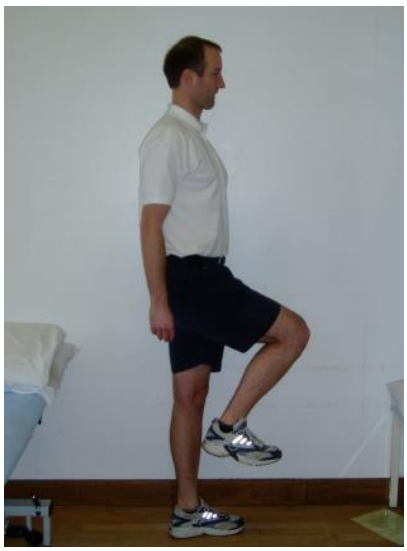
Repeat 10 times, 2-3 times per day.

2. Buttock contractions and bridging

- Lie on your back.
- Bend both knees until your feet are flat on the bed.
- Squeeze your buttocks and lift them off the bed as far as you can.
- Try to keep your pelvis level throughout the movement and hold for 5 seconds at the top.
- Slowly lower back down.

Repeat 10 times, 2-3 times per day.

3. Hip flexion in standing



- Keeping your body upright throughout the movement and hold onto a firm surface.
- Bring your knee up to the same level as your operated hip.
- Hold for 2-3 seconds.
- Slowly lower back down.

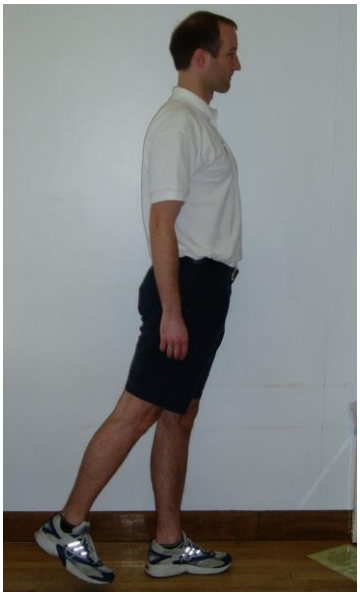
Repeat 10 times, 2-3 times per day.

4. Supine hip abduction exercise (lying)

- Lie flat on your back.
- Keeping your toes pointing up towards the ceiling and your heel on the bed, take your operated leg out to the side as far as possible.
- Hold for 2-3 seconds.
- Return slowly.

Repeat 10 times, 2-3 times per day.

5. Hip extension in standing



- Keeping your body upright throughout the movement and holding onto a firm surface.
- Take your operated leg backwards slowly, as far as possible, so your foot is off the floor.
- Hold for 5 seconds.
- Return slowly back to the floor

Repeat 10 times, 2-3 times per day.

6. Prone lying hip extension

- Lying on your stomach keeping your legs straight, lift your operated leg up towards the ceiling so your knee is clear of the bed.
- Try and keep your pelvis in contact with the bed.
- Hold for 5 seconds at the top.
- Slowly lower back down.

Repeat 10 times, 2-3 times per day.

POST-OPERATIVE EXERCISES - Weeks 2 to 6

1. Side lying hip abduction

- Lie on your side with your operated leg on top.
- Lift your operated leg as high as possible keeping your knee straight and foot pointing forward.
- Hold for 5 seconds.
- Return slowly back to the bed.

Repeat 10 times, 3 times per day.

2. Side lying hip rotation

- Lie on your side with your operated leg on top.
- Bend both knees to a 45 degree angle.
- Keeping your ankles together, slowly roll your operated leg up as far as possible.
- Hold for 5 seconds.
- Return slowly back to the starting position.

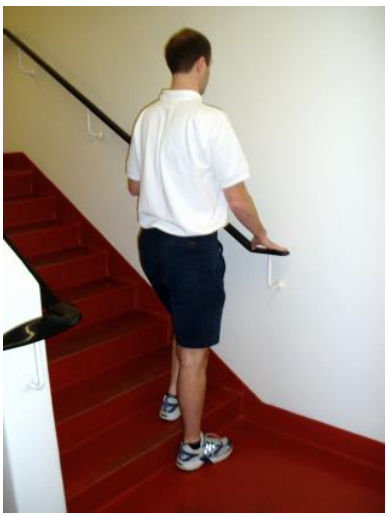
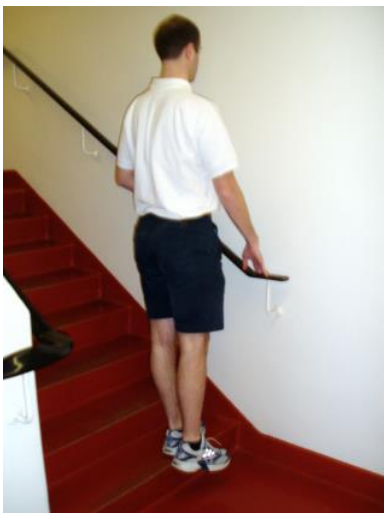
Repeat 10 times, 3 times per day.

3. Buttock contractions and bridging


- Lie on your back.
- Bend both knees until your feet are flat on the bed.
- Squeeze your buttocks and lift them off the bed as far as you can.
- Try to keep your pelvis level throughout the movement and hold for 5 seconds at the top.
- Slowly lower back down.

Repeat 10 times, 3 times per day.

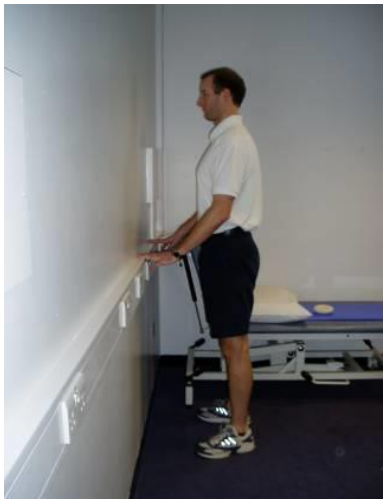
4. Side step up

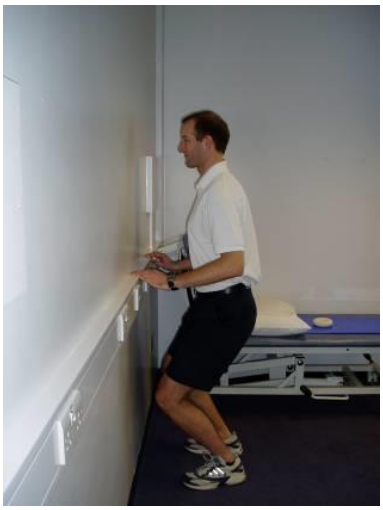



- Hold onto a firm surface if possible.
- Put your operated leg sideways onto a step.
- Straighten your knee on the operated side taking the other foot off the floor.
- Hold for 5 seconds.
- Slowly lower down until your un-operated foot is back on the floor.

Repeat 10 times, 3 times per day.

5. Squats





- Hold onto a firm surface.
- Feet shoulder width apart.
- Bend both your knees into a half squat taking your knees over your toes.
- Hold for 3-5 seconds.
- Straighten your knees to return to a standing position.

Repeat 10 times, 3 times per day.

6. Prone lying hip extension

- Lying on your stomach keeping your legs straight, lift your operated leg up towards the ceiling so your knee is clear of the bed.
- Try and keep your pelvis in contact with the bed.
- Hold for 5 seconds at the top.
- Slowly lower back down.

Repeat 10 times, 3 times per day.

7. Prone hip extension with knee flexion

- Lie on your stomach.
- On your operated leg, bend your knee to a 90 degree right angle.
- Keep your knee bent as you raise your operated leg off the bed, trying to keep your pelvis in contact with the mattress.
- Hold in this position for 5 seconds.
- Return slowly back down.

Make sure you do not arch your back when lifting your hip.

Repeat 10 times, 3 times per day.

POST-OPERATIVE EXERCISES - 6 Weeks to 6 months

1. Side lying hip abduction

- Lie on your side with your operated leg on top.
- Lift your operated leg as high as possible keeping your knee straight and foot pointing forward.
- Hold for 5 seconds.
- Return slowly back to the bed.

Repeat 20 times, 3 times per day.

2. Side lying hip rotation

- Lie on your side with your operated leg on top.
- Bend both knees to a 45 degree angle.
- Keeping your ankles together, slowly roll your operated leg up as far as possible.
- Hold for 5 seconds.
- Return slowly back to the starting position.

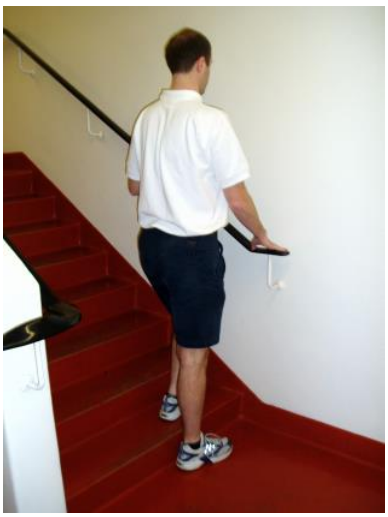
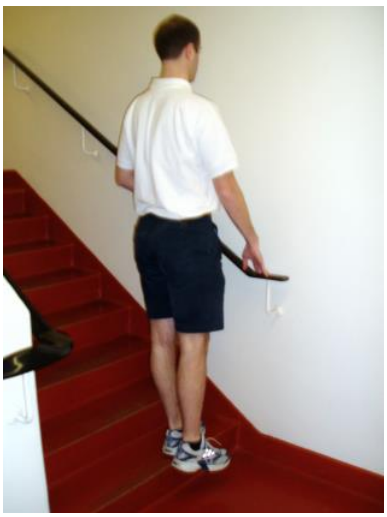
Repeat 20 times, 3 times per day.

3. Buttock contractions and bridging


- Lie on your back.
- Bend both knees until your feet are flat on the bed.
- Squeeze your buttocks and lift them off the bed as far as you can.
- Try to keep your pelvis level throughout the movement and hold for 5 seconds at the top.
- Slowly lower back down.

Repeat 20 times, 3 times per day

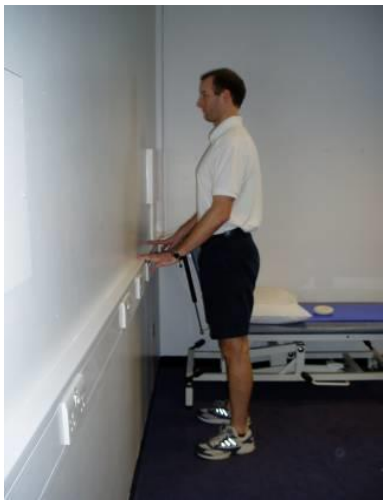
4. Side step up

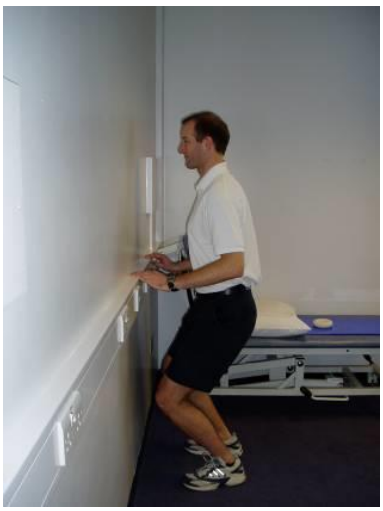



- Hold onto a firm surface if possible.
- Put your operated leg sideways onto a step.
- Straighten your knee on the operated side taking the other foot off the floor.
- Hold for 5 seconds.
- Slowly lower down until your un-operated foot is back on the floor.

Repeat 20 times, 3 times per day.

5. Squats





- Hold onto a firm surface.
- Feet shoulder width apart.
- Bend both your knees into a half squat taking your knees over your toes.
- Hold for 3-5 seconds.
- Straighten your knees to return to a standing position.

Repeat 20 times, 3 times per day.

6. Prone lying hip extension

- Lying on your stomach keeping your legs straight, lift your operated leg up towards the ceiling so your knee is clear of the bed.
- Try and keep your pelvis in contact with the bed.
- Hold for 5 seconds at the top.
- Slowly lower back down.

Repeat 20 times, 3 times per day.

7. Prone hip extension with knee flexion

- Lie on your stomach.
- On your operated leg, bend your knee to a 90 degree right angle.
- Keep your knee bent as you raise your operated leg off the bed, trying to keep your pelvis in contact with the mattress.
- Hold in this position for 5 seconds.
- Return slowly back down.

Make sure you do not arch your back when lifting your hip.

Repeat 20 times, 3 times per day

ADVICE ON BENDING AND PICKING THINGS UP - This advice should be followed forever.

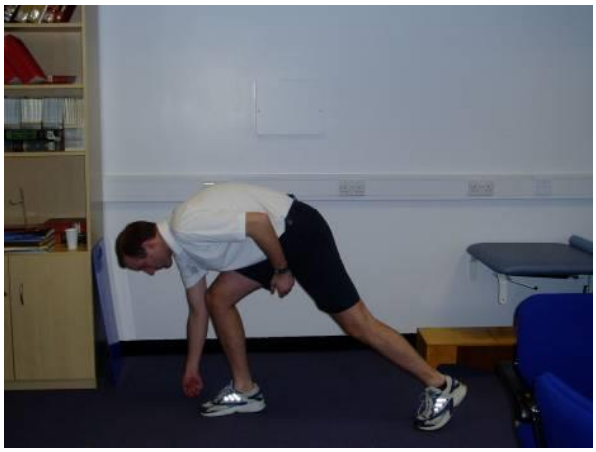
Bending when sitting



- With your feet turned in and your knees wide apart you may bend forward slowly.
- Keep your body and your elbows between your knees (as shown above).
- Avoid twisting to either side.

Two ways of picking things up

Method 1



Extend your operated leg out behind you to avoid flexing your hip beyond a right angle.

Method 2

Place your feet wide apart, bend your knees as shown, keeping your arms inside your legs.

Total Hip Replacement
Advice Sheet from 2 weeks to 6 weeks

Mobility
Progress to fully weight bearing.

Exercise
Continue with your exercises as instructed by your physiotherapist or specialist nurse, to increase your strength. Increase your walking distance, as you are comfortable.
You may commence swimming once your wound is healed.
You may use a static cycle but ensure the seat is in a high position.
You may recommence playing golf and gardening by about 6 weeks.

Wound
If your wound is tender to touch you may massage it firmly using a moisturising cream to desensitise the skin and underlying tissues.

Stairs
Progress as you feel comfortable.

Housework
Increase the amount of housework that you do over the next few weeks. Be careful not to bend or twist.

Driving
You will be advised when you may recommence driving at your two week review appointment. You must be able to safely perform an emergency stop and change gear comfortably. Please inform your insurance company.

Sleeping
You can lie on the operated side as soon as it is comfortable to lie on the wound. If you wish to sleep on the un-operated side you should use a pillow between your legs for the first 6 weeks after surgery.

Sexual relationships
Resume when comfortable, but preferably with your partner on top for the next 3 months. Be careful not to force your hip into an awkward position.

Returning to work
You may be able to return to work between 4 and 6 weeks after your surgery, provided you have a sedentary job.

Travelling abroad
We do not advise travelling abroad or flying for at least the first 6 weeks after your surgery.

Total Hip Replacement
Advice Sheet after 6 weeks

Mobility

As soon as you can weight bear fully without pain, you may start to discard any walking aids. Be careful not to get into a habit of limping. If you find that without a stick you limp excessively, there is no harm in using one for a few weeks longer.

Exercise

Continue with the exercises as instructed by your physiotherapist or specialist nurse; this will increase your strength. Increase your walking distance, as you feel comfortable.
Daily exercises should be done for 6 months, then ideally 2-3 times a week for ever.

Stairs

Progress as you feel comfortable and as weight bearing allows.

Housework

Increase the amount of housework that you do over the next few months. Be careful not to bend or twist.

Wound

If your wound is tender to touch you may massage it firmly using a moisturising cream to desensitise the skin and underlying tissues.

Driving

Begin driving when you are comfortable to do so. You must be able to safely perform an emergency stop and change gear comfortably.

As a guideline we would recommend that you do not consider driving for at least the first 2 weeks after your surgery. Thereafter, if you can walk unaided it is safe to start driving.

Sleeping

You can lie on the operated side when it is comfortable to lie on the scar.
From 6 weeks onwards, if you wish to sleep on the un-operated side, you no longer need to use a pillow between your legs.

Sexual relationships

Resume when comfortable, but preferably with your partner on top for the next 3 months.

Restrictions

Between 6 weeks and 3 months after your surgery you may return to all normal activities with the exception of high impact sports (see below).
Ensure that when you are bending your hip beyond 90 degrees you do so carefully, using the methods demonstrated in this booklet.

Returning to work

You will be able to return to work between 4 and 6 weeks after your surgery provided you have a sedentary job. If you have a manual job it may be 6 to 12 weeks before you can return.

Sport/Leisure

Most sporting activities can be resumed after 3 months, depending on comfort and level of competition.

Low impact sports such as swimming (breaststroke after 2 months), cycling, doubles tennis, gym work (after instruction) and golf present no problem.

High impact sports are not recommended, therefore are participated in at your own risk, such as jogging, singles tennis, squash, jumping activities or football.

Gardening should be done with care. If possible use a low stool and long-handled tools.

Skiing should only be considered if you are an experienced skier.

Travelling abroad

Your total hip replacement will probably be detected by airport security machines.
We do not advise travelling abroad or flying for at least the first 6 weeks after your surgery. Three months is recommended before you fly long-haul.

We are happy to give advice or answer questions regarding your hip replacement.
Please contact us if required.

Further Information

Exclusive video content and in-depth information relating to major hip and knee orthopaedic procedures, as carried out by the Orthopaedic Team at Hampshire Hospitals NHS Foundation Trust, can be found at

http://www.hipandknee.tv/

National Joint Registry (NJR) Website
http://www.njrcentre.org.uk/

National Institute for Health and Clinical Excellence (NICE) Website
http://guidance.nice.org.uk/

NHS Website
http://nhs.uk/

British Orthopaedic Association Website
http://www.boa.ac.uk/

Arthritis Research UK Website
http://www.arthritisresearchuk.org/

More information about anaesthesia at
http://www.rcoa.ac.uk/

If you have any questions, problems or need advice once you are at home, then phone the Orthopaedic Ward, Orthopaedic Education and Follow up Clinic or the Occupational Therapy department and they will do their best to help.

Orthopaedic Education and Follow Up Clinic - 01256 313580
Orthopaedic Ward D1 - 01256 313681
Occupational Therapy and Physiotherapy - 01256 313205

If you are treated for a DVT or PE (blood clot) or are prescribed antibiotics for problems with your wound, please contact: **Orthopaedic Joint Review Clinic - 01256 313459**

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