Total Joint Replacement

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Frequently Asked Questions:

Preoperative:

Q: How should I choose where to have my surgery performed?
A: The following are some factors you should use to choose surgeon and facility:

1) Educate yourself about the procedure and ensure that your expectations are appropriate. Our facility offers a total joint arthroplasty course as do many and I strongly recommend attendance. Some insurance policies are mandating participation.
2) Choose a surgeon and facility with whom you are comfortable with and consider getting a second or multiple opinions.
3) Ensure the surgeon you choose is a high-volume surgeon performing at least 50 replacements each year. It has been clearly demonstrated that high-volume surgeons achieve more reliable outcomes with fewer complications. The exact number has been argued upon.

Q: How will I know when I need to have my joint replaced?
A: Make sure you are aware of the non-operative interventions (refer to our conservative treatment handout) and feel you have given them a reasonable attempt. If told you are a candidate for replacement surgery, you should consider proceeding if you have severe pain that limits normal daily activities, moderate or severe pain at rest, significant swelling that fails to improve, advancing leg deformity (bowing or shortening), stiffness which persists, or you are increasing your intake of anti-inflammatories.

Q: What is the chance of success?
A: Success is difficult to assess. The most important factor relates to your expectation of success. Total joint replacement is one of the most successful operations when performed in the right patient. While total joints have seen great advancements, they are still not better than your native joint prior to arthritis. Most patients will answer yes to the following three questions **1 year** after surgery:

1. Are you glad you had the surgery?
2. Did it fulfill your expectations?
3. Would you do it again?

Despite the success of hip and knee replacement surgery, in knee replacement 15% of patients will report some level of discomfort or dissatisfaction. In hip replacements the number is lower.

Q: What is the recovery time?
A: There will be individual variations in recovery time. Most will be able to walk without an assist device (crutches, cane, walker) within a few weeks and return to normal function by 3 months. Wearing in and improvement occurs over the first year or two.

Q: How long will I be in the hospital?
A: While some centers are attempting to make joint replacement an outpatient procedure (I do offer outpatient arthroplasty procedure in appropriate candidates), I feel most patients will require 1day of hospitalization. Pre-existing medical conditions (heart problems, diabetes, hypertension, kidney problems, pulmonary problems) may lengthen your hospital stay.

Q: Will I go home or to a rehabilitation unit?
A: Most will be discharged home and participate in an outpatient physical therapy program. Many insurance programs do not recognize total joint replacement as criteria for admission to a rehabilitation facility unless extenuating medical conditions exist. If social or health issues prevent discharge home, you may be transferred to a skilled nursing facility with therapy pending insurance approval. Please note that if you are considering a rehabilitation unit after surgery it would be advisable to visit the facility prior to surgery.

Q: When can I drive?
A: For surgery on the right leg it is recommended that you not drive for 4 weeks. You may drive thereafter if you feel comfortable applying enough force to brake suddenly and you are no longer taking narcotics for pain control. For left leg surgery you may drive as soon as you feel comfortable and are no longer taking narcotics.

Q: When can I travel?
A: As soon as you feel comfortable. It is recommended that you stretch and walk each hour during long trips to prevent blood clots in your legs (deep venous thrombosis).

Q: When can I return to work?
A: For a sedentary job (ex. desk work) you may return in 1-2 weeks. For more labor-intensive work, you should plan on at least 3 months. Average time to return to work across all jobs is under 9 weeks.

Q: What activities are permitted?
A: You may return to all low-impact activities when you feel comfortable (walking, golf, swimming, bicycling, skiing). You should avoid high impact activities such as running and jumping.

Q: How long will my joint replacement last?
A: The literature reports a 0.5-1% chance of requiring additional surgery each year. So, at 10 years, 90-95% are functioning normally and at 20 years 80-85% remain normal. After 20 years the success declines more rapidly. There is promising data that the newer components may exceed these expectations.

Q: Will my legs be the same length?
A: Knee replacements rarely notice any real or functional differences. For hip replacements a leg length discrepancy may occur requiring the use of a shoe lift. The chance of this occurring is increased by a prior leg length difference, severe hip arthritis, and/or severe back issues. For hip replacements, achieving stability of the hip joint super-cedes exact equalization of leg lengths.

Q: Do I need to see my primary physician prior to surgery?
A: I feel it is very beneficial to see or at a minimum notify your primary physician to ensure that your health status is optimized prior to surgery. If you do not have a primary physician, then we will assist you in obtaining one for evaluation.

Q: Do I need dental clearance prior to joint replacement?
A: Ordinarily no. If, however, you suspect you have a dental infection, have poor dental hygiene, or have not had a dental check-up in 12 months then it would be advisable to proceed with a formal dental examination.

Q: What are the chances of complications?
A: Complication rates vary. The most important risk of complications is related to the health status of the patient. Patients with health issues are at greater risk of complications. Some of the most important include but are not limited to; diabetes, heart disease, pulmonary disease, kidney disease, rheumatoid arthritis, vascular disease and obesity. Diabetics should have optimum blood glucose control and those whose HbA1c are elevated will likely be postponed. Patient who are found to have active infections or illnesses must delay surgery until the issue is resolved. The risk of infection at our facility is below the national average. National average being between 1-2%. Patients whose BMI (body mass index) exceeds 40 will be required to reduce weight prior to surgery.

Perioperative Questions:

Q: What type of anesthesia will I have?
A: Ultimately that decision is made between you and the anesthesiologist. Anesthesia continues to evolve so I will defer to the recommendations of our Anesthesiologists.

Q: Will I have a catheter in my bladder (Foley)?
A: This varies based on patient factors but currently we are trying to minimize the use of catheters.

Q: Will I have an intravenous (IV) line?
A: Yes. Having IV access for surgery is essential for the rapid administration of medications. You will receive IV antibiotics 1 hour prior to surgery and usually no longer than 24 hours after surgery.

Q: Will I require a blood transfusion?
A: National statistics are 3-5% need for transfusion for knee replacements and 11-19% for hip replacements. Our facility employs tactics to decrease the need for blood transfusion. Our transfusion rate is below 2%. We can usually identify who might require a transfusion before surgery (persons who are anemic prior to surgery or who have more complicated medical or surgical issues). If you elect to refuse blood products you should notify us prior to scheduling surgery.

Q: Are narcotics necessary?
A: I have had patients not use narcotics, but it is very important that the patient's pain be well controlled so that they may participate and progress with therapy. Playing "catch up" on pain control is not ideal. Some patients do react poorly to narcotics and final pain medication treatment will be tailored postoperatively. Patients who have been on narcotics leading up to surgery may experience increased difficulties with pain control and should consider eliminating or at least reducing narcotics prior to surgery. Please be honest about your narcotic consumption prior to surgery so that we may be able to identify the best pain management plan for your recovery efforts.

Q: When can I shower?
A: Once a waterproof dressing is applied you may shower. Typically, the day after surgery. You should keep a dressing on the incision for at least 2 weeks.

Q: When can I immerse the site in a bathtub or pool?
A: Typically, 3-4 weeks after surgery. I favor closer to 4 weeks just to be on the safe side.

Q: (*For knee replacement only*) Do I need a CPM (continuous passive motion machine)?
A: There is no evidence that a CPM improves recovery or outcome in the long term. For patients who elect to use the machine, the duration of use is typically 3-4 hours per day for 3 weeks. Persons receiving a partial knee replacement will find that their insurance is unlikely to cover the device and I do not feel it is necessary.

Q: When will my sutures/staples be removed?
A: Often I use an absorbable suture placed below the skin and Dermabond (super glue for the skin) on top and therefore there are no sutures/staples to remove. If, however, your skin condition required sutures/staples they are typically removed at 10-14 days. If skin tape and glue is used, be sure **NOT** to remove the tape.

Q: How long will I be on pain medication?
A: It is common to require pain medication for up to 2-3 months. Initially you will be taking a narcotic. You may choose to switch to an over-the-counter medication such as ibuprofen or acetaminophen as soon as you are comfortable. Most discontinue narcotic by 3-4 weeks. Requiring narcotics beyond 6 weeks is unusual. Narcotics will **NOT** be offered after three months.

Q: How long will I be on an anti-coagulant ("blood thinner")?
A: I typically recommend Aspirin 81 mg every 12 hours in patients deemed at standard or low risk for clotting events for 14 days followed by once daily 81 mg Aspirin for an additional 4 weeks. Patients deemed at higher risk for clotting will receive more aggressive prophylaxis.

Q: Can I consume alcohol during my recovery?
A: If you are taking Coumadin you should avoid alcohol. Only modest consumption should occur if you are taking narcotics (I do allow for a glass of alcohol when in the hospital). Beyond this, you may consume in moderation at your own discretion.

Q: How long should I take iron supplements?
A: I no longer recommend iron post-operatively as its benefit has been called into question and it can contribute to constipation which is common after surgery and while taking narcotics.

Q: Should I apply ice or heat?
A: Initially ice is most effective at reducing swelling. You may use which ever makes you most comfortable.

Q: How long should I wear compressive stockings?
A: I prefer the use of the compressive stockings (TED hose) until the first postoperative visit (2 weeks). After discontinuing, if your ankles swell then you should use them until this normalizes. For long trips they are recommended for 3 months following surgery.

Q: Can I use stairs?
A: I recommend going upstairs leading with your non-operative leg and going down stairs lead with your operative leg. "Good leg up, bad leg down." This will be taught to you by our therapy team.

Q: Will I need physical therapy?
A: As a matter of habit I use formal therapy but in select situations you may not need therapy. Initially they may need to come to you until you are able to present to an outpatient program. Typical duration is 6-8 weeks.

Q: When can I engage in intercourse?
A: For knee replacement and anterior hip replacement as soon as you are comfortable. For posterior hip replacement you should wait for at least 6 weeks and focus on your hip precautions.

Post Operative Questions

Q: I feel depressed. Is this normal?
A: It is not uncommon. Factors such as pain, narcotic usage, increased dependency on others, and limitations in mobility can contribute to mild depression. These feelings usually subside as you recover. If these feelings are pervasive or persistent please bring them up to me or your primary physician.

Q: I have insomnia. Is this normal?
A: This is a very common complaint. Over-the-counter Benadryl or Melatonin may be effective. If not, you may require a prescription medication.

Q: I am constipated. Is this normal?
A: It is very common. A stool softener (Colace over-the-counter) is recommended. Drink plenty of water. Our hospital provides a post-operative plan to assist with constipation. It is very important that if you have painful constipation that you cease all narcotic consumption and notify us or present to an emergency department.

Q: How much knee range of motion do I need? (*knee replacement only*)
A: You need 70 degrees of flexion to walk normally, 90 degrees to ascend stairs, 100 degrees to descend stairs. If you have not achieved 90 degrees of knee flexion by 6 weeks you may need to have a manipulation under anesthesia. You should be able to achieve near full extension by 4 weeks. The component used can allow between 140-150 degrees arc of motion. Patients with prior surgeries or limitations in range of motion prior to surgery are much more likely to have difficulty obtaining optimum range of motion.

Q: My legs feel different in length. Is this normal?
A: The degenerative process that is arthritis took years if not decades to develop. Rapid operative correction usually makes the operative leg feel different in length whether it is or not. Give yourself some time to adjust. If there is a true leg length discrepancy, you may require a shoe lift. In the case of hip replacement, a stable hip is of greater importance than exact equalization of leg lengths.

Q: Will I set off security detectors at airports and other locations?
A: Probably. Wallet cards indicating surgical implants are no longer recognized. You will have to inform the security officer of your surgery and may be asked to demonstrate the incision so wear appropriate apparel. Over 1 million total joint replacements are performed each year, so you are not alone.

Q: Do I need antibiotics before dental work or other surgeries?
A: Avoid any invasive procedures for 6 weeks after surgery. For simple dental cleaning antibiotics are not required. For invasive procedures it has been recommended to take antibiotics prior to the procedure for 2 years after surgery. The most recent update states antibiotics are not required unless the patient's immune status is compromised. I recommend antibiotics for dentistry of any form for the first 1-2 years and then at patient discretion. If your dentist has a recommendation, then you should take that into consideration as well.

Q: Do I need antibiotics if I cut myself, get a viral infection, or any other type of bacterial infection?
A: Simple "nicks" do not require antibiotics but if you have an injury that is obviously infected or requires medical assistance then you should seek medical attention and notify the provider that you have a joint replacement. Viral conditions do not require antibiotic coverage. If you have a bacterial infection you should consult your primary physician. Apparently, if you sleep with a bat in the room you require rabies shots.

IMPORTANT:

Q: What can I do to improve my chances of a successful joint replacement?
A: I am so glad you asked! To obtain a successful outcome you must be an active participant in the process. The rehabilitation can be demanding for some patients. Patients who are more de-conditioned going into surgery tend to have a more difficult time after surgery. Patients who have a greater number of risk factors are of course at more risk for complications and suboptimal outcomes. There are some risk factors you can't control but there are others that are considered modifiable. You should make every effort to improve your chances of having a fantastic outcome.

1) Deconditioning: you should engage in a light exercise program and try to build up your muscle strength and endurance leading up to surgery. You can see a physical therapist prior to surgery but be sure you do not exhaust too many visits prior to surgery.
2) Tobacco use: you should refrain from tobacco 6 weeks leading up to surgery. If you unable to halt product usage, then you should enroll in a smoking cessation program.
3) Nutrition: Pre-operative malnutrition impairs the healing process and makes you more susceptible to infection.
4) Obesity: BMI greater than 40 should enroll in nutritional counseling program, long term weight loss program, and have bariatric consult. BMI 30-39.9 should enroll in nutritional counseling program and consider acute weight loss program. 20 pound weight loss in overweight persons decreases complications.
5) Alcohol abuse: seek counseling for cessation program. If addicted to alcohol leading into surgery, you could suffer from withdrawal while in the hospital which can lead to seizures and death. Pain management is more difficult in those who abuse alcohol.
6) Chronic narcotic use: if you take chronic narcotics, you should wean down the dosage and preferably halt the usage for several weeks leading up to surgery. Persons taking narcotics regularly leading up to surgery have poorer outcomes and it is much more difficult to obtain optimum pain control after surgery. The use of chronic narcotics also places the person at greater risk for respiratory events.

7) Medical conditions: ensure that your primary care giver is aware that you are considering joint replacement and ask that they review your medical conditions and ensure you are a good candidate to proceed with surgery. Diabetics should have their Hemoglobin A1C below 8 and their fasting blood glucose controlled. Cardiac concerns may require a stress test prior to surgical consideration.
8) Depression or Anxiety: patients with these issues are more likely to have a difficult time with the recovery process and their overall satisfaction regarding the surgical outcome is much lower than persons without these issues. If you are experiencing moderate to severe depression or anxiety issues, you should **NOT** proceed with surgery.
9) Fibromyalgia: Patients with fibromyalgia are known to have greater difficulty with pain management post- operatively. Gabapentin or Lyrica started pre-operatively may benefit post-operative course.

For additional information refer to our website at www.brincetonphippsmd.com, www.animasorthopedics.com, or the American Academy of Orthopaedic Surgeons at www.aaos.org, American Association of Hip and Knee Surgeons at www.aahks.org or visit any of the joint manufacturers websites. I typically use Stryker or Smith and Nephew.