Mr Rishi Chana FRCS (Tr& Orth)
Consultant Orthopaedic Surgeon

Total Hip Replacement Pro's Cons and Risks :

It was a pleasure to review you in my clinic. We have determined that the hip has arthritis and the back has some wear and tear but the deep seated buttock and thigh pain that you are taking medication for is hip related.

There has been a past medical history noted as well as the arthritis and treatment & no history of a DVT or VTE problems.

You have no known allergies and are not aware of a Nickel allergy.

On examination today there is an antalgic gait, the hip was extremely irritable to examine causing groin and thigh pain with discomfort.

The X-rays show bone on bone arthritis of the hip.

Unfortunately you have got hip arthritis that is evident both on the scans.

I have explained the implications of this to you today and explained that the joint has reduced thickness with regards to the cartilage and in some areas there is bone on bone rather than the articular cartilage which explains the pain and stiffness with the joint. There are also cysts caused on both sides of the joint because of pressure of the bone on bone and this is all part of the arthritis picture.

This is a physical problem, there will have good days and bad days and you may have flare ups which should be managed with analgesia and limited exercise regime and self help programmes which I have directed you towards today. I have advised you to look at the www.surreyimsk.com and arthritis websites, as well as an information sheet today and sent recommend some physiotherapy. I have also advised you to contact your insurer as they may have a self help programme.

If things get worse then one could always consider options including injection which could temporarily help the pain. Depending on how things progress, ultimately if you need to have a more long term definitive option we have touched on the implications and outcomes of joint replacement surgery and again you has been given an information sheet on this. I have explained that at this moment in time there is no need to do anything at the moment and one should monitor the symptoms and continue with the self help and self education programme that we have agreed on at the moment. Please come and see me at your convenience once you have had time to reflect and digest the information above and we will have further consultations in order to come up with treatment agreement plan.

I have explained that the options would be to continue with conservative treatment, have a local anaesthetic and steroid injections which could last for up to three months at a time but then would cause the pain to come back or consider a total hip replacement. There is a small risk of infection or the steroid flaring up the pain before making it better. The risk is 1 in 1000. An infection may need a washout and antibiotics.

We talked about the option of a hip replacement as this is the one and only form of long term definitive care that will offer an improved quality of life and long term pain relief.

I have explained that the hip replacement would use an uncemented titanium stem with an uncemented titanium shell and a plastic liner into the shell and a ceramic ball, therefore, the bearing would be ceramic on plastic and there is no risk of metallosis or Nickel allergy. I use a posterior approach hip replacement surgical technique procedure. The wound and soft tissues take a few weeks to heal. During this time, there are recommended restrictions on how you move turn and twist to reduce the risks of wound healing and dislocation.

The procedure itself takes about an hour, you will be with us for approximately two to three days in hospital and then will be discharged when safe to recover and mobilise with crutches for a few weeks in your own home. The clips come out at two weeks and most people at the six to seven week stage feel 80% better and most people at three months feel 90% better. I have explained it takes the rest of the year to get fully better to a 100%.

The risks involved in this operation include having a scar, there is a 1% risk of infection, there are also risks involved with having myocardial infarction or CVA (a stroke) and this as well as other complications can result in fatality, according to the past medical history this is low in this patient's case. I have explained that the

wear rates cause the hip to wear out after about 25 years, and there is also a small risk of loosening and fracture if one were to fall over and if this happens then you would need revision surgery. If a deep infection occurred then one would need revision surgery and this can happen in 1 in 500. This does however involve two or three operations, long stays in hospital and the need for intra-venous antibiotics. Thankfully, I have not had this problem with my experience so far. We always try and get the legs to match up with the length but during the surgery I always achieve stability first and then leg length secondary, although more than 95% of the time the legs are measured within 5mm of each other which is an acceptable standard and a norm within the population. Another risk is a dislocation and you will have patient education with the physiotherapist about bending and twisting to avoid dislocation. Please avoid flexion and big twists beyond 90 degrees (sitting position and full rotation) and also extending the leg behind the pelvis and twisting as it can come out the front. The risk of this is 1%. The other risks involve bleeding, about 3 to 5%. The femoral and sciatic nerves can also become involved during the surgery and these are usually resolved if they become injured within six to nine months, the risk of this is 1 in 200, if the sciatic nerve is more permanently involved this can result in a foot drop and as an outpatient you will have crutches and orthotics to help with this. At the time of surgery, instruments are inserted into the thigh bone (femur) to hollow them out so we can insert the stem. During this, bone marrow can become dislodged into the blood stream and this can cause injury to the lungs in the form of a fat embolism. This can become worse if cement is also used for the stem preparation. This happens in all cases to a very minor extent but rarely, especially if you have a weaker respiratory system this fat embolism syndrome can cause the lungs to become inflamed and congested with fluid. This may require high dependency unit support and monitoring and possible assisted breathing whilst the lungs recover, which may take a few days but can also increase the risk of a chest infection. Very occasionally, 1 in 200 cases, a muscle that goes over the pelvic shell into the thigh bone that flexes the hip called the psoas muscle becomes inflamed or irritated because of the cup of the socket part of the hip replacement. This occurs in more petite females because of relative size differences and if this occurs then we treat this discomfort with physiotherapy and occasionally steroid injections. They very rarely (never in my hand so far) require further surgery.

Other risks:

**Leg length inequality**

It is very difficult to make the leg exactly the same length as the other one. Occasionally the leg is deliberately lengthened to make the hip stable during surgery. There are some occasions when it is simply not possible to match the leg lengths. All leg length inequalities can be treated by a simple shoe raise on the shorter side.

**Wear**

All joints eventually wear out. The more active you are, the quicker this will occur. In general 80-90% of hip replacements survive 20-30 years.

**Failure to relieve pain**

Very rare but may occur especially if some pain is coming from other areas such as the spine.

**Unsightly or thickened scar**

**Limp due to muscle weakness**

**Fractures (break) of the femur (thigh bone) or pelvis (hipbone)**

This is also rare but can occur during or after surgery. This may prolong your recovery, or require further surgery. Discuss your concerns thoroughly with your orthopaedic surgeon prior to surgery.

**Summary**

Surgery is not a pleasant prospect for anyone, but for some people with arthritis, it could mean the difference between leading a normal life or putting up with a debilitating condition. Surgery can be regarded as part of your treatment plan-it may help to restore function to your damaged joints as well as relieve pain.

We have discussed our risk assessment for VTE and I have explained the NICE guidelines are to use TED stockings, mobilisation and chemical prophylaxis for four weeks and we will stick to these guidelines in order to minimise risk of a DVT and PE.

A risk of using chemical injections to thin the blood (clexane or fragmin, a form of heparin) is that the blood becomes too thin and forms a haematoma or collection of blood around the joint. This may require a further operation to wash out the blood and prevent an infection. This can happen in 1 out of 200 cases. If an infection takes hold, this can lead to further surgery and even amputation in 1 in 10,000 cases. The other thing to keep in mind is that up to 1 in 10,000 of people using clexane or fragmin can develop Heparin Induced Thrombocytopenia (HIT). This is a condition where the blood platelets become consumed due to the blood thinning injections. This can be an emergency where you need to be admitted and treated for generalised clots within the body which can lead to multi-organ failure in severe cases as well as a platelet transfusion. A blood test to measure your levels will usually be performed to check your platelet levels are fine.

**Patient instructions**

We discussed and talked about signs and symptoms suggesting VTE (e.g., swelling, pain, redness, or venous distension in a limb, as well as pleuritic chest pain or sharp pain on breathing) because 75% of postoperative VTE occurs following discharge from hospital. Please consult your physician immediately if you experience any of these symptoms or any experience necrotic reactions (black skin, not bruising) at an injection site, because this may suggest HIT. Finally, you should seek immediate medical attention for symptoms

suggesting a severe allergic reaction, such as breathing difficulty, wheezing, and swelling of the face, lips, tongue, or throat.
Early mobilisation should be encouraged to diminish the likelihood of developing a VTE. If long-term prophylaxis is given, pre-arranging for patients to practice injections or for community-based organisations to be involved in giving the injections is recommended.

As an individual by signing the form below you have confirmed that you have read and understood the information above and are happy with these explanations and accept the risk profiles, I have also advised you to look at the Surrey Orthopaedic Clinic and iwantgreatcare.org websites and BMI hip replacement leaflet, I have given you my card with a 24 hour hotline should there be any problems after recovery so that they can contact us if there was a situation and I will see you due course for surgery.

Kind regards

Yours sincerely

**Mr Rishi Chana**
**Consultant Hip & Knee Surgeon**

I have read, reflected and understood the conversation above. As part of my Personalised Treatment Contract I have discussed and conveyed my specific goals, worries, concerns and questions with Mr Chana we have addressed my personal circumstances and attitude to the risks and implications of surgery.
These are outlined below and by signing this confirm that a shared decision about all aspects of my care have been completed to my entire satisfaction.

My goals or outcomes expected of the treatment including surgery are:

Want to sleep, and be able to walk and drive without pain.
Pain free mobility to get on with life.

My specific concerns pertinent to my personal circumstances are:

The hip is slowing me down.
It should last another 25 to 30 years.

I accept the risk profile and procedure tailored to my personal circumstances and concerns raised through the consultations and give Mr Chana informed consent to perform the agreed surgery / treatment plan specified above. I have also reinforced my understanding of the plan above by explaining what I am going to say to my family at home about things back to Mr Chana so we are both happy with our understanding and I will not hesitate to contact Mr Chana should there be any further thoughts or queries regarding my care.

Signed

Hip Precautions:

Avoid any extreme movement and combined rotation.

Dont's: Please do NOT…

Do NOT extend your hip beyond 0 degrees (this is pushing your leg backwards, behind the pelvis) and avoid rotating the leg outwards so your foot points outwards. This can cause a dislocation as the hip levers out the front of the socket. Avoid large swinging steps and avoid letting the leg trail behind as you walk.

Do NOT sit or slouch or lay on your back with your leg extended outward and the foot pointing outwards. AVOID movements with any combined rotation, outward movement and extension (straightening of the hip like when in a standing position or lying flat on your back or lifting the pelvis forward.)

Do NOT try and do pelvic lifts or bridges for the first 4 weeks.

Do NOT sit with the hip beyond 90 degrees with the leg or foot rotated inwards, keep the knee and leg and foot pointing forward. This can cause a dislocation though the back of the hip socket.

Remember this is an artificial hip and must be treated with care.
AVOID THE COMBINED MOVEMENT OF BENDING YOUR HIP AND TURNINGYOUR FOOT IN.
This can cause DISLOCATION. Other precautions to avoid dislocation are

- You should sleep with a pillow between your legs for 6 weeks. Avoid crossing your legs and bending your hip past a right angle
- Avoid low chairs
- Avoid bending over to pick things up. Grabbers are helpful as are shoehorns or slip on shoes
- Elevated toilet seat helpful
- You can shower once the wound has healed
- You can apply Vitamin E or moisturizing cream into the wound once the wound has healed
- If you have increasing redness or swelling in the wound or temperatures over 100.5° you should call your doctor
- If you are having any procedures such as dental work or any other surgery you should take antibiotics before and after to prevent infection inyour new prosthesis. Consult your surgeon for details
- Your hip replacement may go off in a metal detector at the airport

The 'safe zone' for movement is between 20 and 90 degrees of hip flexion relative to the pelvis and spine. Please be very mindful of the leg being in line with the hip and avoid combined rotational movements.

DO the following:

Sit at a position of 70 degrees with the hip, leg and knee and foot in line pointing forwards, not inward or outwards.

Move around for 15 to 20mins every hour.

Move the hip from 90 degrees flexion to normal standing position (this is 0 degrees of extension) but AVOID rotating the leg when at 90 degrees or fully straight.

Your calf pump exercises but do not overdo the pelvic exercises.

## STANDING PRECAUTIONS

Do not step backwards with your surgical leg or extend your surgical leg behind you.

Do not pivot on your surgical leg.

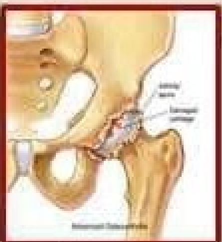
When turning, pick your feet up and move your entire body.

Avoid turning your leg outwards when standing.

Avoid crossing your legs at the ankles when standing.

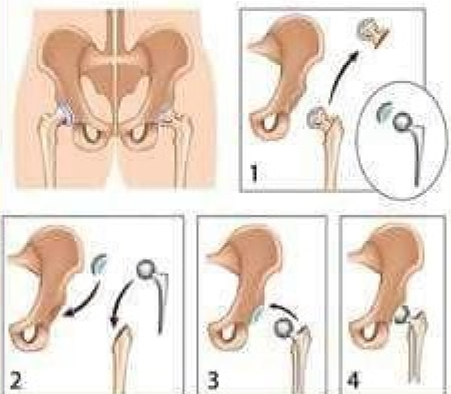
Keep your knees and toes pointing straight ahead when standing and walking.

# * PRECAUTIONS AFTER



When needed ?

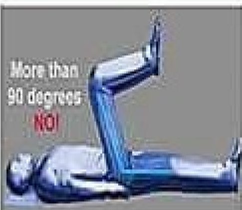
Osteoarthritis (OA),
Rheumatoid arthritis(RA)
Joint fractures
Diseases




## What is total hip replacement / THR?

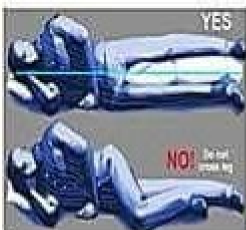
It is also known as total hip arthroplasty (THA). Hip replacement surgery involves replacing the worn out (diseased and painful) parts of the hip joint with an artificial hip joint implant designed to allow movement and stability close to that of a normal knee.

Don't bend the hip past 90 degrees.
This means don't raise your leg in bed

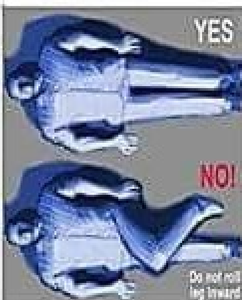



Don't raise your thigh past ninety degrees when you are sitting or laying down.

Don't bend too far when standing




Don't turn the foot of your operated leg inward. This means when lying on your back, don't roll your affected leg toward the other leg as you might do when rolling over. Also, don't stand pigeon-toed. Keep the toes of your affected leg pointed forward when you stand, sit or walk.




Don't allow the knee of your operated leg to cross the midline of your body. This means don't let your knee move across your body past your navel (belly button). This precaution is especially important when lying on your side or trying to turn in bed. When lying on the unaffected side, place pillows between your legs to keep your hip in the correct position. When sitting, do not cross your affected leg.

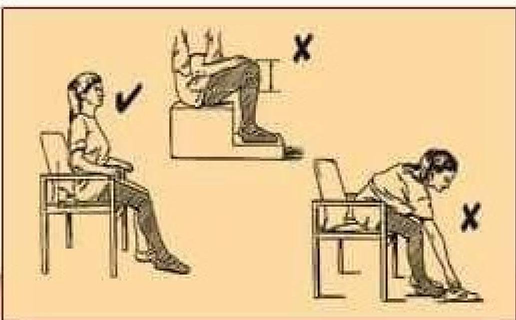
### Getting in and out of bed

1. **Sit** down on the bed in the same manner as you would sit in on a chair (see page 10).
2. **Slide** your buttocks backward until your knees are on the bed.
3. **Pivot** on your buttocks as you lift your legs onto the bed.
4. Use a pillow to keep your legs apart when lying in bed.
5. Reverse the procedure to get out of bed.

Do not bend your operated hip beyond a 90° angle.

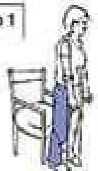
Do not cross your operated leg or ankle.

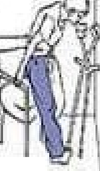
Do not turn your operated leg inward in a pigeon-toed position.



### Standing up

1. **Move** your **buttocks** to the edge of the bed or chair so that your feet are flat on the floor.
2. **Bend** your **healthy leg** under you to hold your body weight.
3. **Keep** your **operated leg straight** out in front of you.
4. **Do not** bend forward.
5. With your hands, **push** off the surface you are sitting on. Put most of your weight on your healthy leg.

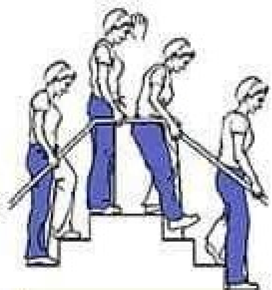


### Walking

The physiotherapist will give advice on how to walk with walking aids (crutches or a walker).
It is possible to turn around either way but it is important **NOT** to **pivot** or **twist** the operated leg. Use small steps when turning.

3. Put your **weight** on the crutch handles. Step down with the healthy leg.



stairs

washrooms