



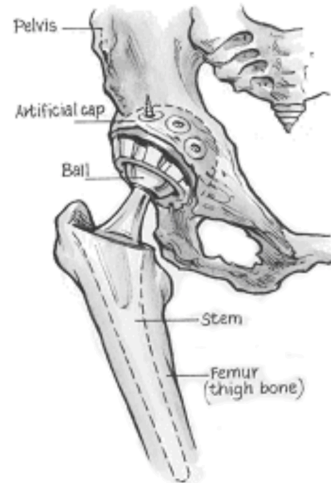
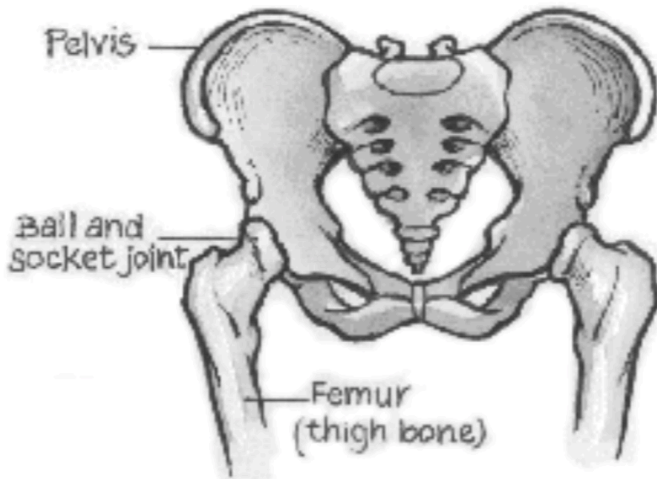
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Patient Information – Total Hip Replacement

1. What do I need to know about the condition?

The hip is a “ball and socket” joint. The ball is formed by the head of the thighbone (femur) which fits snugly into the cup shaped bone in the pelvis (acetabulum).



The bones are coated in cartilage, which acts as a cushion between the two bones and allows movement. The aim of total hip replacement is to relieve pain and improve movement. Total hip replacements are usually performed for people who have arthritis that is getting worse and is no longer responding to other treatments.

The most common type of arthritis is osteoarthritis, which happens with aging, congenital abnormality of the hip joint, or previous injury to the hip joint.

2. What do I need to know about this procedure?

The hip joint is a ball and socket joint. The ball is the head of the thighbone and fits into the socket, which is part of the pelvis.

A total hip replacement removes the damaged areas of bone. An artificial ball and stem which fits into the thigh bone replace the head of the femur. The socket is replaced with an artificial cup. The artificial joint is called a prosthesis.

Usually, bone cement is used to fix the prosthesis into the bone. In other cases, a prosthesis is used which allows bone to grow onto the outer surface of the prosthesis.

Your surgeon will discuss with you the most suitable type of prosthesis for your condition and health. The operation takes 2 – 4 hours.

3. What are the benefits of having this procedure?

The pain should gradually improve making it possible to take up activities, which could not have been done prior to surgery because of pain and stiffness in the hip joint.

4. What are the risks of not having this procedure?



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The pain may become so severe that independence with every day activities such as showering, walking, shopping, gardening, climbing stairs, getting out of a chair, may be lost.

5. My anaesthetic

This procedure will require an anaesthetic.

Your anaesthetist will discuss the options available.

6. What are the risks of this specific procedure?

There are risks and complications with this procedure. They include but are not limited to the following.

General risks:

- Infection can occur, requiring antibiotics and further treatment.
- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Aspirin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).
- Small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.
- Heart attack or stroke could occur due to the strain on the heart.
- Blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.
- Death as a result of this procedure is possible.



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Specific risks:

The risk	What happens	What can be done about it
Clots in the legs	Blood clots can form in the legs. This can happen in 1 in 2 people, although drugs and compression stockings are usually used to help prevent this.	The clots can break off and travel to the lungs, and can cause death in 2 in 1000 people.
Wound infection	Infection after hip replacement occurs in about 1 in 100 people.	Infection is a major complication. This may require further surgery and possibly, the new hip to be removed.
Dislocation of the hip joint	The hip joint can dislocate in 1 in 50 people.	The hip can usually be put back in without surgery. A brace may be worn to give added support for some weeks. On rare occasions, further surgery may be necessary.
The hip joint may break	The joint may break during surgery in 1 in 1000 people – and increases to 1 in 16 for artificial joints inserted without bone cement. After surgery, the risk is 1 in 1000 for new hip replacements – and increases to 1 in 24 who have a revision of hip replacement.	A second operation may be required to repair the break.
Nerve injury	The nerves around the hip joint may be injured during the surgery in 1 in 100. The risk is higher in those people who have a replacement for congenital dislocation – 1 in 20.	Pain, and/ or paralysis which can cause permanent disability.
Retention of urine and bladder infection	A tube (catheter) into the bladder at the time of surgery. After surgery, sometimes the bladder may not empty after the catheter is removed and may have to be re-inserted. A urine infection may happen in 1 in 16 people.	Drugs to relax the bladder and possibly another tube into the bladder. Antibiotics will be given to treat infection.
Blockage of the bowel	The bowel may become paralysed after the surgery causing pain, bloating, nausea and vomiting.	Drugs may be given. A drip may be put into the vein and a tube put up the nose, down the back of the throat and into the stomach until the bowel recovers.
The artificial joint will loosen or wear out	The artificial joint may loosen in 1 in 40, which can happen over time. 9 out of ten hip joint replacements are still working after 10 – 15 years.	Further revision of the hip joint replacement may be required.
Leg length may be different to the un-operated side	The leg length may be different to the other side.	Further treatment may be required eg. shoe raise and surgery may be necessary to correct the difference.
Bleeding into the wound	Possible bleeding into the wound after the surgery.	This can cause swelling, bruising, blood stained discharge. This may be painful, and require surgical drainage or become infected, needing antibiotics.
Infection around hip joint years later	Infection can spread to the artificial hip joint from other areas in the body.	The hip joint may have to be removed. To prevent this, you will need to have antibiotics before other procedures, operations and dental work.
Failure of the hip joint	The hip joint may fail within five years of surgery (up to 1 in 11 people.)	Further hip revision surgery to correct the cause of the failure.
Increased risk in smokers.	An increased risk of wound infection, chest infection, heart and lung complications, thrombosis	Giving up smoking before operation will help reduce the risk.
Death	Death is extremely rare due to hip replacement.	



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7. What are some alternative treatments?

Walking aids such as a walking stick.

An exercise program can strengthen the muscles around the hip joint and sometimes improve positioning of the hip and relieve pain.

Nonsteroidal anti-inflammatory drugs, or NSAIDs. Some common NSAIDs are aspirin, ibuprofen and celebrex.

Corticosteroids, such as prednisone or cortisone reduce joint inflammation but can weaken the bones in the joint. Side effects from corticosteroids are increased appetite, weight gain, and lower resistance to infections.

Herbal treatment.

Glucosamine, Chondroitin.

Osteotomy. The surgeon cuts the bone at a point away from the damaged joint and tissue and restores the joint to its proper position, which helps to load weight evenly across the joint.

For some people, an osteotomy relieves pain. Recovery from an osteotomy takes 6 to 12 months. The function of the hip joint may get worse and the patient may need more treatment.

8. What do I need to know about recovery from this procedure?

After the operation, the nursing staff will closely watch you until you have recovered from the anaesthetic.

You will then go back to the ward where you will recover until you are well enough to go home, usually 7-10 days after surgery.

If you have any side effects from the anaesthetic, such as headache, nausea, vomiting, you should tell the nurse looking after you, who will be able to give you some medication to help.

• Pain

You can expect to have pain in the operation site. You will have either:

- An injection into your spine, an epidural, which may be joined to a fine tube and a pump which sends painkiller into your spine.
- A patient controlled painkiller which, when you press a button, releases a painkiller into your IV drip.

These pain-killing devices will stay in for 24 – 48 hours depending on the amount of pain you have.

• Diet

You may have a drip in your arm. The drip will be removed by the second day after your operation.

To begin with, you can have small sips of water, then slowly take more until you are eating normally.

• Wound

Your wound will be a cut about 20cm down the outer side of your thigh and will be closed with dissolvable stitches. A dressing will cover the cut.

You can shower 1 or 2 days after surgery. A waterproof dressing will be put on over the top. Your dressings will be changed as ordered by the surgeon. Continue to keep your wound clean and protected until healed and no seepage is present.



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- Lungs and blood supply

It is very important after surgery that you move as soon as possible. You will be shown which of your pre – operation exercises to continue after surgery. Pump your feet backwards and forwards and bend and straighten your non- operated leg at the knee. This prevents blood clots forming in your legs and possibly travelling to your lungs. This can be fatal.

You will start walking the second day after surgery with the use of walking aids. You will be told when you can put your full weight on your new hip. Also, you need to take ten deep breaths every hour, to prevent secretions in the lungs becoming stagnant. If this happens, you may develop a chest infection. At all costs, avoid smoking after surgery as this increases your risk of chest infection.

- Exercise

You will feel tired for a few weeks after surgery. You need to take things easy and return to normal duties, as you feel able to. It takes about 3 months to recover.

You should not drive during the first 3 months and avoid being a passenger for 6 weeks. You will be given exercises to do for a month after your surgery. You will also be shown how to safely climb stairs, shower, dress and toilet yourself.

There are a number of movements to avoid for 3 months.

- never bend your hip past 90degrees (a right angle).
- do not bend down to pick up from the floor.
- do not cross your legs at knees or ankles.
- use pillows between your legs when lying on your back.
- do not lie on your operated hip. To lay on your side, lie on the un-operated side and use several pillows between your legs.

You will be told about these before you go home.

9. How do I look after my hip joint?

- Joint replacements can become infected at any time after the surgery from the first post-operative day to many years down the line. You can take the following steps to help prevent infection:
- Take antibiotics before dental or any medical procedure.
- See your doctor to treat all suspected urinary tract infections.
- Look for signs of infection in the hip including pain, redness, swelling or increased warmth.
- Your new joint replacement may trigger airport metal detector alarms. We will give you a certificate that verifies that you had a hip replacement.
- Keep in mind that you need to protect your hip replacement to ensure a long lasting, successful result. Follow all instructions concerning any activity restrictions.

10. What do I need to tell my doctor?

- Tell your doctor if you have;
- redness, swelling or warmth around the cut.



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- leakage from the cut.
- fever and chills.
- severe hip pain that is not relieved by prescribed painkillers.
- sudden sharp pain and clicking or popping sound in the hip joint.
- leg shortening with your leg turning outwards.
- loss of control over leg movement.
- loss of leg movement.
- further surgery planned for the future i.e. dental work, bladder catheterisation, examinations of the bowel, bladder, rectum or stomach.