Message from Your Surgeon

Dr. Pfefferle, a native of Tiffin, Ohio, received his degree in mechanical engineering from The Ohio State University. He also completed his medical school education at The Ohio State University where he was awarded the John B. Roberts award for excellence in orthopedic academic performance and research. Dr. Pfefferle then completed his orthopedic surgery residency training at Summa Health, where he routinely scored above the 98th percentile in the country on the annual orthopedic training exam. As a chief resident he was awarded Teacher of the Year. Dr. Pfefferle then completed an additional one year fellowship in adult hip and knee reconstruction at the prestigious Anderson Orthopedic Clinic in Alexandria, Va.

Dr. Pfefferle’s clinical focus is hip and knee replacement. Dr. Pfefferle has a special interest in rapid recovery and advanced pain control, anterior hip replacement, partial and total knee replacement as well as complex revisions of failed hip and knee replacement.

Dr. Pfefferle has published research in multiple orthopedic journals and received awards for excellence in research. He has presented his research at local, state and national conferences.

According to Dr. Pfefferle, “Hip and knee replacement are two of the most successful surgical procedures in modern medicine. With modern surgical techniques and implant design, today’s hip and knee replacements offer rapid recovery with less pain with greater durability.”

“My goal is to treat each patient as if they were a member of my own family. I enjoy helping each patient reach their own individual goals.”

Kiel J Pfefferle, MD
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>Primary Total Hip Replacement</td>
<td>6</td>
</tr>
<tr>
<td>Rapid Recovery Hip Replacement</td>
<td></td>
</tr>
<tr>
<td>Approaches to the Hip</td>
<td></td>
</tr>
<tr>
<td>Bearing Surfaces</td>
<td></td>
</tr>
<tr>
<td>Revision Hip Replacement</td>
<td>9</td>
</tr>
<tr>
<td>Surgical Complications</td>
<td>10</td>
</tr>
<tr>
<td>Preparing for a Hip Replacement</td>
<td>11</td>
</tr>
<tr>
<td>Your Joint Replacement Team</td>
<td></td>
</tr>
<tr>
<td>Scheduling Surgery</td>
<td></td>
</tr>
<tr>
<td>Preoperative Planning</td>
<td></td>
</tr>
<tr>
<td>Discharge Planning</td>
<td></td>
</tr>
<tr>
<td>Medical Clearance/Pre-Admission Testing</td>
<td></td>
</tr>
<tr>
<td>Reducing the Risk of Infection</td>
<td></td>
</tr>
<tr>
<td>Stopping Medications Before Surgery</td>
<td></td>
</tr>
<tr>
<td>Financial Arrangements</td>
<td></td>
</tr>
<tr>
<td>Preoperative Physical Therapy Sessions and Pre-Hab</td>
<td>14</td>
</tr>
<tr>
<td>Joint Academy</td>
<td></td>
</tr>
<tr>
<td>Pre-Hab</td>
<td></td>
</tr>
<tr>
<td>Presurgical Exercises</td>
<td></td>
</tr>
<tr>
<td>Day of Surgery</td>
<td>16</td>
</tr>
<tr>
<td>Reporting to the Hospital</td>
<td></td>
</tr>
<tr>
<td>Clothing</td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td>Post-Anesthesia Care Unit (PACU)</td>
<td></td>
</tr>
<tr>
<td>Family Waiting Area</td>
<td></td>
</tr>
<tr>
<td>Postoperative Course</td>
<td>17</td>
</tr>
<tr>
<td>Pain Medicine</td>
<td></td>
</tr>
<tr>
<td>Wound Care</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>18</td>
</tr>
<tr>
<td>Your Rehab Team</td>
<td></td>
</tr>
<tr>
<td>Postoperative Physical and Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>Preventing Postoperative Hip Dislocations</td>
<td></td>
</tr>
<tr>
<td>Going Home</td>
<td>20</td>
</tr>
<tr>
<td>Final Discharge Instructions/Prescriptions</td>
<td></td>
</tr>
<tr>
<td>Written Discharge Instructions</td>
<td></td>
</tr>
<tr>
<td>Going Home By Car</td>
<td></td>
</tr>
<tr>
<td>By Airplane</td>
<td></td>
</tr>
<tr>
<td>Getting into Your House and Using Stairs</td>
<td></td>
</tr>
<tr>
<td>Returning for Your First Postoperative Visit</td>
<td>21</td>
</tr>
<tr>
<td>Long-Term Considerations</td>
<td>22</td>
</tr>
<tr>
<td>Use of Antibiotics to Prevent Hip Infections</td>
<td></td>
</tr>
<tr>
<td>Follow-Up Visits</td>
<td></td>
</tr>
<tr>
<td>Common Questions asked about Hip Replacement</td>
<td>23</td>
</tr>
</tbody>
</table>
Introduction

The information in this manual will help familiarize you with the total hip arthroplasty procedure as performed by the Orthopedic Institute physicians. We will explain in details the steps you will take to prepare for surgery, what will occur on the day of your surgery, and what you can expect during your postoperative period. We also describe your home care after surgery. Once you and your physician have decided that hip replacement surgery is needed, you will naturally have many questions. Experience has taught us that each patient has different expectations. It is important to us that all of our patients know what to expect preoperatively and postoperatively. We believe the guidelines in this booklet will help you achieve the greatest satisfaction from your hip replacement.

Primary Total Hip Replacement

More than 330,000 total hip replacements are performed annually in the United States. Hip replacements are performed to alleviate conditions caused by osteoarthritis, rheumatoid arthritis, fractures, dislocations, congenital deformities, and other hip-related problems. The surgery involves replacing the damaged surfaces of the hip. The head and neck of the femur (thigh bone) are removed and replaced with a ball and stem, called the femoral component. Then, the damaged hip socket is lined with a metal “cup.” A liner is placed into the cup. The liner can also be made from different materials, but is usually plastic, or ceramic. The ball can be made of different material, such as metal or ceramic. The ball of femoral component fits into this liner, or bearing surface, creating a new movable joint.

The immediate benefits of total hip replacements are excellent. In most uncomplicated cases, patients can expect to have reduced pain, have improved hip mobility, and have a reduced limp soon after surgery. The operation usually takes about 45-90 minutes, much less time than many other surgical procedures.
Rapid Recovery Hip Replacement
At the Orthopedic Institute, we believe a team concept will speed up recovery and the ability to return to work. This team approach includes patient education, presurgical planning, better anesthesia, less traumatic surgery, better pain control and faster return of function.

We have been working on minimally invasive techniques for many years. We are using specially designed instruments that allow all patients to have the smallest incision possible. We must make the incision long enough to do your surgery safely. Your weight plays a big part in how long your incision will be.

We use several different surgical approaches: anterior, anterolateral, and posterior. Your surgeon will determine which approach is best for your hip. Most patients benefit from all the minimally invasive advances and go home the day of surgery, or after one to two nights in the hospital. Most patients will be walking and/or moving their hip on the day of surgery.

Approaches to the Hip
There are multiple ways or “approaches” which allow the surgeon to gain access to the hip joint. Each approach carries with it unique advantages and complications and potentially different precautions postoperatively. You may talk to your surgeon about the specific approach for your surgery.

Bearing Surfaces
Hip bearing surfaces consist of a metal or ceramic ball on a metal stem and a metal cup with a polyethylene or ceramic liner. The metals used are titanium and cobalt chromium. Before your surgery your surgeon will measure your x-rays and select the component that is the best fit for you.
Revision Hip Replacement

The revision of the porous-coated components usually is necessary because of wearing out the polyethylene liner in the cup. In many cases patients may have no symptoms, and the diagnosis of a damaged joint surface is made from patients’ x-rays. Revision surgery is advised in these cases to prevent further bone damage that could lead to a more complex procedure later. Although rare, other reasons for revision surgery are dislocation, loosening, infection and fracture.

For this reason, we ask our patients with well-functioning hip replacements to see us annually for 1-2 years then every 3-5 years after the initial postoperative period. This is necessary to monitor signs of wear from our long-term patients’ x-rays. These signs can appear gradually as the liner starts to wear.

Preparation for revision surgery is more complex than for an initial surgery. Revision patients who had their primary surgery at another institution can help us by obtaining detailed records of previous surgeries so that we know exactly what types of parts need to be replaced. Revision surgery can be relatively straightforward when it involves just the exchange of a ball and liner. However, the procedure is complex when it involves replacing a stem or cup. When the procedure includes removing cement or repairing damaged bone, the operation takes longer, and a patient’s recovery time will likely be significantly longer than for the first-time hip replacement.

Scar tissue from previous surgery and bone from the failed hip replacement require special attention both during and after surgery. For example, bone graft may be used to rebuild areas where bone loss has occurred. Patients may also require a blood transfusion when revision surgery takes longer.

We customize the rehabilitation plan for each revision patient on the basis of difficulty and the extent of surgery. Customized rehabilitation can be as simple as limited exercise or limited weight bearing, or as complex as using a brace for 6-12 weeks.
Surgical Complications

Along with the advantages of hip replacement, the possibilities of complications exist. Complications may include infection, hip stiffness, nerve palsies, blood-clot formation, leg length inequality, hip dislocation, or fracture of the femoral or pelvic bone during insertion of the prostheses. We hope that by making you aware of these potential problems and by discussing them openly, you will have more confidence in our expertise and ability to avoid complications.

Dislocation, which occurs when the ball at the top of femoral component comes out of the hip socket, is seen in up to 1-2% of primary total hip arthroplasties and in about 5-10% of revision arthroplasties. Dislocations are treated initially without surgery, and most patients who dislocate never require further surgery. We will discuss preventative measures for dislocations and the treatment of dislocations in a later section.

Patients with arthritic hips often develop shortening of the affected leg. One of our goals with a hip replacement is to equalize leg-length as much as possible. While this is possible in more than 90% of our cases, it may not be feasible with large differences in leg lengths. Also in a small number of patients it is possible that in order to maximize stability the operative leg actually has to be made slightly longer than the nonoperative leg. In revisions cases and in some primary cases, muscle and bone loss requires us to lengthen your leg to optimize the stability of your hip.

Less than 1% of primary and revision patients have any nerve injuries, and most individuals with such injuries recover with time.

Fractures occur during surgery in less than 2-3% of patients. In almost all of these cases, the fractures consist of very small cracks in the bone. These heal rapidly and do not interfere with the patients’ normal recovery from joint replacement. If the fracture is large, it may require operative treatment and also restricted weight bearing for a longer period than that required for an uncomplicated total hip replacement.

Infection occurs in less than 0.5% of primary hip patients and in up to 5% of revision patients. If the infection is diagnosed quickly, a thorough washout of the hip may be all that is needed to cure the infection. If it develops into a chronic infection, then the implants must be removed for 2-6 months to allow treatment with antibiotics. After the infection is cured, new hip components may be reimplanted.

Another complication of any hip surgery is a deep venous thrombosis (a blood clot in the leg). To avoid this complication, we treat patients with blood thinners and/or pneumatic compression devices.

Risks from anesthesia also exist and vary for different patients and types of anesthesia. We encourage patients to discuss their options with the anesthesiologist on the day of surgery. We believe that well-informed patients approach the surgical procedure and postoperative experience with greater enthusiasm and less apprehension. By discussing your procedure, its risks and benefits, as well as our techniques, alternative treatments, and expected outcomes, we hope to reassure that we are committed to your well being.
Preparing for a Hip Replacement

Your Joint Replacement Team
A team of professionals will help you through all phases of your surgery. This team includes your physician and his clinical staff, physical therapist, case manager, physician assistant, nurse, occupational therapists, and support personal. Other important members of our Joint Replacement Team include our Orthopedic Residents; they are among the brightest young future orthopedic surgeons in the country. You may meet one of the doctors on your first visit to our office. Under the supervision of your physician, each resident assists in the clinic and in surgery, provides postoperative patient care with daily rounds, and participates in our research.

Scheduling Surgery
If you do not schedule surgery at the time of your office visit, our scheduling secretary, who will help you select a surgery date, is available to answer any questions. To allow adequate time for the necessary preparations, a surgery date is usually set well in advance of your decision to proceed with hip replacement surgery. You will initially get a date for surgery, but the time of your surgery will not be determined until the week before the surgery date.

Preoperative planning
Once you have a surgery date, you will need to prepare. This includes preoperative interviews and tests which will need to be done within 30 days of your surgery date. We also have you attend a Joint Academy class prior to surgery. We also encourage you to bring someone with you to help you get to your appointments and function as your “coach” and advocate throughout the joint replacement process including Joint Academy.

Discharge Planning
Most patients recuperate much better at home with the help of family and friends; therefore, our care map promotes discharge to your home. Your team will assist in identifying the kind of help you may need after discharge and advise you of care options. It is important that your discharge plan be worked out with the team before surgery.

You should take an iron supplement starting a week prior to your surgery. This can be purchased at your local drug store without a prescription. This iron supplements should be taken after meals. Iron will change the color of your stools to a tarry black. In addition, the supplement may be constipating, in which case a laxative may be needed.
Preparing for a Hip Replacement (continued)

Medical Clearance / Pre-Admission Testing

All patients must be evaluated by a medical doctor prior to surgery to determine if it is safe to proceed. This visit will include a medical history, physical examination, and laboratory tests (blood count, chemistry profile, and urinalysis). You may also need a chest x-ray and electrocardiogram that has been done within the past year. Additional tests may be required if you have other specific medical problems. The examination must be completed within 30 days of your surgery.

As you consider joint replacement surgery, our team is here to help you achieve the best surgical outcomes and recovery.

As a part of your Pre-Admission Testing (PAT), we have set criteria for BMI (Body Mass Index), A1C (Diabetes Control), Hemoglobin (blood level) and Albumin (Nutritional Measure).

Clinical research shows that if these four criteria are met prior to surgery, complications such as infection, hospital re-admission and blood transfusion can be avoided.

Reducing the Risk of Infection

Any source of bacteria within your system must be eliminated before your surgery. Abscessed teeth and pending dental work should be taken care of prior to your hip surgery. A urinary tract infection is an additional source of contamination. Although frequency, urgency, and burning are symptoms of a urinary tract infection, or prostate problems, you may have an infection without symptoms. The doctor who clears you for surgery will order a test of your urine. If an infection is found, antibiotic treatment may be required prior to your hip operation.

Our goal is to reduce the number of bacteria you carry on your skin prior to surgery. We will instruct you to use an antibacterial wash in the days prior to your surgery. Because certain bacteria are carried in your nostrils, we may instruct you to use an ointment to treat these bacteria. Furthermore, the skin around your hip and operative extremity should be free of any open lesions such as cuts, scrapes, bug bites, etc. If you have any questions, please call your physician’s office.

Stopping Medications Before Surgery

Patients should stop taking aspirin and other non-steroidal anti-inflammatory medicines (Advil, Ibuprofen, etc.) at least ten days before surgery to avoid increased bleeding associated with these medications. You may take Tylenol for pain during this time.

If you are taking blood thinners, such as Plavix, Coumadin or Pradaxa, these also can create bleeding problems; it is important to discuss their use with the prescribing physician to determine the dosage program that will best prepare you for surgery.
Ten days prior to the surgery, you should also discontinue the use of most herbs/supplements: echinacea, ephedra, feverfew, garlic, ginger, gingko biloba, ginseng, goldenseal, kava, saw palmetto, St. John’s Wort, valerian, vitamin E, glucosamine chondroitin, and fish oil.

Financial Arrangements
The Orthopedic Institute will make every effort to assist you in meeting the policy requirements of your insurance company. You need to determine whether your insurance requires pre-authorization for surgery and whether a second opinion is required. A call to your insurance carrier will answer these issues, if they are not clearly stated in your policy.

We accept a number of health care plans with fixed fee schedules and will be happy to provide you with information about our participation in your plan. The Orthopedic Institute will bill Medicare or your commercial insurance for the cost of the surgery. You as a patient are responsible for the balance stipulated by your type of insurance. The Summa Orthopedic Institute billing office and our staff are available to assist you with questions about reimbursement and billing procedures. Your hospital bills are handled by the hospital’s billing office. To contact billing with Summa Health, please call 330.315.0454.

If you are responsible for a deductible associated with the surgery, you will be responsible for paying this prior to the date of surgery.
Preoperative Physical Therapy Sessions and Pre-Hab

Joint Academy
Patients who are having a hip/knee replacement will be scheduled to attend Summa’s Joint Academy class. In this class, you will learn important information related to what to expect from surgery, exercises to improve strength and motion before surgery, discuss and answer critical questions related to your support after surgery, evaluate your needs when you return home and much more. It is imperative that you have a support system at home to assist you initially. We require that you and your coach/support person attend the class with you.

Pre-Hab
This is a collaborative program between Summa and the Akron Area YMCA. This program provides you with a 90-day membership to the YMCA to be utilized to aid in your strength and motion before surgery and aid in your recovery after you are done with formalized outpatient rehabilitation. You may choose to take advantage of the pre-hab program that we have set up with local YMCA’s to assist you in this process. Ask your Joint Academy instructors for more information.

Presurgical Exercises
You will be instructed on the following exercises either in Joint Academy, pre-physical therapy or pre-hab. The exercises should be completed as instructed prior to your surgery.

1. Ankle Pumps: Move your foot up and down. Repeat up to 25 repetitions, twice daily.

2. Quad Sets/Knee Tighteners: Lying on your back with your legs straight, push down the back of the knee against the bed. Maintain the muscle contraction in the thigh for five seconds. Relax. Repeat up to 25 repetitions, twice daily.

3. Gluteal Sets/Buttock Tighteners: This exercise can be done lying down, sitting, or standing. Squeeze the buttock muscles together and hold for five seconds. Relax. Repeat up to 25 repetitions, twice daily.

4. Isometric Adduction/Abduction: Sitting in a chair, place your hands along the outside of your thighs. Tensing your thighs, pretend as if you are trying to push your thighs apart; maintain the tension for 5 seconds. Then, place your hands on the inside of your thighs and pretend you are pushing your thighs together by tensing them for 5 seconds. You should be exerting your thigh muscles, not your hands or arms. Repeat up to 25 repetitions, twice daily.
5. **Straight Leg Raise**: Lie on your back with your right leg bent. Tighten your left knee and thigh and lift your leg off the bed just a few inches, making sure to keep your knee straight. Hold for the count of three. Do the same exercise with the opposite leg. Repeat the exercise using your right leg. Repeat up to 10 repetitions, twice daily. Do not perform this exercise if it causes you pain.

6. **Chair Push-Ups**: Sitting in a chair with arm rests, push yourself up using your arms. Begin by using your feet to assist you, then progress to putting more weight onto your arms to lift yourself. Hold three seconds. Repeat up to 10 repetitions, twice daily.
Day of Surgery

Reporting to the Hospital
On the day of surgery, you will report to the Registration Desk. Bring your photo ID and insurance cards for verification. You will be escorted to an area where you will change into a hospital gown. An identification bracelet will be placed on your wrist. An admissions nurse will make sure that your medical work-up has been completed. You will then be escorted to an area where a nurse will make you comfortable and provide warm blankets. An intravenous line will be started. You will see your surgeon and the anesthesiologist before going into the operating room.

Clothing
Hospital gowns are suggested during the day of surgery. You are encouraged to bring loose fitting jogging clothes, t-shirts, pajamas, sweat pants, or shorts for the rest of your stay, so that you will be more comfortable when you are walking around. Tennis shoes, loafers, or comfortable support shoes should be worn; we do not recommend bringing new shoes.

Anesthesia
On the day of your surgery, you will meet with the anesthesiologist and anesthesia staff (nurse anesthetist) to go over your medical history and the type of anesthesia that will be utilized for the surgery. Most patients will have a spinal anesthesia and will also be given medications that allows them to sleep during the procedure. This avoids the use of a breathing tube during the operation. A spinal anesthesia is generally our preferred method of anesthesia for joint replacement surgery, however there are some situations in which it may not be indicated, and the anesthesiologist will discuss any such situations with you.
Post-Anesthesia Care Unit (PACU)
A typical hip replacement operation takes approximately 45-90 minutes. Revisions surgery often takes longer since it is more complex.

After surgery, you will be moved from the operating room to the post-anesthesia care unit (PACU), often referred to as the recovery room, where the nurses will monitor your vital signs and oversee your recovery from anesthesia. Your stay in the PACU lasts approximately 1-2 hours.

You may receive oxygen through nasal breathing tubes for up to 24 hours. To empty the bladder, you may have a urinary catheter. Pneumatic compression stockings are also placed on both legs to help improve circulation. An air pump inflates and deflates air-filled pressure compartments within the stockings. This rhythmic change in pressure promotes blood flow and also helps prevent blood clot formation.

Family Waiting Area
Family members are usually not permitted to visit with patients in the PACU. At the end of the surgery, the surgeon or the resident will discuss the details of the procedure with your family members. If family members leave the waiting area, they should let the staff know where they will be. If members of your family are unable to be present on the day of your surgery but would like to talk with your surgeon, they should leave a phone number where they can be reached.

Pain Medicine
We want you to be comfortable but also awake and alert enough to do exercises, including breathing exercises to prevent lung congestion and leg exercises to prevent blood clots. When you have recovered from anesthesia, your pain usually is managed by oral or intravenous pain medications.

We recognize that post op pain is a significant source of fear for patients. Adequate pain control is very important to us. We have designed a comprehensive program to improve your experience by decreasing pain with a “multimodal” pain program. This process starts before surgery, using a combination of different medications that work together to reduce the amount of narcotic medications you require and to maximize your pain control. The narcotic medications can cause side effects such as nausea, itching and constipation, which we would like to avoid. The medication prescribed will not take all of your pain away but it will allow you to rest and make you as comfortable as possible.

Wound Care
Your wound will be covered by a dressing after surgery. It should usually be removed after 7-10 days. You can shower as long as there is no drainage from the wound. After the dressing is removed it is not recommended to apply any cream, ointment or lotion to the wound unless specific instructions are given by your surgeon. Most of the time, your stitches will be under the skin and will dissolve on their own. If you have staples or external stitches they can be removed 10 days after surgery as long as there is no drainage.

Postoperative Course
If the wound is draining, the dressing should be changed daily. The wound should be dry and without drainage by about five to seven days postoperative. If there is persistent drainage from the wound after this time period, you should call our office immediately. If there is worsening redness around the incision, you should also call our office immediately. These may be signs of a superficial or deep wound infection and you may have to return to the office for an evaluation by one of our staff.

Other common concerns after hip replacement surgery include swelling and bruising. These can be quite significant in nature and can appear anywhere from the thigh to the toes. These are typically worse at night which can contribute to trouble sleeping comfortably for more than one to two hours at a time.

Rehabilitation

Regaining muscular control of your leg is our first and most important goal after surgery. All patients receive therapy to help strengthen muscles and also to reinforce postsurgical precautions to prevent dislocation. We want to encourage your independence and discharge to the comfort of your own home.

Family members or friends who may be assisting you after discharge are encouraged to attend all therapy sessions to learn about the appropriate techniques and the amount of assistance that they should offer you after your joint replacement. By being independent, you will be using your own muscles to strengthen and protect your new joint.
Before discharge all joint replacement patients should have practiced how to:

- Dress and bathe
- Get in and out of bed, chair, shower or bathtub, and a car
- Walk with a walker or crutches
- Go up and down stairs
- Carry out the specific home exercise program

**Your Rehab Team**

We believe that your family is an important part that will work with you to develop goals based on your individual needs. The rehab team includes your surgeon, the residents, nurses, therapists and case managers. Family members or friends are urged to attend both physical and occupational therapy sessions to learn appropriate techniques of care and how to assist you at home.

**Postoperative Physical and Occupational Therapy**

A comprehensive therapy regime is important to your full recovery. Therapy will start the day of the surgery and continue at home. Your first session will include a group of simple exercises in bed, standing at the side of the bed, and walking as soon as you are able. You can expect to use a walker, 2 crutches, or a cane for a period of up to six weeks after surgery.

Therapy programs are individually designed by your surgeon based on findings at the time of surgery. Most patients are allowed full weight bearing with the use of a walker or crutches for support. In the weeks that follow surgery, transitioning to a cane is encouraged as patients begin to feel more comfortable with walking. The therapy program may also vary for patients depending on the clinical scenario. The surgical approach will also determine the design of your therapy program. Before discharge, you should understand the specifics of your exercise program. The physical and occupational therapists review the list of activities you can and cannot do after surgery and provides practice sessions to reinforce precautions against dislocation, to improve arm and leg strength, and to increase overall endurance before you go home. If you have any questions about sexual relations after surgery, please discuss your questions with the physical therapist or your surgeon at the follow-up visit.

**Preventing Postoperative Hip Dislocations**

Dislocations are rare, but if they occur they most often occur the first three months after surgery. Before surgery, the physical therapist begins teaching you special precautions and how to avoid dislocation. After surgery, everyone will be reminding you not to bend the hip too much, not to twist at the waist, and to avoid turning your leg in or out.

Many patients’ hip joints are so stable after surgery that they do not have dislocation precautions. If you are one of these patients, the therapist will tell you not to worry about dislocation but you should still avoid extreme bending and twisting. Again, your therapist will go over this after surgery.
Final Discharge Instructions/Prescriptions
Your nurse will see you before discharge and answer any questions you may have. At the time of discharge, the nurse will give you your prescriptions and review discharge instructions. Most patients have some discomfort at home when they perform their exercises. You will receive a prescription for pain medication, but once home, you should begin to decrease the number of pills you take and increase the interval of time between doses. Pain medication should be taken before therapy or sometimes at bedtime, as needed for your comfort; a non-narcotic medicine can be used in between. Applying ice to your hip after therapy helps to control discomfort.

Written Discharge Instructions
You should receive a copy of our discharge instructions to remind you that:

1. It is normal to have swelling and bruising in your lower legs after surgery. Walking frequently during the day and doing your exercises will help strengthen your muscles and reduce the swelling. If you have swelling, we recommend you elevate your legs, and apply ice to your hip for 15 minutes. If the swelling continues to worsen, or becomes increasingly painful, please call your surgeon’s office.

2. You can take a shower when your wound is dry. If you have plastic dressing, it is waterproof. If you have a telfa dressing, remove it before you shower and replace after the shower.

3. You should have a copy of your home exercises from the physical therapist. Do your exercises three times a day.

4. You should be walking in your home, frequently, as able. Use your crutches, cane, or walker as instructed by your therapist. You are encouraged to walk outside with assistance. Often people will notice some clicking in the hip with activity. This does not mean there is something wrong with the prosthesis.

5. Your hip will be sore but pain will dissipate over time. You will be given a prescription for pain medicines that can be used primarily BEFORE THERAPY and AT BEDTIME. Extra-strength Tylenol, anti-inflammatories or Ultram can be used in addition to or instead of narcotic. To ease your discomfort, apply ice to the hip after activity.
Going Home By Car
Patients are able to go home by car after hip replacement surgery. If your trip will take more than two hours, plan on allowing one or more stops for walking and exercising your legs. Please be sure to arrange your ride home prior to surgery.

By Airplane
If you need to travel by air, it is important to request a bulkhead or first class seat, so that you will have enough room to stretch out your leg during the flight. It is advisable to have a travel companion, who can help with your luggage and with getting on and off the plane. Occasionally, your surgeon may recommend that a long airplane ride be postponed for several days after discharge from the hospital.

Getting into Your House and Using Stairs
The physical therapist will teach you how to go up and down steps. You should have someone help you with steps until you are comfortable and secure with them. Remember that when you use a staircase, your crutches go under your arm on the opposite side from the railing. To go up the stairs, start with your unoperated leg; to go down, begin with crutches and the operated leg.

Returning for Your First Postoperative Visit
Your surgeon or physician assistant will see you approximately 4-6 weeks from the time of your surgery. This will be arranged for you by our staff. This first follow-up visit will include an examination of the hip. X-rays of the operated hip will be obtained to evaluate the alignment and fixation of the implant. You will receive new instructions concerning your allowed activities and the amount of weight you can put on the operated leg. Arrangements can be made on an individual basis for out-of-state patients.
Use of Antibiotics to Prevent Hip Infections

Each year in the United States more than 800,000 knee and hip replacements are performed. The infection rate for these procedures is very low. Joint replacement surgeons attempt to lower the infection rate by using prophylactic antibiotics during surgery.

Infections that develop around the hip weeks or months after discharge are a rare but serious complication. Infections that occur after six months are usually the result of an infection elsewhere in the body, which spread by bacteria “seeding” and travels to the hip through the bloodstream. Urinary tract, skin, dental, or respiratory infections are potential causes of such hip infection and should, therefore, be treated aggressively.

In addition, since bacteria are normally found in the mouth and intestines, “seeding” might occur during some dental procedures, bronchoscopy, cystoscopy, or endoscopy and cause infection around your joint. Let your dentist and internist know that you have an implanted hip prosthesis. Please see our guideline for antibiotic prophylaxis prior to procedures for a more complete description.

Follow-Up Visits

We strongly recommend a return visit to your surgeon to confirm that your prosthesis is functioning well. These visits are important whether or not you are having problems with your hip. The plastic part of the implant eventually may show signs of deterioration. This can only be determined by studying your follow-up x-rays and doing a physical examination.
Common Questions Asked About Hip Replacement

Q. How does the doctor decide if I need a total hip replacement?
A. This decision is based on the degree of pain you have, how difficult it is for you to walk, and how much these problems interfere with your activities or quality of life. Other important factors in the decision include evaluation of your x-rays and your health status.

Q. How long does the surgery last?
A. The surgery lasts 45-90 minutes, depending on the condition of your hip at the time of surgery.

Q. How big will my incision be?
A. The size of the surgical incision depends on multiple factors including the complexity of the surgery and the size of the implant.

Q. How long can I expect to have pain after surgery?
A. The time varies for each patient. Many patients report that there is very little pain right after surgery, but postoperative soreness may continue for 3-4 weeks.

Q. How long until bone ingrowth occurs?
A. Bone ingrowth occurs between 6 weeks and 1 year.

Q. How long after surgery will I have to limit weight bearing on my leg?
A. The amount of weight you are allowed to put on your leg varies from full weight bearing to just the weight of your foot. Several surgical factors are considered in making this decision and your surgeon will inform you of your weight bearing status following the procedure. Most patients are cleared to be full weight bearing, as tolerated.

Q. Why do I have to take a blood thinner after surgery and how long will this continue?
A. A blood thinning medicine is recommended to prevent blood clots and is usually discontinued after your first follow-up appointment.

Q. When are the staples or sutures removed?
A. If you have staples, they are removed in 10 to 14 days after surgery, if there is no drainage from the wound site. Dissolvable sutures are often used and do not require formal removal, although the wound should be intermittently checked for redness or drainage.

Q. How long will it be before I can take a shower or bath?
A. You may shower if the wound is covered or if there is no drainage.
Q. When can I resume sexual activities?
A. You can resume sexual activity 3-6 weeks after surgery. The physical therapist will review safe techniques.

Q. When can I drive a car, swim, or ride an exercise bike?
A. The timeframe depends upon the stability of your hip and the type of vehicle you drive or exercise bike you own. Usually swimming is not permitted until the incision is completely healed. You can drive when you are off all narcotic pain medicine and have full control of your leg. This is usually between 2–4 weeks depending on your recovery.

Q. When can I start playing tennis or golf?
A. Usually you can return to impact sports after 3-4 months. Please ask your surgeon.

Q. When will I be able to return to work?
A. This depends on the type of work you do as well as several other factors. This is determined on an individual basis and you should discuss with your surgeon.

Q. How long should I keep doing the exercises?
A. You should do the exercises given to you at discharge until you return for your visit. At that time, you may be given a new set of exercises. You should continue to exercise until your muscles are pain-free and you can walk without a limp. It is a good idea to continue your exercises as a lifetime commitment to keeping your muscles strong.

Q. Do I need an x-ray at 12 months if my hip feels fine?
A. Yes. X-rays are an important part of each follow-up visit and are essential in determining the amount of bone ingrowth, position of the prosthesis, and the condition of the bone around the prosthesis. A patient may not have any symptoms, and x-rays assure us that there are no problems developing.