

Total hip replacement

Your operation to replace your hip with an artificial joint



Introduction

The purpose of this leaflet

Before you agree to have your hip replacement it is important to know all you can about it. This includes:

- why you need this operation
- what it will be like
- how it will affect you
- what risks are involved
- any alternatives.

The information in this leaflet is a guide to common medical practice. Each hospital and doctor will have slightly different ways of doing things, so you should follow their guidance where it is different from the information given here. Because all patients, conditions and treatments vary it cannot cover everything. You should mention any worries you have. Use the information in this leaflet when making your treatment choices with your doctors. You can ask for more information at any time.

You will need to sign a consent form. This records what you agree to. It also allows you to consent to other procedures that become necessary. Make sure everything is quite clear to you. Mention anything you do **not** wish to have done. You can change your mind even after giving your consent.

Important terms used in this leaflet

Acetabulum (*ass-ee-tab-you-lum*) - The cup in the pelvis that receives the head of femur.

Anaesthetist - A specialist doctor trained in anaesthesia and life support. They give anaesthetics, look after patients under anaesthetic and give pain relief after the operation.

Angina - Chest pain due to heart disease.

Arthritis - A degenerative disease of joints.

Cartilage - A covering of the ends of bones that reduces friction when bones move on each other. Cartilage is the white glistening layer that you see on the end of a lamb or chicken bone where it forms a joint

Femur - The thighbone.

Head of femur - The ball on the end of the femur that fits into the hip socket in the pelvis.

Neck of femur - The part between the shaft and the head of the femur.

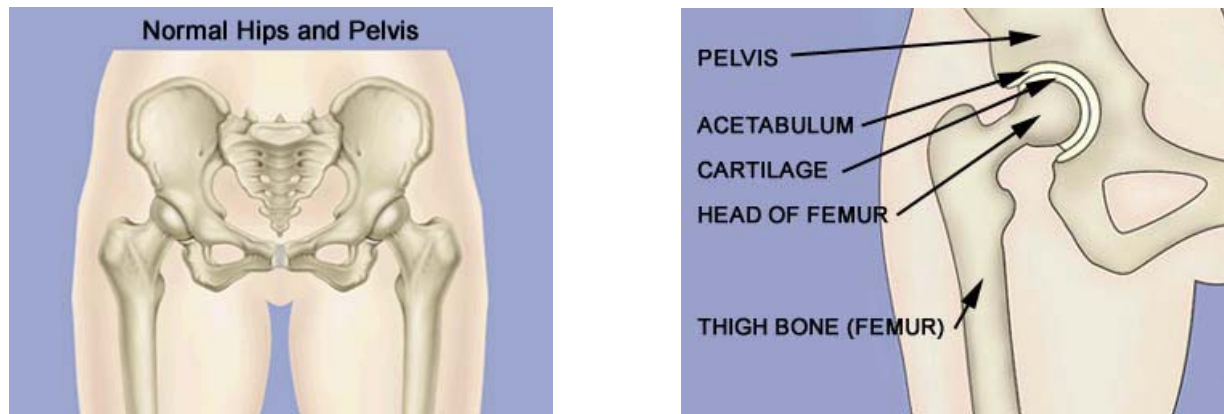
Prosthesis (*pros-th'ee-sis*) - An artificial joint made of metal and plastic.

What is the problem?

You have arthritis of your hip joint. This is causing pain and, possibly, reduced movement of the joint.

What is the hip joint?

The hip is a ball and socket joint. The socket part of the joint is a cup in the pelvis, called the acetabulum. The ball at the top of the thighbone is called the head of femur. Between the shaft and the head is called the neck of femur. Normally, the surfaces of each bone are covered with a layer of cartilage. This allows the bones to move smoothly on each other.



What has gone wrong?

The cartilage in your hip joint has worn away due to the arthritis. The bones are now rubbing against each other. This is why your hip is stiff and painful.

The aim

We replace both the ball and socket of your hip with an artificial joint, called a prosthesis. This operation is called a total hip replacement or THR for short.

The benefits

The range of movement in your hip may not improve very much, but the pain in your hip should go. As a result you will be able to walk further and climb stairs more easily.

Are there any alternatives?

Painkillers and anti-inflammatory tablets may control the pain. Exercise may improve the movement of your hip. Physiotherapy can help reduce the pain if your arthritis is not too advanced.

A new operation to renew the socket and just put a new cap on the head of femur is still experimental. It is only suitable for relatively young patients if the arthritis is not too advanced.

An operation to cut the neck of the femur and fix it at a different angle, called an osteotomy, is sometimes done in very young patients.

A new operation, called a minimally invasive hip replacement, but not all patients are suitable for the minimally invasive approach. There is a higher complication rate following minimally invasive hip replacement that has to be balanced against the advantages.

What if you do nothing?

Arthritis is not dangerous in itself. But without an operation your hip will become more painful and your mobility will be reduced.

Who should have it done?

You should have your hip replaced if **all** the following apply to you:

- The pain in your hip interferes with your life.
- Tablets do not make the pain bearable.
- X-rays show that your joint is damaged by arthritis.

Who should not have it done?

You should **not** have a hip replacement operation if **any** of the following apply to you:

- You have angina or shortness of breath that limits your walking more than your hip pain.
- You have a urinary infection, called a UTI. This may result in infection of your new hip. We will test your urine. If it is infected, we will give you antibiotics before your operation.
- You are a man with prostate problems. If you have poor urinary flow it is better to have this investigated and treated before we replace your hip.

Preparation

At home

This is a major operation. You can help by preparing for it. This may make your recovery quicker. Visit your doctor to check that any raised blood pressure, diabetes, lung or heart disease, or any other illness is under control. Eat healthily and go on a diet if you are overweight. Exercise as much as you can.

Get support from relatives and friends. You will need someone to take you to and from hospital, and to help with daily tasks, such as shopping, during your recovery.

Gather some loose fitting clothes for after your operation. They will be easier to get on and off when your wound is uncomfortable.

Collect together any medicines, tablets and inhalers that you take. Keep them in their original packets and bring them to hospital.

Do not wear any jewellery to come into hospital. If you cannot remove your wedding ring it may be left on but the nurse will put tape around it before your operation.

Do not wear nail varnish when coming in to hospital. A monitoring device is put on your finger during the operation/procedure to measure the oxygen level in your blood. Nail varnish can stop this working properly.

You may have a home visit from the occupational therapist to get your house ready for after your operation.

Smoking

Smoking increases the chance of heart and lung problems. These problems include wheezing and chest infection. If you smoke, having an operation is a good reason to give up. To get the best benefit from stopping smoking you need to give up six to eight weeks before the surgery. This will cut down the risk of serious problems during and after the operation. Even if you give up a few days before the operation it will help. The anaesthetic can make you cough. If you have not been smoking, you will cough much less.

Eating and drinking

The hospital will give you instructions about eating and drinking. It is important to follow these. The details may differ from those given here. If you are having a general anaesthetic do not eat any food for at least six hours before. This includes sweets and chewing gum. This is called fasting. Some hospitals allow you to drink clear fluids (watery drinks and coffee or tea without milk) up to two hours before.

Fasting keeps your stomach empty and reduces your chance of vomiting during the anaesthetic. While under a general anaesthetic you lose the reflex that makes you cough when something is in your throat. If vomit enters your lungs when you are unconscious it will damage them and cause

breathing problems. After your operation you will feel less sick and be less likely to vomit if you have not eaten.

You should also fast before a regional anaesthetic. If the regional anaesthetic fails you may need a general anaesthetic. Fasting is also a routine safety procedure when having an anaesthetic with sedative drugs given through a drip.

Diabetics - If you are a diabetic, your care depends on how serious your operation is, how long it takes, your type of diabetes and how well it is managed. You should make the doctors aware that you are a diabetic in advance. We may admit you a few days before your operation to have your diabetes monitored and your blood sugar corrected.

Preadmission clinic

Many hospitals run preadmission clinics and may ask you to attend a week or two before your operation. This allows you to have your tests before coming to hospital. You will discuss your problem and your medical history, including past illnesses, operations, allergies and drugs you regularly take.

Remember to bring along any medicines, tablets and inhalers that you take, in their original packets. We may test your blood and urine, and measure your blood pressure. We may also take a heart tracing (ECG) and an x-ray of your chest. You may also have an x-ray taken of your hip.

In hospital

A nurse or receptionist will welcome you to the ward. They will confirm you are the correct patient and give you a name band to wear. They will show you to your bed and ask you to change into a hospital gown or your nightwear.

Hand in any drugs you regularly take. The doctors need to know which drugs you are taking so that your drug treatment in hospital is correct and does not react with your usual medication. Please tell the nurses if you are allergic to any drugs or dressings.

If you have not been to a preadmission clinic, we will do the checks and tests now. We will take your pulse, temperature and blood pressure again.

We may give you support stockings, called TED stockings, to wear during and after your operation. We may also give you an injection into your tummy of a drug that thins your blood. These precautions help to prevent blood clots in your leg veins, called a deep vein thrombosis or DVT. They may be continued after your operation.

The anaesthetist, who gives you your anaesthetic, will examine you. They will ask you to open your mouth as wide as possible to make sure you have no problems with your jaw or neck. They will listen to your chest with a stethoscope. They will ask you questions about:

- any medical problems you have, especially with your heart, lungs or diabetes
- any drugs that you regularly take
- any loose or broken teeth, dentures, caps or crowns
- any allergies that you have
- any previous anaesthetics you have had
- any previous anaesthetic problems in your family
- the last time you had something to eat or drink.

A junior surgeon will interview you. They examine you and explain the operation. They mark the operation site with a skin marker. You will be asked to sign the consent form. This should record which hip is being operated on and what information has been given to you. If any part of the operation is not clear ask for more details. The surgeon who will do your operation will also visit you. They will check that all the preparations are complete.

We usually arrange the time of your operation the day before. The nurses will tell you when to expect to go to the operating theatre. Do not worry if there are changes to the exact timing.

A physiotherapist may visit you. They show you how to keep your chest clear and how to move about after your operation.

The nurses will ask you to remove all jewellery, watches and make-up. You also have to remove any contact lenses and false teeth.

You need to take your regular drugs, unless there is a reason not to. The anaesthetist may prescribe a sedative drug, called a premed, to be given an hour or so before your operation.

Before your operation you will be asked to empty your bladder. A ward nurse and a theatre porter will take you to the operating suite on a trolley. There will be several checks of your details on the way.

The Operation

Arrival in theatres

When you arrive in the theatre suite your anaesthetist and a trained anaesthetic assistant will greet you. They will check your personal and medical details. In the anaesthetic room they will attach equipment to watch:

- **your heart rate** - they will put sticky pads, called electrodes, on your chest. This is called an electrocardiogram or ECG
- **your blood pressure** - they will place a cuff on your upper arm. This may be tight when reading your blood pressure
- **the oxygen level in your blood** - they will place a probe on your finger.

The anaesthetist will insert a plastic tube, called a cannula, into a vein on the back of your hand or the lower part of your arm. S/he will attach a drip to this cannula and secure it in place with tape.

The anaesthetic

The type of anaesthetic depends on your overall health and the preference of your anaesthetist. You will normally have a general anaesthetic and be unconscious during the operation, as this is most common type of anaesthetic for this operation. But there are other options to consider. You may have the operation done with:

- a general anaesthetic with a nerve block
- an injection in the spine only, called an epidural
- a general anaesthetic with an epidural for pain relief

With the epidural injection only you will stay awake for the operation but the anaesthetist may give you drugs to make you sleepy, called sedation. You should discuss the various options with your anaesthetist.

General anaesthetic

If you are going to have a general anaesthetic the anaesthetist will place a mask over your face. S/he will ask you to take deep breaths of oxygen through the mask. This is a routine safety procedure to make sure your lungs are full of oxygen before you are given the drugs for the general anaesthetic. If you are worried about the mask you may be able to hold it over your face, if you wish. When you have taken deep breaths of the oxygen for two to three minutes the anaesthetist will put drugs through the cannula and within 10-20 seconds you will begin to feel sleepy. This is called an intravenous induction of anaesthesia.

When you are unconscious the anaesthetist passes a breathing tube or an airway into your mouth to assist your breathing. Anaesthetic gases or drugs keep you unconscious. You will wake up in the recovery room when the operation is over.

General anaesthetic with nerve block

As well as the general anaesthetic the anaesthetist may use a regional nerve block. This is an injection of local anaesthetic into the nerves that supply the wound area. This gives good pain relief during the operation and for several hours afterwards. We usually do the nerve block when you are unconscious.

General anaesthetic with epidural

As well as a general anaesthetic, the anaesthetist may use an epidural. This is an injection in your back that numbs the lower half of your body. This gives excellent pain relief during the operation. It also gives further pain relief for several days as a catheter is left in and the anaesthetist can give more anaesthetic through it.

The epidural may be put in before the anaesthetic starts, or once you are unconscious. If it is put in before, you will have an injection of local anaesthetic to numb the skin where the epidural needle goes in. If it is put in after, the procedure will be the same as for a general anaesthetic. When you are unconscious staff will turn you on your side and the anaesthetist will insert the epidural.

Epidural

Sometimes, instead of a general anaesthetic, the anaesthetist gives an epidural only. You will be conscious for the operation but the anaesthetist may give you sedative drugs to make you sleepy and relaxed. This may be the best way to have your operation if a general anaesthetic cannot be used. This is usually due to other medical conditions that you have, such as a bad chest or heart problems. These conditions would make a general anaesthetic more dangerous. It may also be possible to do an epidural at your request.

We will give you oxygen to breathe, either through a clear facemask or a tube at your nostrils. We will then position you for the epidural. You may be sitting up with your feet resting over the side of the trolley onto a stool. Another way is for you to lie on your side with your knees bent up towards your chest and your head bent forward. Both these positions curve the spine and make the injection easier. It is important that you are comfortable, as you need to lie still while the epidural is done. The anaesthetist cleans your back with an antiseptic liquid. This will feel cold. S/he will inject some local anaesthetic into the skin, making it numb. Then s/he will insert the epidural needle at a level between your bottom and your shoulder blades. It goes between two pieces of your backbone to end up near your spinal cord.

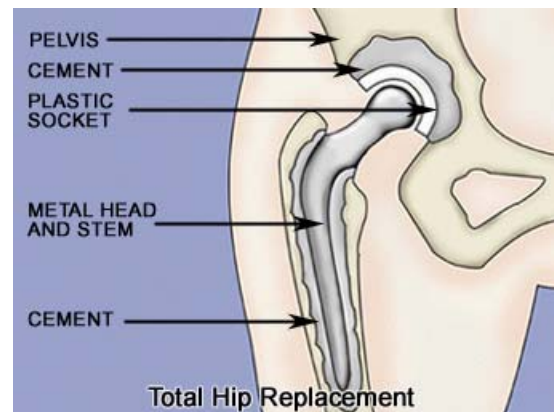
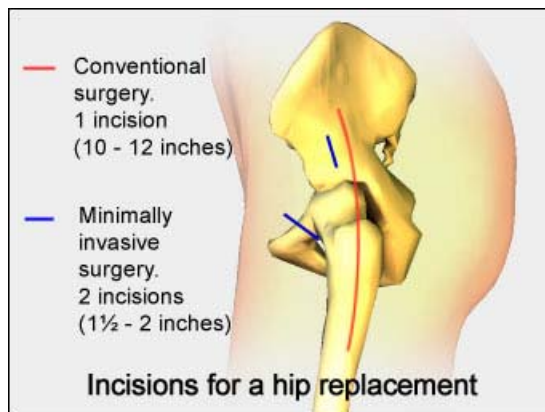
When the needle is in the correct place we pass the end of a long tube, called an epidural catheter, through the needle and into the space close to the spinal canal. Then we remove the needle leaving the epidural catheter in place. We tape the catheter firmly to your skin, so that it

cannot move. It is taped up your back and draped over your shoulder. The anaesthetist injects local anaesthetic down the catheter with you lying on your back. You should notice that your legs feel heavy and are difficult to move. This takes between about five to twenty minutes. This is normal. You may not notice the numbness until the anaesthetist tests your feeling with an ice cube. S/he will check how far up your body the numbness is reaching.

When the anaesthetist is happy that the numbness is above the level of the planned operation you will be taken into the operation theatre.

The operation

We make a cut about 25cm long down the outside of your hip and thigh. Some surgeons perform the operation through one or two very small incisions. This is known as a minimally invasive hip replacement. The advantage of the smaller incisions is that patients may be able to go home the day after surgery. Not all patients are suitable for the minimally invasive approach. There is a higher complication rate following minimally invasive hip replacement that has to be balanced against the advantages.



We remove the damaged ball and socket. We replace these with an artificial joint consisting of a metal ball on a stem, and a plastic socket. We fix the stem into your femur. We fit the plastic socket into in your pelvis.

There are many different types of artificial hips. Some are held in with special bone cement, some are not. If you wish, we can explain the type we intend to use and the reasons for our choice.

We close the skin with stitches or clips. We may leave a drain in the wound. This drains blood from the wound into a bottle. This will have to stay for a day or two after your operation. A dressing is put over the wound to protect it.

Blood transfusion

You may need a blood transfusion to help you through the operation. Without one the operation would be much more risky or even impossible. If you are very anaemic a transfusion before the operation will correct your shortage of healthy red blood cells. During or after the operation, a blood transfusion would correct any large loss of blood. This keeps the blood flowing to vital organs, such as your brain and kidneys.

There are many checks on the blood before it is given to you. These are to make sure that it is the correct blood group and that it is free from infection. The chance of a wrong blood group or infection with hepatitis (liver infection) or HIV is less than one in 10,000 transfusions. Similar infection risks apply to other blood products such as plasma and platelets. If you do not wish to have a blood transfusion under any circumstances you need to put it in writing. Your surgeon may

not agree to perform a hip replacement if you do not wish to have a blood transfusion. You should discuss this with your surgeon.

How long does it take?

The operation usually takes about 2 hours. Including anaesthetic and recovery times, you are likely to be away from your ward for 3 hours or more.

Who will be doing it?

The orthopaedic team will do your operation. There will usually be:

- an operating surgeon
- an assistant and a scrub nurse
- an anaesthetist, who looks after you under the anaesthetic and gives pain relief after the operation
- a trained anaesthetic assistant.

Operating theatre nurses and other hospital staff also assist. There will be a consultant surgeon and anaesthetist in charge, but a suitably experienced surgeon may actually do your operation. If the consultant surgeon is satisfied with the experience of that surgeon, the consultant may not be present during the operation.

Risks and complications

Are there any risks or complications?

A complication is when something unwanted happens during your treatment. A risk is the chance of a complication happening. A side effect is an extra effect in addition to the desired effect. Although we consider modern surgery and anaesthetics to be very safe all medical procedures have some risks. The risks increase if you:

- are unhealthy
- are very ill
- are overweight
- smoke
- have certain medical conditions, such as heart or lung disease.

General anaesthetic - side effects

- **Drowsiness** - You may feel slow and forgetful for 24 hours.
- **Nausea** - If you feel sick after the operation we may give you anti-sickness drugs, called anti-emetics.
- **Muscle aches** - You may need a muscle relaxant for the operation to be done. A machine breathes for you. The relaxant may cause aches and pains for a few days.
- **Itching** - Some painkillers, called opiates, can cause itching. We can give other drugs to treat this.
- **Headaches** - This may be due to the anaesthetic, dehydration or stress. Painkillers can be given.
- **Sore throat** - The breathing tube or airway may cause a sore throat lasting from a few hours to a few days. We can give painkillers to relieve this.

General anaesthetic - risks and complications

- **Low blood pressure** - We correct this with fluids or drugs through the cannula.

- **Tooth damage** - It is possible to damage your teeth when putting in the breathing tube or airway, especially if you have loose teeth, caps or crowns.
- **Allergic reaction** - Most reactions are minor and treated with antihistamines. If you have a serious allergic reaction affecting your circulation and lungs we will monitor you closely. You may need admission to a ward with intensive care and monitoring.
- **Malignant hyperpyrexia** - This condition runs in families. General anaesthetic gases and drugs can cause a severe temperature rise in patients who suffer from this disease. It is important to tell the anaesthetist about any problems you or any member of your family has had with previous anaesthetics.
- **Aspiration of stomach contents** - It is possible to vomit under the anaesthetic and this can get into your lungs. This can happen despite all the precautions, such as not eating for six hours before the operation. This is a serious complication and may require treatment in the intensive care unit.
- **Awareness** - Rarely, patients report being able to hear and feel during their operation. Some patients may have concerns about this. It is more common during operations where only a light anaesthetic is used, such as a Caesarean section. This is rare, about one in 1000. Discuss your concerns with your anaesthetist.
- **Difficulty breathing** - When you come round from the anaesthetic you may have a sensation of difficulty in breathing. There are many reasons for this. The anaesthetic can slow your breathing and make you cough. The nurses in recovery will sit you up and reassure you. You will be given oxygen through a mask or tubes at your nostrils.
- **Chest infection** - You may get a chest infection, particularly if you smoke. Working with the physiotherapists to clear the air passages is important in preventing this. You should avoid smoking.
- **Death** - The risk of death due to anaesthesia in the UK is stated as one in 200,000. This is about 20 times less likely than dying in a car crash.

Epidural - side effects

- **Difficulty moving your legs** - This is quite normal. The drugs that make you numb also block the nerves that control movement. This means that your legs will be difficult to move and feel heavy. This will pass off when the anaesthetic has worn off.
- **Itching** - Some painkillers used in the block, called opiates, can cause itching. We can give other drugs to treat this.
- **A fall in blood pressure** - The anaesthetic affects the size of the blood vessels in the legs, making them wider. This lowers your blood pressure. Giving fluids through the drip corrects this. The anaesthetist can also give a drug through the drip to increase the blood pressure.
- **Nausea or sickness** - The lowering of the blood pressure can make you feel sick. The anaesthetist can give anti-sickness drugs, called anti-emetics, through the drip to correct this.
- **Backache** - Some patients may complain of backache after the block. Backache is common after surgery and may be more related to lying on the operating table or staying in bed for a length of time.

Epidural - risks and complications

- **Difficulty passing urine** - The block may temporarily affect the nerves that control your bladder. You may already have a urinary catheter for the operation. If not you may need one put in. The problem stops when the block wears off.
- **Headache** - The epidural needle can puncture the covering of the spinal canal. This causes a leak of the fluid around the spinal cord, called cerebro-spinal fluid or CSF. This can give

you a headache. Treatment requires lying flat in bed, strong painkillers and plenty of fluids. The chance of this is less than one in 100 (1%). If the headache will not go away a 'blood-patch' is done. This is a similar procedure to the epidural. It involves the anaesthetist injecting your own blood into your back to block the hole in the covering.

- **Difficulty breathing** - Sometimes the block can affect the nerves that supply your breathing. This is rare. If it happens before the operation the anaesthetist will stop the block. You will be sat up and given oxygen through a facemask. If it happens during the operation the situation is different. The anaesthetist may give you a general anaesthetic and breathe for you until the operation is over. By the end of the operation the block should have worn off so you will be able to breathe normally again.
- **Injection into a vein** - If a large amount of the local anaesthetic goes into a blood vessel during the epidural, you may have a fit. This is very unusual. In some cases it causes the heart to beat irregularly.
- **A blood clot in the spinal canal** - A blood clot can form in the spinal canal, due to the puncture of a vein. This is an emergency situation and you will need an urgent MRI Scan. If a clot is seen on the scan an immediate operation is needed to remove it. In the worst cases your legs can be paralysed. It may be that you are no longer able to control your bladder or bowels. This is very rare, about one in 200,000.
- **Infection** - If the epidural catheter becomes infected it will need to be removed. You may need antibiotics to treat this infection. The infection is usually only in the skin at the site of the catheter.
- **Failure of the block** - Commonly a 'partial block' happens. This is where you lose some sensation, but not enough to keep you from feeling some pain. This could be because the epidural catheter has moved out of position. The block can stop working completely. If the block does not work, or you get a partial block, other painkillers, such as morphine, may be used to control your pain. Local anaesthetic can be injected into the wound. If the pain of the operation is unbearable a general anaesthetic may be needed instead.

Risks and complications of the operation

- **Pain** - With any operation there is likely to be some pain. There will be pain from injections and drip sites for the anaesthetic. The wound can be uncomfortable after a hip replacement. This will get less over the first few days.
- **Blood clots** - Blood clots can form in the veins in the calf muscles. This is called deep vein thrombosis or DVT. The incidence of a DVT that requires treatment is about 3 in 100 patients. In less than one in 1000 patients the clots move through the blood stream to the lungs and cause a blockage in the circulation, called a pulmonary embolism or PE. This is very serious and can be fatal. We will give you TED stockings to wear and, maybe, blood thinning injections to help prevent this. Getting moving as soon as possible after your operation is the best way to reduce the risk of this.
- **Bleeding** - When the skin is cut during an operation there is always some bleeding. This is always controlled. Significant injury to major blood vessels is very rare during a hip replacement.
- **Infection** - Minor wound infections can occur in one in 10 patients. Infection of the joint itself is very serious and may occur in one of every 100 patients. In severe infections, we may have to temporarily remove the artificial joint. We will give you antibiotics just before or during your operation to minimise the risk of infection.
- **Dislocation** - The metal ball of the new joint may slip out of the socket, called a dislocation. This occurs in one or two of every 100 hip replacements. If your hip dislocates you will need an operation to put it back in place. Your hip replacement can dislocate if you put your leg in the wrong position. The therapists will teach you positions to avoid in the early days after

surgery. Dislocation is more likely within the first 6 weeks but can occur even years later. In a small number of patients, repeated dislocation may occur. You would then need another operation to replace the hip joint.

- **Nerve damage** - There are two major nerves close to the hip joint, which can be injured during the operation. This is rare and occurs in less than one in 100 operations. This can result in some weakness or numbness, usually affecting the foot. In some cases it is permanent.
- **Bone damage** - The femur can break while we are trying to put in your prosthesis, though this is very rare. The exact treatment depends on the nature of the break. We may have to use wires around the femur to hold it in position.
- **Loose prosthesis** - The stem or the socket of the artificial joint may become loose. Also the implant may wear out after many years of use and a new joint may be needed. This occurs in about 5 patients in every 100 by ten years after surgery.

Side effect of the operation

As a result of your arthritis, your affected leg may be 1-2cm shorter than the other leg. When your artificial hip is put in we try to make your legs of equal length. Sometimes the leg that has been operated on remains a little shorter or ends up a little longer. Most patients adapt to a difference of up to 1cm. If the difference is more than 1cm, you may need a platform added to one of your shoes.

Recovery

Immediately after the operation

You will usually wake up in the recovery area. This area has specially trained staff to look after you following your operation. They make sure that any nausea or pain is treated. They monitor your heart rate, blood pressure and breathing.

You will be conscious a minute or two after the operation ends. You will wake up with an oxygen mask on your face. This helps you come round from the anaesthetic. You may have a blood transfusion or clear fluid drip. You may have one or two fine plastic drainage tubes coming out of the skin near the wound, connected to containers. Your legs may be held apart by a special pillow. This is to prevent you from your crossing your legs, which may dislocate your new hip.

You are unlikely to remember anything until you are back on the ward. Once you are safe to return to the general ward we will take you back.

Will it be painful?

You will have some pain from injections and drip sites. You may have a sore throat from the breathing tube or airway. We have many ways of making sure you have a minimum of pain:

- **Local anaesthetic** - The surgeon may inject local anaesthetic into the wound at the end of the operation.
- **Regional blocks** - These are local anaesthetic injections that block the nerves that supply the wound area. They give good pain relief after your operation.
- **Suppository** - A theatre nurse may insert a painkilling suppository into your rectum at the end of the operation, before you wake up. This is long acting and gives good pain relief for about 12 hours after the operation. This can be repeated. You may have to give verbal consent before this is done.
- **Painkillers** - You can have painkilling tablets or injections when you need them. The injections are usually given into the buttock.

- **PCA** - Sometimes patients control their own pain relief by pushing a button on a pump that delivers painkillers. This is called patient controlled analgesia or PCA. You can press the button and the pump gives you a measured amount of painkiller, which is set by the staff on the ward. It is safe because the pump cannot deliver too much painkiller. The benefit of this is that you do not have an injection each time you need painkillers.
- **Epidural** - If you have an epidural for the operation the anaesthetist can leave a catheter in the epidural space. This is used to give extra painkillers to keep you numb below the waist for 2 or 3 days. This provides good pain relief.

Some of these types of pain relief are not suitable for some patients. You should discuss the type of pain relief to be used with your anaesthetist before your operation. There are other information leaflets covering these types of pain relief.

On the ward

The physiotherapist will help you get out of bed on the first or second day after your operation. It is important to get out of bed soon after your operation despite any discomfort. You will not do the wound any harm and the exercise is good for you. You should help your circulation by regularly moving about and not staying in one position too long. With your permission, the nurses and doctors will keep your relatives up to date with your progress.

Catheter - You may have a urinary catheter in your bladder. One may be inserted if you have problems passing urine. The catheter can cause the feeling of leaking urine. This is just an irritation by the tubing and it passes off. The catheter is attached to a bag to collect the urine.

The wound - You may have stitches or clips in the skin. It will have a dressing to cover it. The nurses will check the wound regularly. They will change the dressings when needed. The wound may be sprayed with a plastic covering instead. There may be swelling or bruising around the wound.

We remove your stitches after 10-12 days. Sometimes the wound is held together underneath the skin with an absorbable suture. This is called a subcuticular suture and does not need further attention. The stitch melts away on its own. You can wash the wound area as soon as the dressing has been removed. Soap and tap water are adequate. Salt water is not necessary.

Removal of drains - Drain tubes are usually removed after one or two days.

DVT prevention - To prevent a deep vein thrombosis we may give you special stockings to wear and blood thinning injections. You may have a garment on your foot or leg that is connected to a pump. The pump gently squashes your foot or calf once or twice a minute.

Going home - You should plan to leave hospital about 5 -10 days of the operation. The nurses will make all the arrangements for your discharge including:

- Sickness certificates.
- Painkillers and antibiotics if needed, to take home.
- Spare dressings.
- Visits by community nurses or health visitors.

They will give you an appointment date and time to visit the outpatient department for a check up about six weeks after you leave hospital. The hospital will send a letter to your general practitioner to tell them you have had a hip replacement.

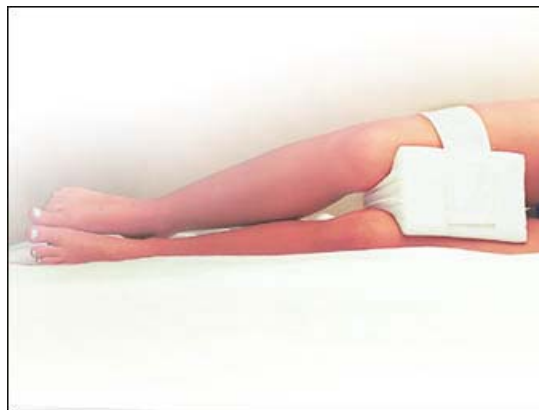
Avoiding dislocation of your new hip

Hip replacements can dislocate, especially in the first six weeks after your operation. You must help look after your new hip by not putting your hip in a position in which it might dislocate. The positions to avoid partly depend on the exact way your operation was carried out. For the first six weeks:

- **Do not** bend your hip beyond a right angle.
- When in bed you may sit up, but you **must not** lean forwards e.g. to reach your foot.
- You **must not** bend your knee up to put on socks or shoes.
- You **must not** sit on a low seat such as a toilet. If necessary, the occupational therapist will give you a raised toilet seat at your pre-operative home visit.



While in hospital, you must sleep on your back. At home, if you must sleep on your side, sleep on your operated side with a pillow between your legs. **Do not** lie on the side that has not been operated on.



Physiotherapy & occupational therapy

The physiotherapist will show you how to get out of bed and how to rise from and sit down in a chair. By the time you go home you will be walking with the help of two crutches. The occupational therapist will show you how to do many daily tasks, such as putting on stockings and washing your feet. They may give you special gadgets to help do these tasks.

At home

When you go home you should be able to move around the house and manage stairs. You will not be able to go shopping for the first few weeks. Please arrange for friends or family to shop for you.

Driving - You must not drive for two months after you leave hospital. This is because you will not be able to do an emergency stop as quickly as normal before then. If you have had your left hip replaced and you drive an automatic car, you may be able to drive sooner.

Work - If you can get to work without driving yourself or by using public transport you may be able to return to work six weeks after your operation. You should not do manual work after a total hip replacement.

Any problems - An infection in the wound will make it red, swollen and very sore. The ward may give you its direct contact number to use if you think all is not well when you are at home, such as any bleeding or too much pain. You can also contact your general practitioner. In an emergency call an ambulance.

Long-term

Artificial joints last for many years. However they can become loose and painful after years of use. A further operation may then be necessary. Overall, 10 years after the operation, 9 out of 10 hip replacements are problem free.

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The information in this leaflet is a guide to common medical practice. It should be used as a basis for discussion with your doctors when giving consent. Also, each hospital and surgeon will have slightly different ways of doing things, so you should follow their guidance where it differs from the information in this leaflet.

Further reading

For more information on arthritis please see our leaflet IPI_297 Osteoarthritis.

You can find more information from NHS Direct on 0845 4647 or at www.nhsdirect.nhs.uk.

Support groups

Arthritis Care - Aims to empower people to take control of their arthritis and their lives. There are 650 branches in the UK, all offering mutual support from other arthritis sufferers, as well as information on managing the condition. www.arthritiscare.org.uk. Arthritis Care, 18 Stephenson Way, London NW1 2HD. Helpline:0808 800 4050 (Mon-Fri, 12-4pm) Tel:020 7380 6500.

Patient Concern - Provides patient leaflets and a patient advisory service specialising in consent-related issues; campaigns for patient choice and empowerment. www.patientconcern.org.uk. Patient Concern, PO Box 23732, London SW5 9FY. Telephone/ Fax: 020 7373 0794. Email: patientconcern@hotmail.com.

The Patients Association - Provides a helpline, information and advisory service and publications; campaigns for a better health care service for patients. www.patients-association.com. The Patients Association, P. O. Box 935, Harrow, Middlesex HA1 3YJ. Helpline: 0845 6084455. Office: 020 8423 9111. Fax: 020 8423 9119

This document is due for review August 2005.