

Total hip replacement

Your operation to replace your hip with an artificial joint



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:

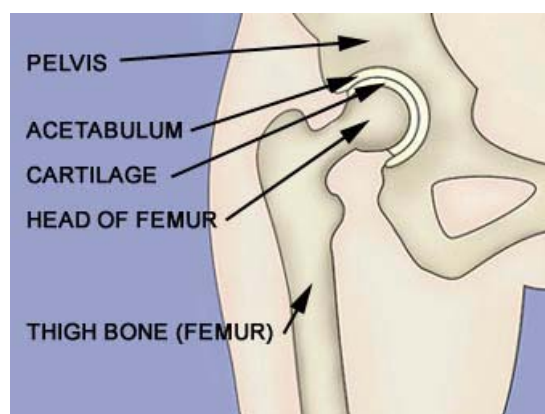
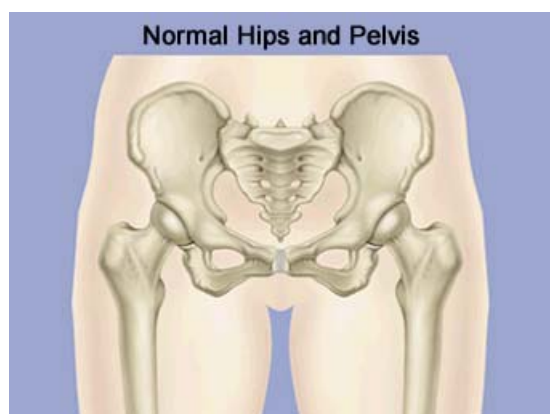
- why you need this operation
- what it will be like
- how it will affect you
- what risks are involved
- any alternatives.

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.

What is the problem?

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

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.

Before the operation

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. Check with the hospital about continuing with any drugs you already take, including the contraceptive pill or hormone replacement therapy (HRT).

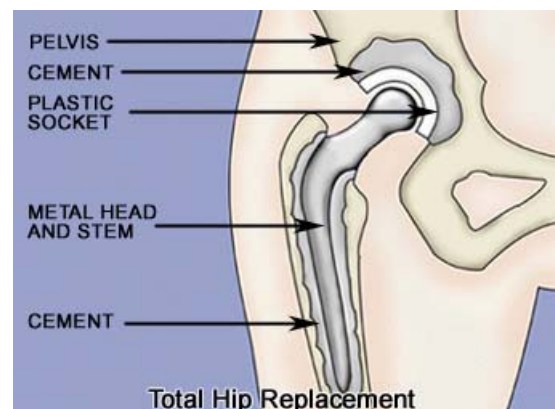
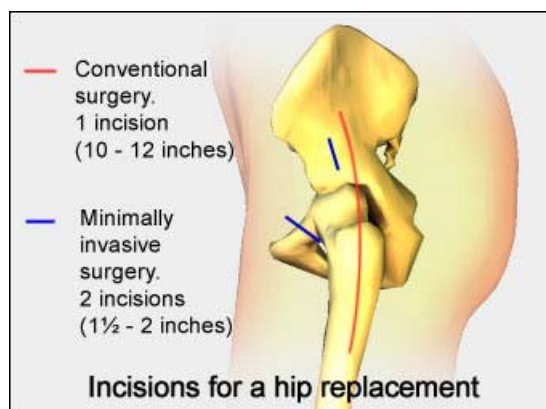
Smoking - Smoking increases the chance of serious problems during and after the operation. If you smoke, having an operation is a good reason to give up. To get the best benefit from stopping smoking you need to give up six to eight weeks before the surgery. Even if you give up a few days before the operation it will help.

Eating and drinking - The hospital will give you instructions about eating and drinking. It is important to follow these. Diabetics will have special instructions; inform your doctor if this applies to you.

Pre-op visits - The anaesthetist will examine you on the ward and discuss your anaesthetic, which depends on your overall health and the preference of your anaesthetist. S/he should cover the possible complications, risks and benefits of each option. There are other information leaflets covering the different types of anaesthetic available. One of the surgical team will visit you. They will check that all the preparations are complete. They mark the operation site with a skin marker. They will ask you to sign the consent form. This should record which hip is being operated on and what information has been given to you.

The operation

We replace both the ball and socket of your hip with an artificial joint. This operation is called a total hip replacement or THR for short. The operation usually takes about 2 hours. 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.

You may need a blood transfusion to help you through the operation. 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.

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.

What are the risks or complications?

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.

Risks and complications of the anaesthetic

Your anaesthetist should discuss the possible complications, risks and benefits of the anaesthetic options with you. There are other information leaflets covering various anaesthetic procedures.

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 three 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.

- **Leg length** - 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.

After the operation

You will usually wake up in the recovery area with an oxygen mask on your face. This area has specially trained staff to look after you following your operation. You may have one or two drains coming out of the skin near the wound. Your legs may be held apart by a special pillow to prevent you from crossing your legs, which may dislocate your new hip. The nurses will give painkillers as necessary.

On the ward - You should help your circulation by regularly moving about and not staying in one position too long. The physiotherapist will show you how to get out of bed on the first or second day after your operation. They will show you how to rise from and sit down in a chair to reduce the risk of dislocation. 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.

Going home - You should plan to leave hospital about 5-10 days after the operation. The hospital will send a letter to your general practitioner to tell them you have had a hip replacement. You will be given an outpatient appointment to check your recovery. We remove your stitches after 10-12 days.

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 upon.

At home

By the time you go home you will be walking with the help of two crutches. 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.

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.

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, nine out of 10 hip replacements are problem free.

Author: Mr Boyd Goldie MBBS FRCS BSC DHMSA. Consultant in Orthopaedics & Trauma

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Further reading

For a more detailed description of this operation, including anaesthetic options and associated risks, please see our leaflet S13_10 Total Hip Replacement - In depth.

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.