

The Enhanced Recovery Programme

for your

Total Hip Replacement Surgery (THR)

Please bring this booklet with you into hospital

This book aims to:

- Help prepare you for your surgery and hospital stay
- Optimise your hospital recovery period after your surgery
- Help you to maximise your recovery once at home

Revised December 2013.

For Review December 2015.

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If you have a question about the date of your operation, or you need to cancel your operation, please contact the Schedulers via SOTC Reception on 0333 200 1728

Sussex Orthopaedic NHS Treatment Centre (SOTC)

SOTC opened in June 2006. We specialise in day and in-patient orthopaedic surgery for patients who come from Brighton and Hove, West Sussex and East Sussex, Downs and Weald areas.

Our Centre provides the following elective orthopaedic procedures:

- Hip and knee replacements
- Anterior cruciate ligament reconstruction
- Arthroscopy
- Spinal surgery
- Shoulder surgery
- Hand and foot procedures

This book is a general guide to recovery from total hip replacement (THR) surgery. However, not all patients have precisely the same conditions or needs. Your doctor, therapist or nurse may make recommendations which deviate from this book; **their changes take precedence**. The long-term benefit of your surgery will largely depend on you continuing your rehabilitation at home. We therefore expect that you will continue to practice what the team has taught you long after you have left us.

Key contacts

Sussex Orthopaedic NHS Treatment Centre Reception	0333 200 1728
Princess Royal Hospital Switchboard	01444 441881
Ward	8830
Physiotherapy / OT	8834
Pre Assessment Clinic	8841
Pre Op Unit	8816

Visiting hours

At the SOTC we realise how important the support of family and friends is during the rehabilitation process. However it is also important that patients receive optimal care and rest periods throughout the day. Therefore our ward visiting hours are:

15:00 – 17:00
and 19:00 – 20:30
(3 - 5pm and 7 - 8:30pm)
Monday – Sunday

The Surgical Team

You will have your operation performed by a trained specialist orthopaedic surgeon.

We would like to introduce you to the consultants who perform total hip replacement surgery at SOTC. (Don't worry if your surgeon isn't pictured here, we are an expanding centre and look forward to welcoming new colleagues in the future!).



Mr B Rogers



Mr E Parnell



Mr J Gibbs



Mr R Pattison



Mr R Gadiyar



Mr V Stipcack



Mr P Stott



Mr M Patterson

What is the Enhanced Recovery Programme (ERP)?

Enhanced recovery is a new approach to the way that care can be delivered to patients having certain operations. This includes total hip and total knee replacement surgery. Enhanced recovery is a fully structured and well organised sequence of clinical care. All the staff looking after you will work from a specific programme, called a care pathway.

Enhanced recovery improves the way in which health care is organised to allow you to get better sooner after your operation. Research indicates that after surgery, the earlier you get out of bed and start eating and drinking, the better. Your recovery will be quicker and complications are less likely to occur.

Benefits of ERP include:

- Preventing long periods of fasting prior to your operation.
- Reducing the stress effect of surgery on your body.
- Minimising the use of tubes and drains after your operation.
- Returning to eating and drinking sooner.
- Reducing muscle wasting and improving mobility.
- Reducing the risk of blood clots by getting up and moving sooner.
- Making you feel better sooner.
- Leaving hospital sooner.

Stages of ERP:

These are the key stages for the enhanced recovery programme:

- Referral from your GP.
- Pre-operative care by the hospital team.
- Care on the day of admission.
- Care by the hospital team during your operation.
- Care by the hospital team after your operation.
- Going home and follow-up support.

We will tell you a little more about how we organise each of these in the next few pages.

Section 1: Referral from your GP

Most patients undergo a total hip replacement (THR) because they are getting pain or stiffness in their hip caused by osteoarthritis (OA). Your GP will have referred you to a specialist orthopaedic surgeon who will discuss the risks and benefits of a THR.

Preparing for surgery

You are more likely to recover faster and more safely by adopting healthy living goals before your operation. In particular; stopping smoking, losing weight (if overweight), and trying to keep yourself active, will all help to improve your recovery. Also, if you are anaemic (lack of iron in your blood), or have poorly controlled diabetes, your GP may need to help you stabilise these problems before you come for your operation, as this may make the surgery safer.

Waiting lists

The waiting list time constantly changes, depending on how many referrals the surgeons receive. The waiting list may vary for different surgeons, this will depend on many factors, including how many patients each surgeon is looking after. Sometimes the surgeon you will have seen in outpatients will have a longer waiting list than another surgeon. If this is the case, and another surgeon has a free space, then the admissions staff may telephone you and ask if you would like your operation performed by another member of the total hip replacement team.

We would like to reassure you that all of our surgeons are competent, and take part in regular reviews and appraisals. All of their data is submitted to the National Joint Registry.

If you would prefer to stick with the surgeon that you have met – don't worry –you are allowed! Please let the admissions staff know your preference when they call.

Hip Joint Structure and Function

To understand a THR you must first understand the structure of the hip joint. The hip joint is described as a ball and socket joint. The ball component is at the top of the thigh bone (femur). The socket (acetabulum) is part of the pelvis. The hip joint allows movement of the leg in all directions and also supports the body during walking.

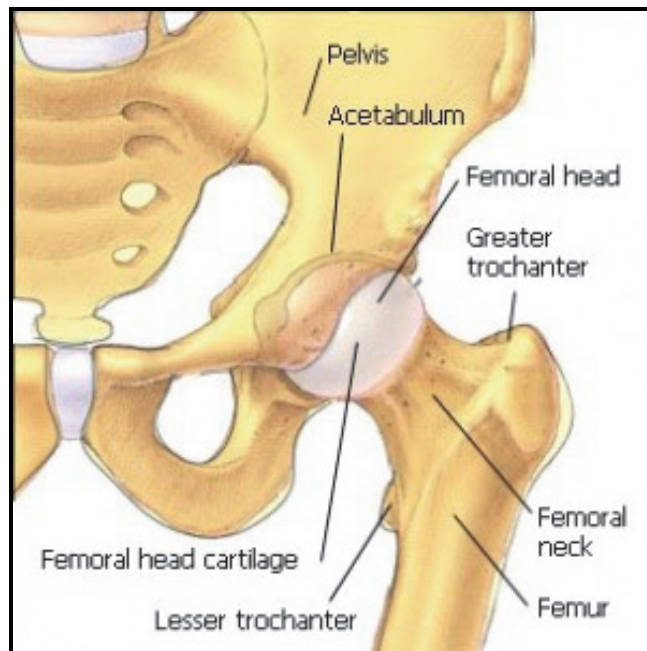
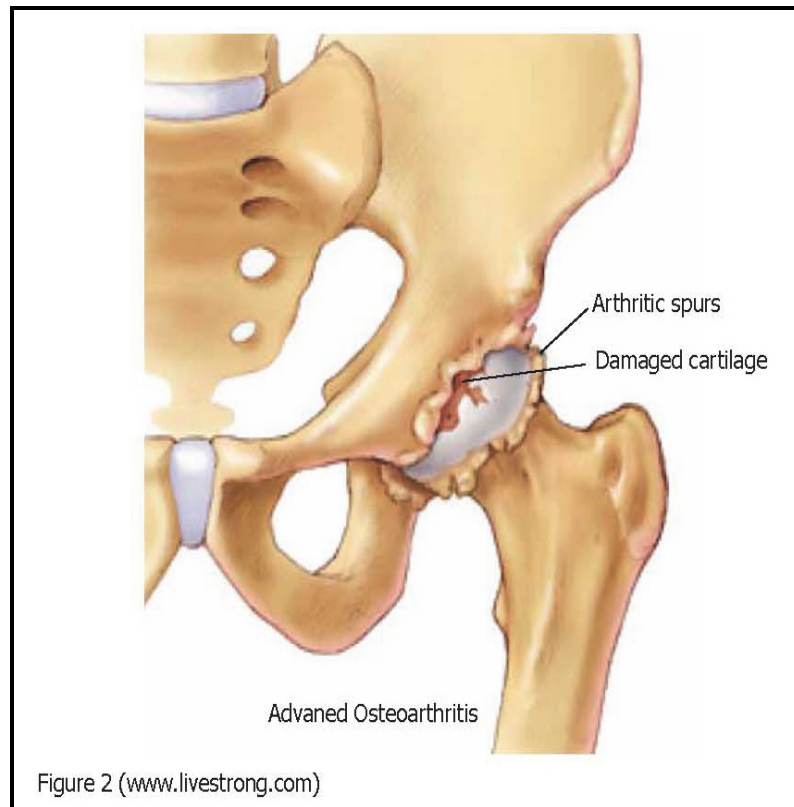


Figure 1 (www.livestrong.com)

In a healthy hip joint (Figure 1) smooth cartilage covers the ball of thigh bone and socket of the pelvis. This allows the ball to glide easily in any direction within the socket.

The Arthritic Joint

THR surgery is considered for patients whose hip joints have been damaged by progressive arthritis, trauma or other rare destructive diseases of the joint. The most common reason for hip replacement is osteoarthritis (OA) of the hip. As osteoarthritis progresses, the cartilage is worn away, and does not regenerate. The smooth joint surfaces are lost and friction develops. As this friction continues, the surfaces of the joint become pitted, eroded and uneven (figure 2). Over time, this can result in pain, inflammation and decreased mobility.



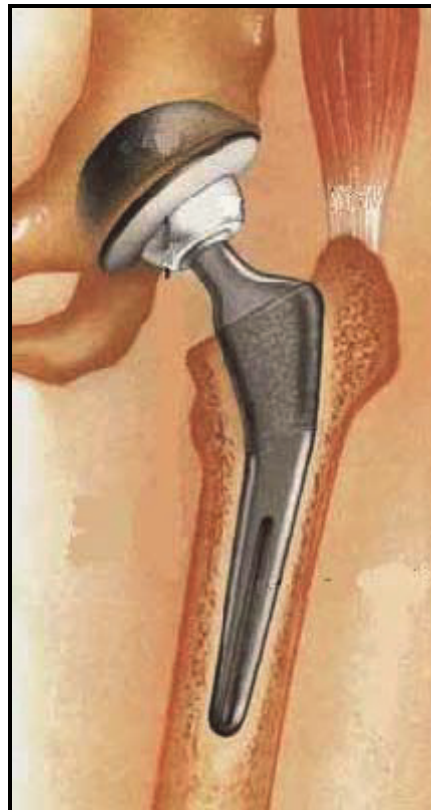
Regardless of the cause of the damage to the joint, progressively increasing pain and stiffness, and decreasing daily function, often lead the patient to consider THR surgery.

Decisions regarding whether or when to undergo THR surgery are not easy. Patients should understand the risks as well as the benefits and discuss with their orthopaedic surgeon before making the decision.

What is a Total Hip Replacement (THR)?

Socket →

Stem →



In a THR, the painful parts of the damaged hip are replaced with artificial hip parts called prosthesis; a device that substitutes or supplements a joint. The THR prosthesis consists of three components: a socket, ball and stem.

- The **stem**, which fits in to the leg bone (femur), made from metal.
- The **ball** or head, which replaces the sphere shaped head of the femur, made of ceramic or metal.
- The **shell and accompanying liner**, which replaces the worn-out hip socket (acetabulum). The shell is made of metal and the liner made of a plastic material called polyethylene. This liner may also be made of ceramic.

When the metal ball is joined with the socket, the new hip allows for smooth, nearly frictionless movement. The aim of a joint replacement is to get you back to full function as soon as possible.

Cemented or Uncemented (Porous)?

There are two main types of fixation: cemented and porous. Both can be effective in the replacement of hip joints. Your surgeon will choose the best solution that is specific to your needs.

Cemented Hip Replacement Implants

The cemented hip replacement implant is designed to be implanted using bone cement (a grout that helps position the implant within the bone). Bone cement is injected into the prepared bone. The surgeon then positions the implant within the bone and the cement helps to hold it in the desired position.

Porous Hip Replacement Implants

The porous hip replacement implant is designed to be inserted into the prepared femur without the use of bone cement. Initially, the femur is prepared so that the implant fits tightly within it. The porous surfaces on the hip replacement implant are designed to permit bone to grow into the porous surface. Eventually, this bone in-growth can provide additional fixation to hold the implant in the desired position.

There have been many improvements made to the materials used in THR implants today. Your surgeon will discuss with you about the best choice for your hip implant. That decision will depend on factors such as your age, general health, quality of your bone, and your level of activity.

Revision Surgery

Revision hip surgery involves the repair of an artificial hip joint that has been damaged or loosened over time, or as the result of infection. The problem lies in the fact that the mechanical components wear and loosen, or the joint itself becomes infected. The majority of revision hip operations require restoration or replacement of lost bone. Bone grafting procedures may alter post-operative management. Patients may be required to use crutches and follow the hip precautions (similar to those for primary THR) for longer periods. At times rehabilitation may progress more slowly than after a primary THR.

All patients undergoing revision surgery will spend a night in the 'Level 1' ward bay, where patients are very closely monitored. They are usually moved onto the main ward the following day, after the doctors' ward round.

Even though patients vary in the speed of their recovery, we find that most people are able to achieve good function and go home between **1 to 4 days** post surgery. However, the outcome of the revision surgery is also dependent upon the complexity of the surgery, your age, general health, the quality of your bone, and your previous level of activity.

Complications of THR Surgery

Hip replacement is usually a very successful operation. However, as with all surgery there can be complications. We do not want to worry you, but we are obliged to make you aware of these (even if the risk is very small) so that you can make an informed decision about having your operation, and the risks involved. Over the next few pages we have put together some information about complications which may be experienced following hip replacement. Please note that this list is not exhaustive. Make sure to discuss any concerns you may have with your Surgeon, who will be able to explain in more detail.

Some people are also more at risk of developing complications due to their own past medical history. The Surgeon will discuss with you any complications that may be more relevant to you.

The National Joint Registry reports on the outcomes of joint replacements in England and Wales. This includes the number of patients who experience post-operative complications. Its 10th Report, published in September 2013 reports that nationally 10% of patients report a wound problem, 5.8% have bleeding after the operation and 2.1% have further surgery.

If you would like to find out more information about complications the reports on the National Joint Registry are free and easy to access. Please visit <http://www.njrcentre.org.uk> for more information.

Infection

Unfortunately, despite many special measures being undertaken to reduce the risk, an infection can occur either in the wound, or deep inside of the new joint.

Wound infections are the most common, affecting up to 5% of patients. This is an infection in or around your skin. They can settle on their own or may require antibiotics.

A Deep infection (approximately 1%) is where bacteria grow inside your new hip. This can happen slowly and not cause problems for months or even years. Deep wound infections can make you feel ill and cause you pain as the infection develops.

If an infection is diagnosed early enough, then the hip can be washed out. This can cure the infection in some cases. If this is not successful, or the infection is found too late, then the joint may have to be removed. Unfortunately, each time that you have surgery more damage is done to the muscles around your hip, resulting in a poorer outcome.

Leg length Inequality

Most people's legs are not naturally the same length. You may have noticed that your feet are subtly different sizes when you go to a shoe shop. This difference is often magnified over the length of your whole leg. Usually arthritis wears down your hip joint, so that you will have lost some length in your affected leg. The surgeon will try to make your leg the correct size for you. This is not an exact science and mistakes can be made.

Most patients feel that their new hip has made their leg too long. When all of the swelling has gone down, most patients feel that the leg is the correct size. Your brain will accommodate small differences (usually less than a centimetre) over three to six months. One study from Bristol, showed that their average leg length inequality was 9mm.

Stiffness

Part of the process of arthritis is the stiffening up of the diseased joint. During a hip replacement, only the ball and socket are replaced, not your muscles and ligaments. If these are stiff and weak before the operation, they will be stiff and weak after the operation. Sometimes with physiotherapy and effort, the stiffness and weakness can be reduced, but it is unlikely that you will get the same function as when you were younger. This means that if you limped before the operation, you may limp after it too.

Pain

As your muscles start to gain movement they can become painful. It is quite common to experience pain on the outside of the hip. There are many things that can be done to help decrease your post-operative pain. These are explained later in this booklet.

There are other causes of pain around a new hip. If you are in pain after your hip, let your surgeon know.

Dislocation (2%)

The hip is a ball and socket joint. In the extremes of movement, the 2 parts of the hip may separate. Your physiotherapist will go through do's and don'ts prior to your discharge.

Blood Clot (Deep Vein Thrombosis / DVT)

This is a blood clot in one of your big veins of the leg. You can get a DVT in your leg by periods of immobility, such as a plane flight. Hip surgery is a high risk factor for getting a clot. Up to 47% of patients would get a blood clot if they didn't have preventative treatment.

We use multiple methods to lower that risk. These are explained later in this booklet.

Despite all of the efforts to reduce the risk of DVT, it is still possible to get a blood clot in your leg. In some cases this clot can travel up to your lung (1.9% of patients). There is a very small chance that you may die if this was to happen (0.05%).

Fracture

The new hip is fitted to your bone carefully. Your bone has to be specially prepared in order to accept it. Rarely, one of the bones in your leg can fracture during this process.

Usually this rare occurrence is recognised during the operation. In some cases it may not be possible to recognise the fracture during surgery, as the fractures can be small, or hidden. In these situations the fracture will normally be seen when the X-ray of your leg is taken after the operation.

The fracture may need to be fixed, and this could result in another operation. Sometimes protecting the fracture by restricting the amount of weight that you are allowed to put through the leg for a period of weeks, can be sufficient to allow the fracture to heal.

As people get older, their bones often get more fragile. If you have a hip replacement and fall over, the bone around your new hip may break. This will then need an operation to correct it.

Blood Transfusion

It is relatively rare to require a blood transfusion if you were not anaemic pre-operatively. These have risks too. The medical team will discuss these with you if you need to have a transfusion.

Ceramic Problems

Sometimes, parts of the hip are made from ceramic. Ceramics are incredibly hard wearing, but they can be brittle. It is possible to break the ceramic from a very hard impact or from repeated smaller forces such as long distance running. Ceramics can also produce squeaking noises.

Bleeding and Haematoma (Bruising)

In order to reduce your risks of DVT you will be given a drug to reduce your blood clotting. This has a side effect of increased bleeding. Usually the bleeding is just around / inside your hip. This usually clots off to form a giant clot within the soft tissues called a haematoma or bruise. (This is not a DVT as it is not inside one of your veins).

Sometimes the bleeding is more severe, and it can make a large bruise that affects your whole thigh. You may notice bruising coming down around your knee or even your ankle. This can be quite painful. Rarely, your surgeon will have to take you back to theatre to remove the haematoma.

Nerve or Vessel Damage (1 in 300 to 500)

The large nerves and blood vessels that supply your leg run close to your hip joint. These can be damaged in the operation, most commonly by either being harmed by one of the instruments, or by your nerve having its blood supply interrupted by swelling.

The damage to the nerve can vary from mild bruising - where it will not work for a few days to a few weeks, to severe and permanent damage to a nerve. Nerve damage can result in part of your leg not working. It may also result in severe pain.

Impingement

A THR can not move to the same degree as a normal hip. Your surgeon will put the hip in at angles that give you the best compromise between stability (the hip not dislocating) and range of movement. Rarely, the surgeon can put the hip in at an angle where the stem may touch the cup. This will result in the parts making contact. This can give you a clicking feeling deep in the groin or buttock, or pain.

Wear

Modern hip replacements have come a long way even compared to 10 years ago. However, it may eventually wear out, and all or some of the parts may need replacing. It is very important that you do not try to 'save the hip' by not walking on it. A hip that has regular activity will perform better than one on that is not used.

Sometimes the hip can become loose within the bone, or the moving parts can break. This can cause damage to your bones. If you start getting more pain in your hip in the future you must seek medical advice.

Section 2: Pre-operative care by the hospital team

Pre-Assessment Clinic

You will attend the pre-operative assessment clinic at the hospital, where you will be assessed by a nurse. You may see an anaesthetist. They will:

- Make a general assessment of your health and give you information about the operation you are going to have.
- Give information about your anaesthetic (see below).
- Provide you with the opportunity to ask any questions about the surgery, anaesthetic, pain relief and recovery.
- Give you some carbohydrate drinks (as long as you are not diabetic). These must be taken as directed by the nurse, and will help to prevent excessive dehydration or starvation which may delay your recovery (see **page 18** for detailed instructions).

Joint School

When you attend the pre-assessment clinic, you will also be seen by the physiotherapist and occupational therapist (OT) in 'Joint School' (or on an individual basis where necessary). Joint school consists of an informative presentation by the therapists, where you will find out more about the role of the physiotherapist and OT, including adaptations to your home environment, exercise programmes, and advice on returning to your normal activities.

Occupational Therapy (OT)

The occupational therapy team will assess your ability to manage at home and give advice about adaptive ways of completing tasks after your operation. They will also organise the provision of equipment in your home environment (such as a raised toilet seat or perching stool) where required.



Physiotherapy (PT)

The physiotherapy team may assess your mobility, advise you on exercises and walking, and discuss the phases of recovery.

What can I do to prepare for my surgery?

You will need to make plans for going home before you even come into hospital. The time you will be in hospital is not long. This information might be useful to talk through with a friend, carer or family member to ensure you have the practical support in place to aid your recovery. The following points will help you prepare for your surgery:

- Practice your exercises (**page 32-33**) to maximise your muscle strength before the operation.
- Keep active (use a walking aid if needed. This will avoid limping and putting stress on your other joints).
- Get some essential shopping done / pre-cook some home meals.
- Eat a balanced diet – your body will need energy to aid recovery.
- Healthy lifestyle - giving up smoking and cutting down on alcohol will help your recovery and reduce the risk of complications.
- Think about how you will manage once you are discharged from hospital. The nurses can teach you (or a friend/relative) how to do your own leg dressings, and injections. **Please speak to the nurses if you think you will need additional help with this.**
- Try to relax and try not to worry!

My to do list

- I know my planned date for going home
- I have told the relevant people where I will be
- I have arranged my transport for getting there and back
- I have packed a small bag with the right things (page 17)
- I have remembered to take my medication with me (enough to last your hospital stay)
- I have checked I have the right equipment and support at home (page 16)
- I have prepared my home environment (page 16)

Preparing your Home Environment

Occupational Therapist advice

Prior to your surgery you will need to think about how you can adapt your home so that you can perform your daily tasks within your precautions and with minimal exertion. These adaptations are outlined below. You will also be able to discuss them with your occupational therapist before your surgery if necessary. Adaptations may include:

- 1) Use of a raised toilet seat (this will be provided on loan for you).
- 2) Use of a firm chair with arm rests. Consider using pillows to raise the height of the seat if the chair is low.
- 3) Having your bed at an appropriate height.
- 4) Ensuring all walking areas are free of clutter.
 - Remove throw rugs and loose carpets.
 - Watch for small pets.
- 5) Storing frequently used items between waist and shoulder height and within easy reach.
- 6) Preparing meals ahead of time and storing them in the freezer.
- 7) If you live alone you might want a friend or relative to come and stay with you for a few days. It may be reassuring for you and help to give you confidence.

Assistive devices:

Depending on your essential needs at home after surgery, the occupational therapist may recommend certain other adaptations or equipment. The occupational therapist will discuss these issues with you if they arise.

Nutrition

Your nutritional status is an important component of your overall health. It provides the building blocks for your body to adequately heal and fully recover from your surgery. Therefore, it is best if your nutritional status is optimal before your surgery. Try to eat healthy, balanced meals with plenty of fruit and vegetables.

If you are overweight, your doctor may prescribe a weight loss programme prior to your surgery since excess weight on an operated joint will increase the risk of requiring further surgery. Excess weight can also cause complications during surgery. If required, you should aim to lose weight gradually at approximately 1-2lbs. per week - losing weight more rapidly can compromise your health. Your doctor or a qualified dietician/nutritionist should supervise your weight loss.

If you are on a doctor-prescribed diet before you come into hospital it is important that you tell the nursing staff and the Sussex Orthopaedic NHS Treatment Centre doctor.

What to Bring to the Centre (SOTC)

Please note: Personal articles and clothing should be limited. There is very little storage space on the ward. Remember that you will require items for your trip home as well as those for your hospital stay. Things to include are:

- This Booklet** –You will need to refer to it daily during your stay
- Night wear** e.g: night dress, loose pyjamas or baggy shorts and t-shirts etc. that can fit over dressings.
- Loose clothing**. We encourage you to get dressed and wear your own clothes as soon as is practical.
- Personal toiletries** (soap, shampoo, deodorant, shaving items, flannels, toothbrush, toothpaste, towels, sanitary towels etc).
- Glasses** if required (rather than contact lenses as glasses are easier to take care of and less likely to be lost in the hospital).
- Dentures/denture pot/hearing aids** if required.
- Flat, securely fitting, non-slip walking shoes or trainers**. No 'flip-flops' please!
- Long handled aids** (helping hand/shoe horn/sock aid etc).
- Any medication** you are taking in its original box/container where possible. Include any you may have been told to stop prior to surgery. Make sure you have enough to last for your hospital stay.
- Telephone numbers** of people you may want to call.
- A book**, magazine or small hobby item.
- Mobile phones** are allowed on the ward and TV's are available.

Please do not bring to the centre:

- Valuables
- Credit cards
- Jewellery
- Flowers
- In excess of £20 cash

Although we will take all reasonable steps to ensure the safety of your personal property, the staff cannot guarantee security of your personal items.

Spiritual support through the Hospital Chaplaincy

The SOTC formally recognises the role that spiritual support can play in coping with and recovering from physical illness. To help meet your personal needs the centre provides chaplaincy and spiritual support services.

Section 3: The Day before Admission

You will be telephoned the afternoon before your procedure to advise you of the time to attend the centre. **It is essential you are available to take this call.** Please note if we are unable to contact you then your surgery may be cancelled. Patients having surgery on Monday will be rung on either Friday or Saturday.

Please telephone the pre-operative unit if you have a cold or you are unwell, as your surgery may need to be postponed.

NIL BY MOUTH FASTING RULES FOR ERP PATIENTS

- Please drink 4 cartons of the pre-operative drinks (if you have been given them) between 18.00 (6 pm) and 12 midnight on the night before surgery. You may eat and drink normally at this stage.
- **YOU SHOULD THEN NOT EAT ANY SOLID FOOD FOR 6 HOURS PRIOR TO ADMISSION.** Do not suck sweets, chew gum or drink milk as this counts as “**SOLID FOOD**”.
- **Please ensure you drink your remaining cartons of pre-operative drink between 2 and 3 hrs prior to admission.**
- **YOU MAY DRINK ONLY WATER UP TO 2 HOURS PRIOR TO ADMISSION.**
- It is advised you do not smoke for 48 hrs prior to your surgery, and do not drink alcohol 24 hrs prior to your surgery to avoid anaesthetic complications.

**DISREGARDING THIS INFORMATION MAY
RESULT IN THE CANCELLATION OF YOUR
PROCEDURE**

**Should you have any questions regarding the information
provided please call the centre on 0333 200 1728**

Section 4: The Day of Admission

Pre-Operative Instructions For The Day Of Surgery

- Please drink your remaining 2 cartons of pre-operative drink 2-3 hours before your admission time.**
- Please leave all valuables at home and remove all make-up, acrylic/false nails, any nail polish on fingers/toes and all jewellery (including body piercings).
- Please bring a dressing gown and well fitting slippers to wear during your stay.
- Please shower/bath the morning of surgery but do not use any creams/lotions. Please wear loose, comfortable clothing.

A waiting area is provided for individuals accompanying patients.

Please follow the instructions given at your pre-assessment appointment regarding your medications and stop all herbal medication 7 days before surgery.

Should you require a sick note please inform your nurse on admission.

The inpatient ward does not allow flowers due to the risk of infection. Please inform your visitors of this rule.

PLEASE CONTINUE TO FOLLOW THE NIL BY MOUTH RULES

Meeting the Anaesthetist and Surgeon

When you arrive at the hospital, you will go to the admission area and be seen by the doctors from the anaesthetic and surgical teams who will be looking after you during the operation. The anaesthetist will explain the type of anaesthetic you are having, and the way in which pain will be controlled after the operation. This is very important, as being comfortable means that you will be able to get up and about more quickly after your operation, and this will speed up your recovery

Section 5: Care by the hospital team during your operation

As part of the enhanced recovery programme the anaesthetist and surgeon will work together to reduce the stress on your body during the operation. This is achieved by:

- The use of modern anaesthetic drugs.
- The use of local anaesthetics which can cause numbness when placed near the relevant nerves.
- The use of different anaesthetic techniques, or a combination of techniques.
- Care to control the fluid levels in your body.
- The use of surgical tubes and drains will be kept to an absolute minimum.
- The use of surgical techniques which will cause minimal damage to the body.

Anaesthetic Information

(Modified from Royal College of Anaesthetists) www.youranaesthetic.info

Introduction

You may have heard that there are several different types of anaesthetic for THR. These include:

- A spinal anaesthetic
- A general anaesthetic
- An epidural anaesthetic
- A nerve block
- A combination of anaesthetics

For patients undergoing THR as part of the enhanced recovery programme at SOTC the most commonly used anaesthetic technique is a combination of spinal anaesthetic with sedation, or light general anaesthetic. This means that you will be unaware of what is happening in theatre.

Your anaesthetist will explain which anaesthetic methods are suitable for you, and help you decide the best options for your surgery.

A Spinal Anaesthetic

This is by far the most commonly used type of anaesthetic for hip replacement within an enhanced recovery pathway. A measured dose of local anaesthetic is injected near to the nerves in your lower back:

- This makes you numb from the waist downwards so that you feel no pain.
- When you see the anaesthetist you can decide whether you wish to be awake or, if you prefer, you can also have drugs which make you feel sleepy and relaxed (sedation).

Advantages – compared to a general anaesthetic

- Reduced blood loss during surgery/ less need for blood transfusion.
- Less risk of blood clots forming in the leg veins (DVT- deep vein thrombosis).
- Excellent pain relief immediately after surgery.
- Less risk of chest infections after surgery.
- Less effect on the heart and lungs.
- Less need for strong pain-relieving drugs after the operation.
- Less sickness and vomiting.
- Earlier return to drinking and eating after surgery.
- Less confusion after the operation in older people.

Common side effects of Spinal Anaesthetic:

- **Occasional low blood pressure** – As the spinal takes effect, it can lower your blood pressure and make you feel faint or sick. This can be controlled with the fluids given by the drip and by giving you drugs to raise your blood pressure.
- **Occasional itching** – This can occur as a side effect of using morphine-like drugs in combination with local anaesthetic drugs in spinal anaesthesia. If you experience itching it can be treated - as long as you tell the staff when it occurs.
- **Difficulty passing water (urinary retention)** – You may find it difficult to empty your bladder normally for as long as the spinal lasts. Your bladder function returns to normal after the spinal wears off. You may require a catheter to be placed in your bladder temporarily, either while the spinal wears off or as part of the surgical procedure.
- **Occasional pain during the injection** – As previously mentioned, you should immediately tell your anaesthetist if you feel any pain or pins and needles in your legs or bottom. This may indicate irritation or damage to a nerve and the needle will need to be repositioned.
- **Headache** – There are many causes of headache, including the anaesthetic, the operation, dehydration and anxiety. Most headaches get better within a few hours and can be treated with pain relieving medicines. Severe headache can occur after a spinal anaesthetic. If this happens to you, your nurses should ask the anaesthetist to come and see you. You may need special treatment to settle the headache.

Rare complications

- **Nerve damage** – This is a rare complication of spinal anaesthesia. Temporary loss of sensation, pins and needles and sometimes muscle weakness may last for a few days or even weeks. Almost all of these will resolve in time, and most patients will make a full recovery. Permanent nerve damage is even rarer and has about the same chance of occurring as major complications of general anaesthesia.

A General Anaesthetic

For some patients, a spinal anaesthetic is not possible for medical reasons, or you may prefer a general anaesthetic.

A general anaesthetic produces a state of controlled unconsciousness during which you feel nothing. You will receive:

- Anaesthetic drugs (an injection or gas to breathe).
- Strong pain relief drugs (morphine or something similar).
- Oxygen to breathe.
- Sometimes a drug to relax your muscles.

You may need a breathing tube in your throat whilst you are anaesthetised to make sure that oxygen and anaesthetic gases can move easily into your lungs. If you have been given drugs that relax your muscles, you will not be able to breathe for yourself and a breathing machine (ventilator) will be used. When the operation is finished the anaesthetic is stopped and you will regain consciousness.

Advantages

You will be unconscious during the operation.

Disadvantages of a General Anaesthetic

Common

- Does not provide pain relief on its own after the operation. You will need strong pain relieving medicines afterwards. These can make some people feel quite unwell.
- More bleeding compared with other types of anaesthetic.
- Breathing after the operation is not as good compared with other types of anaesthetic. There is a greater risk of chest infection.
- More sickness, drowsiness, shivering and a longer period before you will be able to eat and drink.
- Sore throat after the anaesthetic.

Less common

- Occasional confusion and memory loss.
- Possible damage to lips, teeth and eyes.
- Risk of vomit getting into your lungs, especially if you have a hiatus hernia.

People vary in how they interpret words and numbers.

This scale is provided to help.



An Epidural

This is very similar in its effects and side effects to a spinal anaesthetic (see page 14). However, it can be topped up post-operatively and is most likely to be used if you are having both hips done at the same time (a bilateral procedure), or are having your joint replacement re-done (revision surgery).

A Nerve Block - rarely used in an enhanced recovery programme

This is an injection of local anaesthetic near to the nerves that go to your leg. Part of your leg should be numb and pain-free for some hours afterwards. You may also not be able to move it properly during this time.

If you are having a general anaesthetic, this injection may be done before the anaesthetic starts, or it may be done when you are unconscious.

Advantages

- You usually need a lighter general anaesthetic and you should be less sick and drowsy afterwards. This is because you should need less strong pain relieving medicines during and after the anaesthetic.
- You should be more comfortable for several hours after the operation.

Disadvantages of a Nerve Block

- The blocked nerve may take longer than 24 hours to recover.
- Very rarely recovery may be prolonged for a few weeks. Permanent damage is extremely rare

A Combination of Anaesthetics

Many patients having a spinal (and/or an epidural anaesthetic in some situations), will also be either sedated or put lightly to sleep during the operation. YOU DO NOT HAVE TO BE WIDE AWAKE.

- The 'sleep' will be 'lighter' than having a general anaesthetic.
- Any unpleasant after-effects of the general anaesthetic will almost certainly be less.

Section 6: Care by the hospital team after your operation

Post Anaesthetic Care Unit (PACU)

After surgery you will be moved from the operating room to the post anaesthetic care unit (PACU). In PACU you may be given oxygen, an intravenous line delivering fluids, and your pulse and breathing will be monitored until the anaesthetic wears off. Your blood pressure will also be checked regularly whilst you are in the recovery unit. The nursing staff will take the drip out of your arm as soon as possible, and you will be encouraged to eat and drink. You should also start your breathing and leg exercises (page 31-32). You will remain in PACU until you no longer require close monitoring. The anaesthetist or lead nurse will authorise your transfer to the ward when your vital signs are normal and stable.

On the SOTC Ward

Pain management

At the Sussex Orthopaedic NHS treatment Centre we provide a multidisciplinary approach to help manage any discomfort that you may experience from your surgical procedure. Following your surgery, the staff will regularly check if you have any pain and will adjust your pain medication to ensure you are as comfortable as possible.

Your pain after surgery will initially be controlled by a regional anaesthetic (usually a spinal block, but occasionally an epidural). When the effects of the spinal anaesthetic start to wear off, you must ask the nursing staff for oral pain medication.

The nursing staff are well trained on how to manage your pain. Additionally there is an acute pain team (APT) who do a ward round most week days to discuss your pain control. If the APT are not available, the nursing staff can contact the anaesthetist for advice.

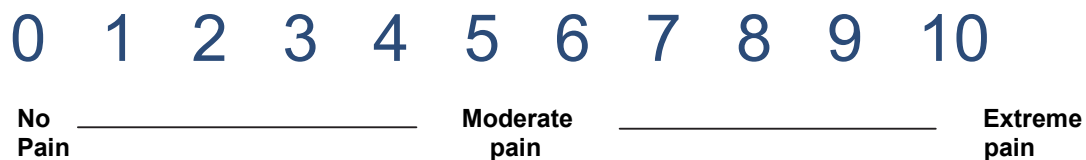
The nursing staff will actively encourage you to take the medication that you are prescribed. You will have medication that will be given regularly, and medication for 'breakthrough' pain ('breakthrough' medication is for when you have pain between regular doses). Make sure you let the nursing staff know if you have pain. **It is essential for your recovery that your pain is controlled; to enable you to walk, and to do your exercises.**

Your pain is easier to control if you do not allow it to become severe before taking pain medication. Therefore it is very important that you tell your nurse or anaesthetist as soon as you are experiencing any discomfort, where the pain is located and if it changes in nature or intensity. For example, sometimes pain is constant and other times it comes and goes.

Remember: please bring in and handover all of your medication to the nursing staff on the ward.

Pain scale

You will be asked to rate how much pain you have on the pain scale below:



Nutrition and wellbeing

On your return to the ward you will be provided with nutritional drinks 3 times a day for the first 2 days. These drinks are IN ADDITION to regular meals and snacks. This combination will keep you hydrated and promote wound healing. During your hospital stay it is important to eat balanced, nutritious meals with adequate calories and protein to maintain your health. **If you have any special dietary needs please inform the catering staff upon your arrival to the ward.** When selecting from your menu, choose balanced nutritious meals. Remember that your body is healing and requires extra protein to assist in the rebuilding process.

If you feel nauseated, please let the nursing staff know. They will address this. Once the nausea has subsided it is very important you try to eat and drink as normal again. DO NOT stop eating or drinking because you feel unwell, as this will affect your recovery.

Constipation

Constipation may occur after surgery either as a side effect of the pain medication or because of reduced physical activity. To solve this problem:

- Keep mobile. This can assist in the management of constipation.
- Increase your water intake. Drink at least 8 glasses of water daily (1 glass = 300mls).
- Try adding fibre to your diet by eating fruits, vegetables and foods that are rich in grains.
- Take the laxatives that the nursing staff give you and continue with them until you are back to your previous pattern.

Your Rehabilitation Guidelines

Physiotherapy

Exercise is an integral part of your rehabilitation following THR surgery. The exercise regime given to you by your physiotherapist will help you to regain the best possible function from your new hip, as long as you perform them regularly. **Remember - you make the difference!** It is extremely important that you understand that your motivation and participation in your recovery is vital in achieving the goals set out for you.

Occupational Therapy

During the course of your stay in the hospital, the occupational therapist may visit you in the ward and review your home setup with you. This is to ensure any necessary equipment is in place. They will also advise you about both your personal and domestic daily activities.

How you can help with your recovery

By actively participating in your exercise and rehabilitation programme, you will obtain the best functional recovery. We appreciate that you will have some discomfort as you participate in your rehabilitation, but it is important that you **do not avoid activity**. Your recovery will be faster and the results more desirable if you persist with the rehabilitation (this includes when you go home!)

NOTE: The Progress Guidelines shown below are milestones rather than events locked to a given day. Some patients may progress through several phases in one day, whereas others may take several days to progress through the phases.

On the day of surgery you can expect:

- To go from the operating theatre to the PACU, and then up to the ward.
- TED stockings (tight long socks) to be on in line with the operating surgeon's protocol.
- A pillow may be placed between your legs whilst lying in bed to keep your hip in a good position.
- To do your breathing and leg exercises (**page 31-32**) in recovery, the sooner you can start moving your new joint the better.
- To get out of bed and take a few steps with a walking aid and assistance from the physiotherapy or nursing staff. (You may have some tubes or wires attached to you. These will not stop you from mobilising unless the physiotherapist/nurse decides it is not safe to do so).

Your Rehabilitation Guidelines

Phase 1

- To do your hip exercises 3 – 5 times per day (**page 32-34**).
- To get out of bed with a walking aid and guidance from the nurse or Physiotherapist.
- To sit in a chair beside your bed.
- To wash your face and upper body independently.

Phase 2

- To increase the frequency and distance of walking.
- To progress from a frame to crutches or a walking stick (if appropriate) as directed by your physiotherapist.
- To progress your exercises as directed by your physiotherapist.
- To gradually increase how long you sit out of bed (including all meals).
- To get in and out of bed with minimal assistance.
- To use the bathroom and toilet (a raised seat will be applied as required).
- To start planning your discharge – Are there any questions you need to ask?

Phase 3

- To be walking independently several times per day.
- To be completing your bed exercises several times per day.
- To be doing your standing exercises as directed by your physiotherapist (**page 34**).
- To learn and practice how to go up and down stairs (if applicable) under the supervision of your physiotherapist (Please read **page 35** so you are familiar with the technique).
- To learn and practice washing and dressing techniques with your occupational therapist, if you have not already done so. (**Page 36-37**).
- To plan your discharge with the nursing staff.

The Three Rehabilitation Rules

Following surgery, your body needs to heal. Soft tissues e.g. muscles, are stretched to gain access to the hip joint thereby weakening the joint and decreasing its ability to support the body. Moving your hip beyond the limits of motion described in these guidelines increases the risk of your new hip joint dislocating. Your surgeon will tell you when you can move beyond these limitations.

Below are the 3 precautions that YOU MUST FOLLOW for at least 6 weeks after your surgery to prevent dislocation of the new joint.

- 1. DO NOT bend your hip higher than 90 degrees**
- 2. DO NOT cross your legs or ankles when lying, sitting or standing**
- 3. DO NOT twist your operated leg inwards**

1. Do not bend your hip higher than 90 degrees (Figure 4)

For example: by lifting your knee above your hip joint, bending over at your waist to pick things, or squatting down. In other words, the angle between your thigh and stomach must be 90° (a right angle) or more at all times.

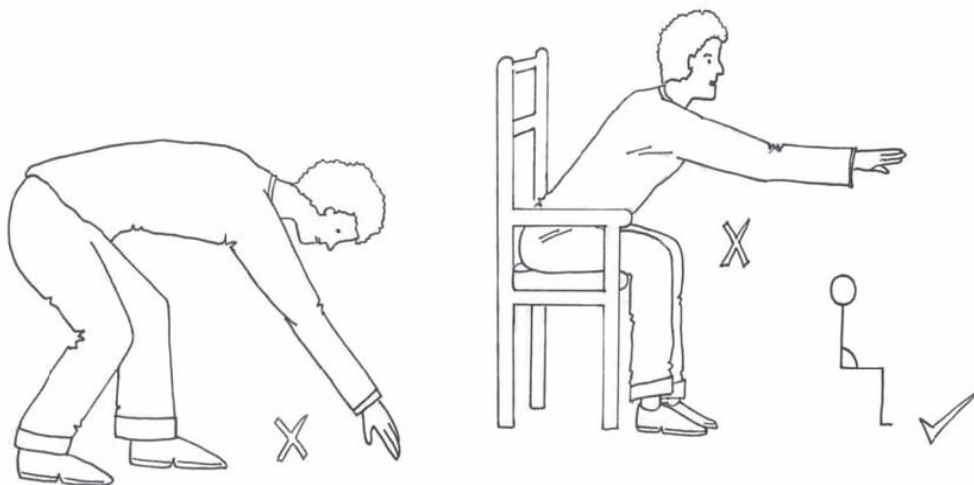


Figure 4

2. Do not cross your legs or ankles when lying, sitting or standing (Figure 5)

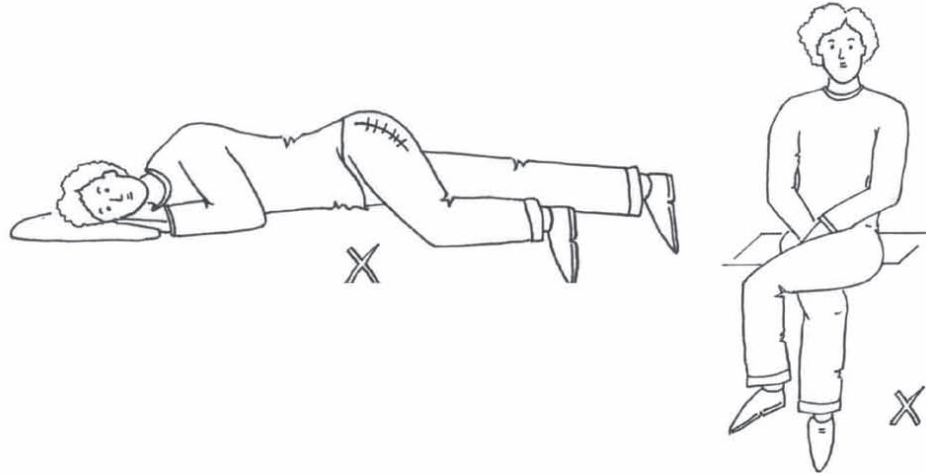


Figure 5

3. Do not twist your operated leg inwards (Figure 6)

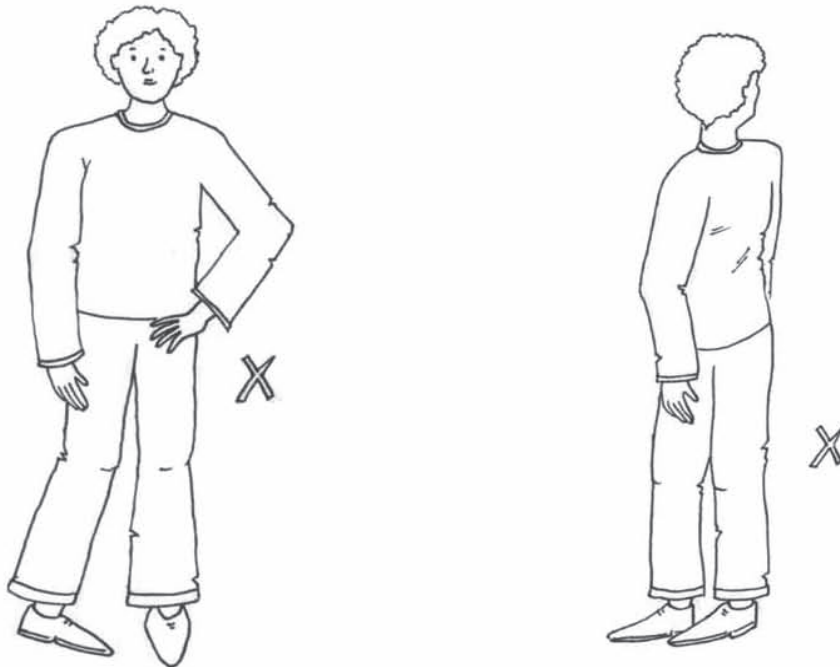


Figure 6

To Follow These Precautions:

- **Avoiding sitting in low, soft chairs** such as sofas and easy chairs. You should sit on a firm chair with good arm supports to avoid breaking rule number 1.
- **Ensure your bed is high enough.** A low bed will allow the hip to bend further than 90 degrees when getting into or out of bed. Also remember not to sit so upright in bed, as you may bend your hip too much.
- **Sleep on your back.** This will need to be done for approximately 6 weeks. Put a pillow between your legs to avoid them crossing and to stop your legs rotating
- **Do not lie on your side, as this can cause your hip to twist/cross.**



(www.eorthopod.com)

Exercises

The exercises in the following pages are a part of your individual exercise programme. The physiotherapist will advise you which exercises to perform, and when you can progress them at home. It is essential that you are an active participant in your recovery to help your body and you hip to regain strength. As your body heals you may feel some stiffness and mild soreness in various muscles. These feelings are normal, however, the exercises should not cause excessive pain. **If a particular exercise is causing excessive pain stop performing it and contact the physiotherapist.** The combination of exercise with rest, ice packs (if necessary,) and pain medication will ensure that you get maximum benefit from your THR surgery.

If you cannot manage the number of repetitions indicated in this booklet start with as many as you can manage and build on this number as you become stronger. Remember little and often is best, so try and make sure you space your exercises out throughout the day.

Preventing Circulation Problems

After your surgery you are at a higher risk of developing blood clots, also known as Deep Vein Thromboses (DVT). In order to minimise this risk you will be prescribed anticoagulant (blood thinning) medication and compressive tights (called TED stockings). Regular circulation exercises are also of great importance to prevent DVT. (see page 30). These gentle exercises improve blood flow and maintain muscle function. However, it is still important to be aware of the signs that indicate that you may have a DVT, both in hospital and when you return home.

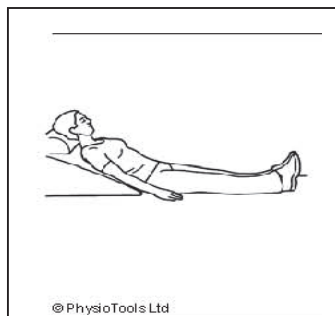
Some signs and symptoms of DVT are:

- Swelling of the calf.
- Pain in the calf, groin or chest.
- Calf pain that is noticeable, or worse when standing or walking.
- A change in colour of your toes compared to the other leg (typically purple).

If you notice any of these signs tell your nurse so that we can investigate and take appropriate action if required. This usually only involves a simple increase in medication or prescribing an alternative medication.

Preventing Lung Problems

After surgery deep breaths are necessary to fully ventilate your lungs and help keep the airways free of mucus and infection. It is important to regularly practice the breathing exercises shown below.



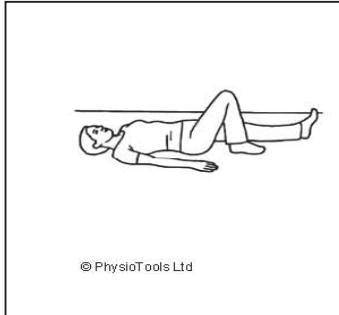
DEEP BREATHING

- 1) Take a slow deep breath in through your nose
- 2) Hold your breath for 3 seconds
- 3) Breathe out slowly through your mouth

Repeat this every half an hour

Early Exercises

Please start these exercises as soon as you are in the recovery unit after your operation.

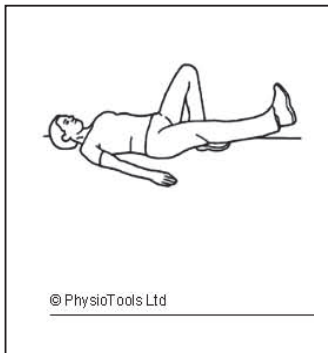


HIP FLEXION

Lying on your back.

- Bend and straighten your hip and knee on the OPERATED leg.
- Do NOT exceed 90 degrees hip bend

Repeat 10 times, 3-5 times per day

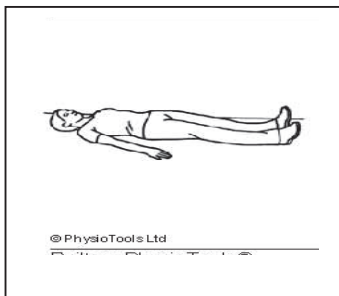


STRAIGHT LEG RAISE

Lying on your back.

- Bend your UNOPERATED leg as shown in the picture.
- Tighten your thigh muscle and straighten your knee (on the OPERATED leg).
- Lift your OPERATED leg off the bed about 10cm / 4 inches, making sure that you keep your knee straight.
- Hold 1-2 seconds, then slowly lower

Repeat 10 times, 3-5 times per day

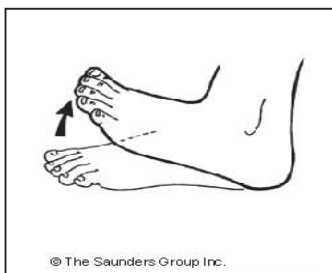


GLUTEAL CONTRACTIONS

Lying on your back

- Squeeze buttocks and thigh muscles firmly together.
- Hold for 5 Seconds, then relax.

Repeat 10 times every hour



ANKLE PUMPS

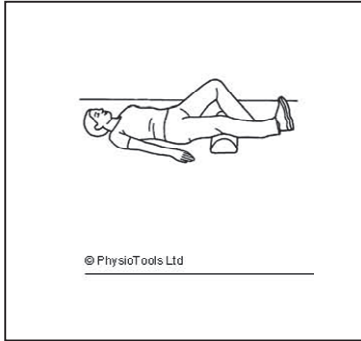
Lying or sitting

- Bring your toes up towards your shins (toes to ceiling) and then down away from you (point your toes).

Repeat 10 times every hour

Bed Exercises

Please continue with the 'Early Exercises' and then also start the bed exercises as soon as you are back on the ward. You should practise the exercises on p32 before your surgery to help with your hip strength and movement.

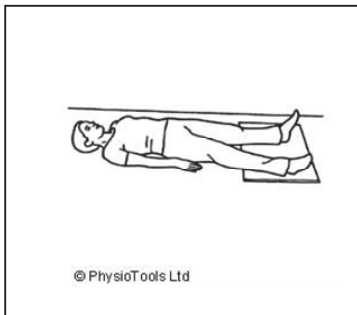


INNER RANGE QUADS

Lying on your back

- Place a rolled up towel under your knee (on the OPERATED side)
- Push your knee into to towel and lift your heel off the bed, so that your knee is straight.
- Hold for 10 seconds and slowly relax.

Repeat 10 times, 3-5 times per day

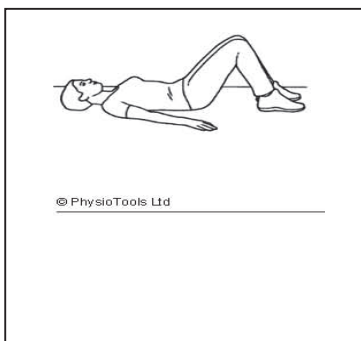


HIP ABDUCTION

Lying on your back

- Keep your toes pointing up to the ceiling
- Slide your OPERATED leg out to the side, then back to the middle.

Repeat 10 times, 3-5 times per day



BRIDGING

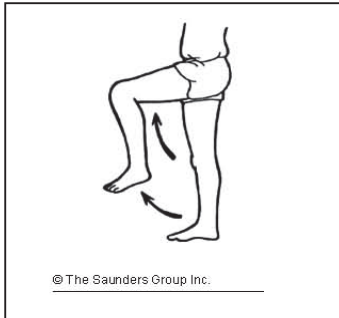
Lying on your back with your knees bent, and feet flat on the bed

- Squeeze your buttocks together and lift your bottom off the bed
- Return to starting position

Repeat 10 times, 3-5 times per day

Standing Exercises

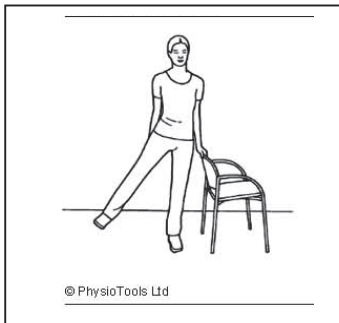
Your Physiotherapist will guide you when to start these exercises. You also need to continue with your bed exercises so space them out regularly throughout the day.



HIP FLEXION IN STANDING

- Lift your OPERATED leg up, bringing your knee towards your chest. DO NOT EXCEED 90 DEGREES HIP BEND.
- Slowly lower
- Repeat the exercise with your GOOD leg.

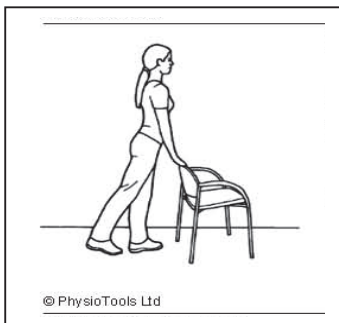
Repeat 10 times, both legs, 3-5 times per day.



HIP ABDUCTION IN STANDING

- Lift your OPERATED leg out to the side
- Keep your toes pointing forwards and your body upright
- Slowly lower
- Repeat the exercise with your GOOD leg.

Repeat 10 times, both legs, 3-5 times per day



HIP EXTENSION IN STANDING

- Bring your OPERATED leg backwards
- Make sure you keep your knee straight and your body upright
- Slowly lower
- Repeat the exercise with your GOOD leg.

Repeat 10 times, both legs 3-5 times per day.



MINI SQUATS

- Slowly bend your knees, as if you are sitting down to a chair
- Make sure your hips are always above your knees
- Slowly straighten

Repeat 10 times, 3-5 times per day

Stairs Technique

Your Physiotherapist will guide you when you are ready to practise the stairs. Please do not attempt the stairs on the ward unless the physiotherapist is with you. The instructions below will help to make sure you have the correct technique.



GOING UP THE STAIRS

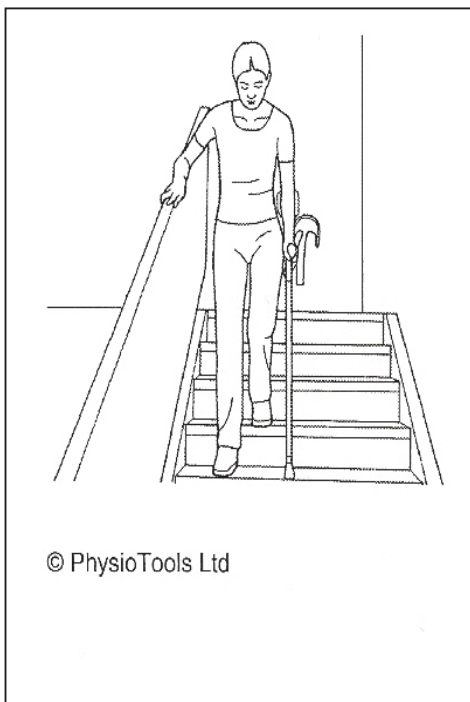
Hold onto the rail with one hand and crutch in the other (or use 2 crutches if you have no rail).

- 1) First take a step up with your UNOPERATED leg.
- 2) Then take a step up with your OPERATED leg.
- 3) Then bring your crutch(es) up onto the same step.

Always go one step at a time.

To help you remember GOING UP:

UNOPERATED LEG → OPERATED LEG → CRUTCH



GOING DOWN THE STAIRS

Hold onto the rail with one hand and crutch in the other (or use 2 crutches if you have no rail).

- 1) First reach your hand down the rail so it is a little way in front of you.
- 2) Put your crutch(es) one step down.
- 3) Then take a step down with your OPERATED leg.
- 4) Then take a step down with your UNOPERATED leg (onto the same step as your operated leg).

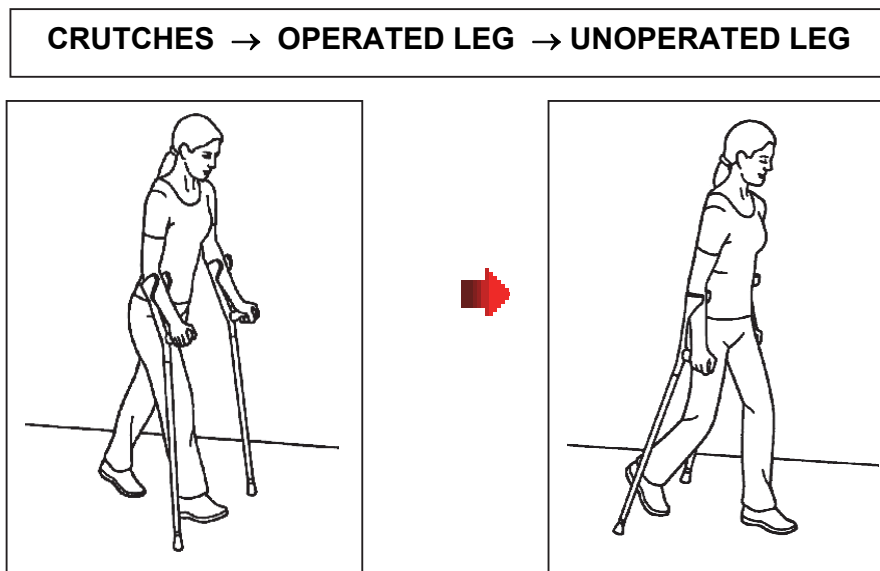
Always go one step at a time

To help you remember GOING DOWN:

CRUTCH → OPERATED LEG → UNOPERATED LEG

Walking with crutches

Your physiotherapist will teach you how to walk with crutches. Some patients will use a walking frame when they first get out of bed, but will soon progress onto crutches as directed by the physiotherapist. The general principle is to place your crutches forward first (making sure they are wide enough for your feet to step through). Next, step your operated leg, and then follow with your good leg. As you get more confident, you can start to walk with equal, long strides. Please ask your physiotherapist for advice on this.



Showering / washing yourself

- You are unable to have a bath for 6 weeks after your operation.
- Keep the wound area dry until either your clips are removed (12-14 days after your operation) or if you have a 'glue' type closure you wait 5 days after your operation. Therefore strip wash for this time period.
- Use a long handled sponge or brush to reach your lower legs and back.
- You may feel you need a seat to strip wash on initially.
- After the wound is clean and dry you may use a walk in shower/ shower cubicle.

There are three safe ways to wash your hair:

1. Standing in a shower cubicle.
2. Standing over the kitchen sink.
3. Leaning backwards in a hairdressers chair.

Dressing

- Always sit down when getting dressed.
- Always dress your operated leg first and undress your operated leg last.
- Always use long handled aids, e.g. a helping hand to put on underwear, shorts/trousers.
- Sock aids are available to purchase to help you put your socks on.
- Use a long handled shoe horn will help you put slippers or shoes on.
- If wearing a skirt pull this on over your head.

To dress your lower half:

- Place your underwear/trousers on your lap and hold the waistband of your operated side with the helping hand. Grip tight.
- Lower the item of clothing to floor holding using just the helping hand so that you do not bend.
- Place your operated foot through the leg of clothing and pull up as far as your knee before you grab the clothing with your 'free' hand.
- Release the helping hand and hold the other side of the waist band.
- Lower to the floor using the helping hand and place your un-operated foot through the free leg of the clothing. Pull up as far as your knee before you grab the clothing with your 'free' hand. Keep your operated foot on the floor throughout.
- Once the clothing item is at your knees, stand, pull up and fasten.



You MUST observe the 3 rehabilitation rules while you shower and dress.

- **Do not bend your hip higher than 90 degrees.**
- **Do not cross your legs or ankles when lying, sitting, or standing.**
- **Do not twist you operated leg inwards.**

Section 7 : Going Home

When can I go home?

- Once you have achieved your discharge goals.
- The doctor says you are medically fit.
- When the nursing staff are happy with your wound, and they have received your drugs from the Pharmacy.

You should start to discuss your discharge with staff as soon as you are back on the ward. Some patients may be able to go home the day after their surgery. Most patients are discharged **1-3 days** after surgery.

Goals for discharge:

- To get in and out of bed independently.
- To be walking independently with your mobility aid several times a day.
- To do your exercises several times a day.
- To wash and dress yourself.
- To walk up and down stairs (if you have them at home).
- To understand about your medication and when to take it.
- To make sure you are aware of your follow up arrangements.

The doctors, nursing staff, physiotherapist and occupational therapist will be in regular contact with you and your family throughout your hospital stay. They will assess your progress and tailor your follow-up care to meet your needs. The nursing staff will constantly be planning your discharge and each individual is different. Before discharge you will be told:

- **What all your medication is for and when to stop it.**
- **That you will have an outpatient appointment in approximately 6 weeks.**
- **How to care for your wound.**
- **To keep your stockings on until your outpatients appointment.**

Please try to get a friend to pick you up from the hospital, if they have suitable transport. Please note that Pharmacy at the hospital is very busy and you may have to wait some time before your drugs arrive on the ward before you can go home.

If you decide to get patient transport please be advised there is a long wait on the day, as this is a service that is in extremely high demand.

Travelling by car

You must not drive for the first six weeks following your surgery, and until your surgeon has cleared you to do so. Speak with your insurance company as they may have policies surrounding using a car after surgery. You can be a passenger as long as the seat is not too low. The following guidelines may help:

- Move the seat right back and slightly recline it.
- A firm pillow will make the seat a little higher.
- Lower yourself down to the edge of the seat with your back towards the door.
- Keep your knee out straight in front of you and push yourself back toward the driver's seat.
- Keep leaning backwards so you do not bend your hip past 90 degrees.
- Sitting on a plastic bag can make it easier to slide and turn on the seat.
- Keep the leg straight and in line with your head whilst you turn and lift your foot into the foot well.



Looking Ahead: Advice for Home

After THR surgery patients do not usually require ongoing physiotherapy but you will need to continue the exercises on your own at home. The centre itself does not provide outpatient rehabilitation. However, if your therapist feels that you require ongoing therapy they will refer you to the appropriate teams.

Please bear in mind that recovering from surgery can be a very tiring process, and can feel frustrating at times. You may wish to keep visits from friends or family spread out over the first few weeks, to enable you to have time to rest and recover.

Wound care

The nurse that discharges you will run through all of the advice you need for wound care and give you a letter that explains when you should change your dressing. The senior nurse from the ward will phone you two consecutive days after you are discharged home to check you are managing well, and to answer any questions you may have. It is also important that you are able to recognise the signs and symptoms of infection:

- **Increased pain**
- **Increased swelling**
- **Increased redness**
- **Increased soiling of the dressing**
- **Temperature over 37.5°C and/or shaking, excessive sweating or shivering.**

If you have any of these symptoms ring the centre immediately and the Nurse/Dr will inform you what to do.

Scar massage

Once your wound is healed, and no longer requiring dressings, you can start to massage the scar. This will help it to flatten and be flexible. Use a non-perfumed moisturising cream and apply firm pressure in a small, circular motion. You should aim to massage it for 2-3mins, at least twice per day.

Long term protection against infection of your artificial joint

Although it is very rare an artificial joint can become infected from another infection in your body. It is important that bacterial infections such as pneumonia, urinary tract infections, or abscesses are treated promptly by your GP, as there is a small risk that they could affect your prosthesis

How do I manage meals, snacks and drinks?

- Try to move items you use regularly from under counter cupboards to work surfaces or wall mounted cupboards.
- A kitchen trolley can be ordered on loan to enable you to transport food/drink safely around your house. Alternatively a shoulder bag or rucksack could be used.
- If necessary, eat your meals in the kitchen seated on a high stool.
- If your fridge is under the work surface try to keep items on the top shelves.
- A microwave could be used to cook meals to prevent you from bending to a low oven.
- Cook and freeze some of your own meals before coming into hospital so they will be easier for you to manage when home.
- Use frozen or ready prepared vegetables on a short term basis.

How will I manage my food shopping?

- Consider internet/telephone shopping or asking someone to do it for you until you are able to drive again.
- Make sure your kitchen is well stocked with basic food items before your surgery.
- In a supermarket, use a trolley – do not carry a basket.

What about cleaning and laundry?

- Prior to surgery ensure you are up to date with all your laundry, including your bedding.
- Try to do a 'big clean' before you come into hospital.
- Use your helping hand to load/unload the washing machine.
- Ask friends and family to help you with these tasks for the first 6 weeks whilst you are following your hip precautions.
- Home from hospital schemes may be able to support you on discharge, please discuss this with the OT on the ward.

Progressing your mobility

Most patients who are discharged from the hospital will be independently walking with two elbow crutches. You should use two elbow crutches, when walking, until you are confident and safe to walk with one crutch. Continue to use two crutches if you have pain or a limp when walking with one crutch. In the same way, once you feel confident with one crutch you may progress to walking independently with no crutch.

When using one crutch always use the crutch in the opposite hand to the operated leg.

As a rough guideline by the six-week follow-up review with your surgeon you should be walking with one crutch outdoors and no crutch indoors. However, it is important to remember everybody is different, you should only progress your mobility if your body is comfortable with it.

The rule for progression is to only progress when you can walk without pain or a limp.

You should do a little bit more walking everyday as is comfortable for your body. Again this is different for everyone depending on your ability and pain levels. It is better to do 3 or 4 short walks a day in the first few weeks rather than 1 long one and wearing yourself out. Keep away from steep hills and slopes for 6 weeks, but gentle slopes are fine if negotiated slowly and safely.

If you are overdoing it, you will most likely be sore, swollen and tired. This is an indication you should cut back your activity levels a little, and pace yourself. Ensure you have adequate rest between activities. Never completely stop all activity unless advised by a medical professional.

Swelling management

Swelling is a normal part of the healing process following a hip replacement. Your hip and leg may remain swollen for several months after your surgery.

To manage the swelling we recommend that you rest for up to an hour in the bed at least once a day during the first six weeks. After you no longer have to adhere to your hip precautions (6 weeks post surgery) it is fine to elevate your legs on a footstool to manage the swelling.

Ice is a natural anaesthetic that helps relieve pain and control swelling. If your hip is swollen applying ice or a bag of frozen peas can help reduce the pain and swelling. Do not leave the ice on for more than 20 minutes at a time and make sure that it is wrapped in a thin towel and plastic bag to protect your wound. You can use the ice as much as required but not more than once an hour.

When can I begin driving?

Most patients are able to resume driving about 6 weeks after surgery. This will depend on muscle strength, coordination and overall healing. Even after 6 weeks you should not attempt driving unless you feel safe to control the car, and can perform an emergency stop. **You MUST obtain clearance from your surgeon before driving.** Failure to do so could render your car insurance invalid.

When can I return to sports?

Our duty is to educate patients regarding risks associated with higher levels of activity after THR. These include: implant loosening, accelerated wear of the articulating surfaces, and injuries. Please discuss returning to sports with your surgeon at 6 weeks post surgery follow up appointment.

When can I fly?

Most orthopaedic surgeons advise their patients not to fly for at least 6 to 12 weeks after a THR. It is possible that sitting for long period of time in a confined space could increase your risk of deep venous thrombosis.

Sexual Relations after a THR

Patients and their partners often have concerns about sexual relations following hip surgery. We hope that by reading this information some of your concerns and questions regarding sexual activity after THR surgery will be answered. If you still have any other questions, please feel free to ask your surgeon, nurse or physiotherapist.

Will I be able to resume sexual relations, and when?

The vast majority of patients are able to resume intercourse after THR surgery. Patients who have had impaired sexual relations because of hip pain or stiffness usually find that after surgery their hip is pain free and has better motion. However after THR surgery we recommend that you do not resume sexual relations for 4-6 weeks to allow the muscles sufficient time to heal.

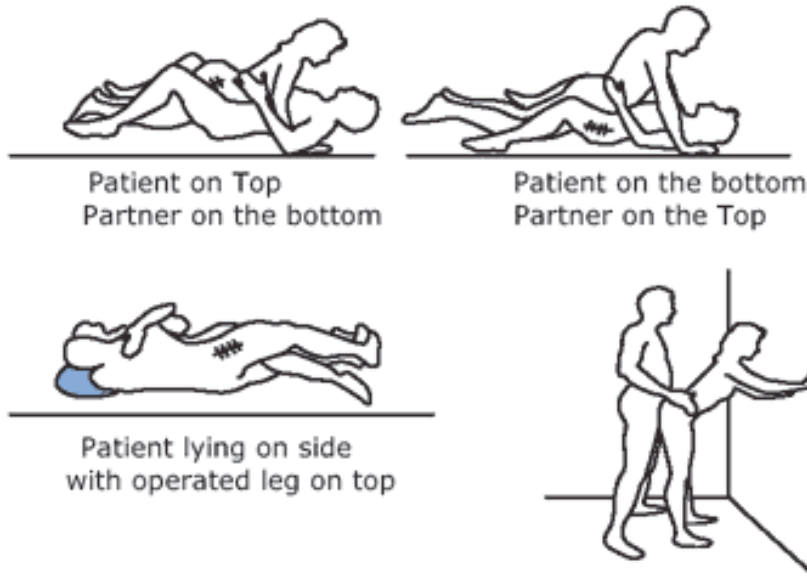
What positions are within my THR precautions during intercourse?

On the following page a number of positions are printed which illustrate sexual positions that comply with and do not comply with THR precautions. Obviously this list is not exhaustive but it is a good indication of how to comply with your THR precautions during intercourse.

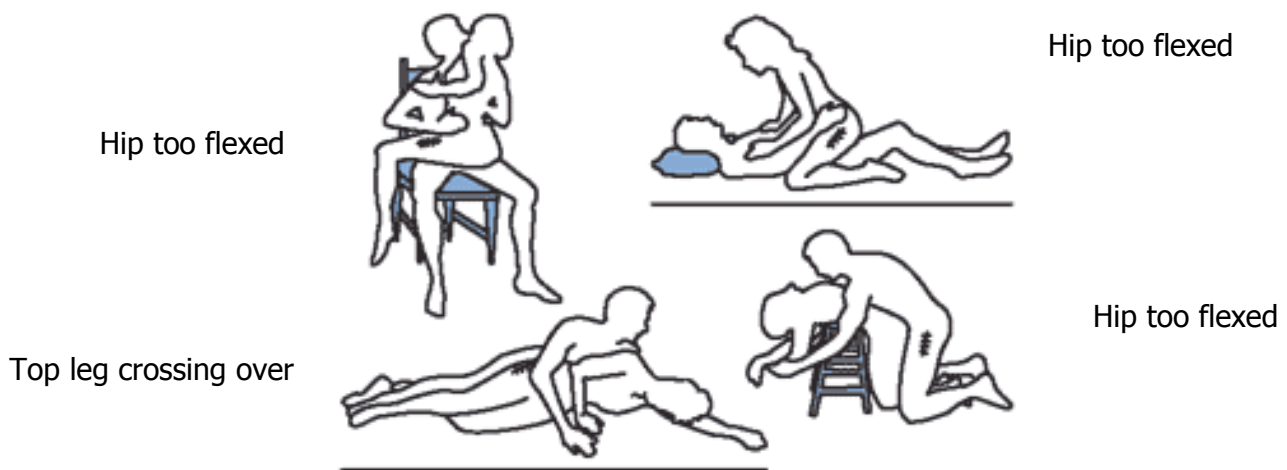
What should I tell my partner?

Good communication between you and your partner is essential. You may have to adopt new positions for intercourse. We suggest that you share this information with your partner and discuss the precautions related to your THR.

Positions for Intercourse which Conform to Precautions Following THR



Positions for Intercourse TO BE AVOIDED Following Total Hip Replacement



Pictures courtesy of www.ranawatorthopaedics.com

How long do I have to continue with the hip precautions?

You must follow the hip precautions until your surgeon has seen you for follow-up at 6 weeks and given the clearance not to do so. Even then, you might find it difficult to do some of these movements. Introduce things slowly and only as you feel comfortable to do so.

Follow Up Appointments

With your Surgeon

Follow up appointments with your surgeon are necessary regardless of how well you feel. They will want to check how you are progressing, how the wound has healed, and if the scar has formed correctly. This appointment will normally be approximately 6 weeks after your operation. You will be notified by post of your appointment date and time after you have been discharged from the ward.

At the 6 week appointment you can discuss any issues with your surgeon. These may include whether you can start driving, and when you will be able to return to specific sports. **Remember to write down in the back of this book any questions you may have that you would like to ask your surgeon at your follow-up appointment. Your surgeon is the only person who will be able to make the ultimate decision regarding your return to specific activities. He will base this on your progress at this point.**

With Physiotherapy/Occupational Therapy

As previously stated not all patients require physiotherapy after they are discharged. However, if you become concerned about your progress, or would like some guidance after you have gone home please contact the physiotherapy department for advice. The number can be found at the front of this booklet.

Similarly not all patients require help or equipment at home. When staff feel that that help at home services are necessary, they will be arranged whilst you are in hospital and you will be informed before you go home. The centre itself does not provide these services as on-going care is carried out by local community NHS teams once you are discharged.

