



ORTHOPEDIC CENTER FOR JOINT
REPLACEMENT & SPORTS MEDICINE, P.C.
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Primer on Total Hip Replacements **An Introduction and Informed Consent**

By James R. Van Horne M.D.

Information and Discussion on Total Hip Replacements

This is a discussion covering the preoperative phase, immediate postoperative phase in the hospital, long-term rehabilitation, and follow-up. You don't have to wade through this stack of paper every time you have a concern. There is a Frequently Asked Questions (**FAQ**) section at the end. If you still have questions, call my office! My staff knows 95% of the answers. The ones they don't know they will find out.

Making a decision to have a total hip replacement

Before you have a total hip replacement, you must be certain to understand:

- 1.) The risks and benefits of total hip replacement.
- 2.) What will happen during surgery?
- 3.) What to expect of your hip.
- 4.) Your restrictions in the immediate postoperative phase and your long-term restrictions.
- 5.) That you, and only you, are responsible for making your hip work.

Once you understand these risks and benefits, you can then decide whether a total hip is right for you. No one can tell you when the right time to have a total hip is. You will know when it is time. My job is to provide you with the information you need to make a decision.



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Timeline for total hip replacement

- 1) You will hate me for 6 weeks after surgery.
 - You will use a walker or crutches at all times.
 - You will have to use a knee immobilizer at night.
 - You cannot drive.
 - You cannot bend your hip more than 90 degrees.
 - You cannot sit in low cushy chairs or couches. You cannot kneel.
 - You will need pain medications for 2-6 weeks.
 - You will have home physical therapy for about a week. You will independently do your exercises 2-3 times a day.
 - Your thigh is swollen. You have blood in your thigh left over from surgery. This is normal. As part of the healing process, your body will reabsorb this blood, and the swelling will go down over 4-6 weeks.
 - Your leg feels long because prior to surgery your muscles had shortened, your pelvis was, and still is, tilted, and your gait was, and still is, abnormal.
 - You will wear your thigh-high stocking for two weeks.
- 2) At 8 weeks, I am not such a bad guy.
 - You will start walking without a walker or crutches
 - You can get rid of your knee immobilizer.
 - You can drive, if you are safe.



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- You may need a short course of physical therapy to work on your gait and pelvic leveling and should start or continue a water exercise program.
 - You will continue an independent exercise program 3-4 times a day. Only you can normalize your gait and level out your pelvis to equalize your leg length.
- 3) At 3 months you will like me.
- You will be returning to most normal activities.
 - You can bend your hip more than 90 degrees.
 - You can sit on couches and cushy chairs.
 - You will have stiffness and “start up” pain, especially in the morning.
 - Your gait should be close to normal, and your pelvis feels level.
- 4) Around 6 months, having a total hip replacement was easy.
- You should be relatively pain free.
 - You should have returned to all your pre-surgery activities. You should be embarking on activities you were unable to do before surgery.
- 5) By a year, it feels like your own hip.



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Risks of total hip replacement

Death, Stroke, Heart Attacks and other major events

The most serious risk of total hip replacement is death. It is a very rare occurrence, but in even healthy individuals, there is approximately a 1 in 675,000 chance of dying from anesthesia or other causes. While this doesn't happen often, you must realize it could happen to you! Stroke, heart attacks, pneumonia and multiple other medical complications can occur. I will work with your medical doctor to determine what your risks of surgery are. Once you know what your risks are, you must decide if the risks outweigh the benefits of having a good hip. This is elective surgery, and you must understand that just about anything can happen.

Infection

The most horrible consequence of a total hip replacement is infection. Nationwide on a first-time hip replacement, the rate of infection is approximately 1 in 150 hip replacements.

We have recently reviewed approximately our last 500 total joints in Grants Pass and found that we have a significantly lower rate of infection than the national average. Our infection rate is approximately 1 in 500 making our rate of infection approximately one-fifth that of the national average. Revision hip replacement and patients with diabetes, rheumatoid arthritis,



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on steroids or other immunosuppressive problems have a higher risk of infection.

I take every precaution to prevent infections. The operating staff wear space suits and have special air sterile rooms that filter the air 30 times every hour. I give you antibiotics before and after surgery, and I promise not to spit in the wound! Even with all these precautions, there are still a small percentage of people who will get an infection.

Getting rid of the infection can be a difficult and long, drawn out procedure. It may involve placement of an intravenous line in your arm or shoulder for long-term antibiotics (approximately 8 weeks) and surgery to wash out your hip. In worst cases, it requires the removal of your infected total hip replacement and one, or more, surgeries to remove the infection from your hip, followed by another hip replacement two or three months later. There are some bacteria that no antibiotic can kill. We do not have those in town (yet!), but we will in the future. There is the possibility that we could not cure such an infection. You could be left with no hip, a fused/stiff hip, or even an amputation at the hip.

Blood Clots

Deep vein thrombosis/phlebitis/blood clots are a risk involved in any surgery. For total hip replacements, it is a major concern. It



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can be life threatening. Blood clots can go from your legs to your lungs and, in the worst case, cause death. With our present precautions, the risk of a “bad” blood clot is about 1 in 2000. I take every precaution to prevent this. You will receive injections of a blood thinner (Arixtra or Lovenox) once or twice a day, for 10 to 14 days after surgery. You will take an aspirin a day for 4 weeks after you finish your injectable blood thinner. I require foot squeezers on your feet to assist in your circulation and compression stockings on your legs to help with circulation.

For those patients on Coumadin/warfarin, I will restart your Coumadin the night of surgery. You will not take shots or aspirin. For those patients on other blood thinners, I may hold those medicines until after you have completed the injectable blood thinner.

Once again, the risk of blood clots is low, but if you do get a blood clot after surgery, you may require treatment with a blood thinner for anywhere from three to six months after surgery.

If you have had blood clots before, make sure that I am aware of this. I will take appropriate precautions to try to prevent new blood clots, but you are at a higher risk.



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Hip Dislocations

During the surgery, I peel back the muscles and stiff lining from the back of your hip so I can access your hip. At the end of surgery, I sew these back in place. The reason I save them and put them back in place is to reduce your risk of hip dislocation, i.e. popping your hip out of the socket. Not all surgeons use this technique of saving and repairing the muscles and lining.

After 6 months, the muscles and hip lining have healed solidly back down into place, and you have a very low risk of dislocation. Nationally, there is a 5% risk of hip dislocation. While in Boston, I demonstrated a reduction of almost 50% in the rate of dislocation just by repairing these muscles and hip lining.

You must allow these muscles and hip lining to heal back in place, giving you a solid hip. Failure to follow your hip precautions and restrictions can lead to a repeatedly dislocating hip! If you listen to the physical therapists and me, do your exercises and follow your restrictions and precautions for six months, you have an excellent chance of never dislocating your hip!

I limit your activities postoperatively for up to six months. Your restrictions include not bending your hip more than 90 degrees for three months. I don't allow you to kneel or lie on your



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stomach for a total of six months. I make you use a walker or crutches for six weeks.

Using the walker or crutches protects you from falling and allows the muscles and hip lining to heal in place. In addition, when you are in bed, you will wear a knee immobilizer (a long tube which keeps your leg straight) to keep you from getting into positions where you can pop your hip out while asleep. In a knee immobilizer, I will allow you to lie on either side (with a small pillow between your legs) as soon as you are comfortable.

Repeated surgeries increase your risk of recurrent dislocations of your hip. Each time you have surgery, your tissues have been invaded and they are never the same. Revision total hip replacements have a higher risk of dislocation.

Leg Length

I strive to give you an ‘anatomically correct’ hip, a hip that recreates what you should naturally have. Recreating what your hip should be gives you the opportunity to have the best function of your hip and muscles. Generally, this makes your leg lengths within a ¼ inch of each other; however, the most important factor I must consider is the stability of your new hip. If I do not tighten the muscles around your hip enough by making your hip long enough, the muscles cannot hold your hip in the socket and you may pop your hip out of the socket. If I have to make your



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leg long to make the hip stay in the socket, you will forgive me. If you have to wear a small shoe lift on the other side to balance you out because I made you longer, you will forgive me. If you dislocate your hip because I didn't make it stable, you won't forgive me.

Other factors involved in leg length include arthritis in the other hip, old fractures, previous total hip replacements, pelvic tilt, scoliosis, and degenerative arthritis of the spine. Any of these problems can make your leg feel long even if it is perfect. Some of these problems we can never correct and you may need a shoe lift. Even if your legs are the same length, your other problems may make you feel long.

Even if I make your legs exactly the same length, you will probably feel long for the first 2-3 months. Among other things, you have been walking out of kilter, your leg was short, and your pelvis was tilted. You will feel long until you level your pelvis out and correct your gait.

Your foot may turn in when you walk or lie down. This is normal and expected. The muscles in your groin are tight because of your arthritis. When I recreate your hip, these tight muscles make your foot turn in. Some surgeons used to just cut these muscles. It corrected the in turned foot but left you with weak muscles. Rather than cut the muscles during surgery, I



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prefer to let you stretch them out. Just think about walking with your foot straight, and it will correct. It will take several months of conscious effort on your behalf.

Other Risks

There is a very small risk of injury to nerves and blood vessels of your leg during surgery (1 in 100). I take every care to protect these, and the risks of nerve or blood vessel injury are extremely low. You must understand that it can happen and, in some cases, the function of the nerve or blood vessel may never return. People with diabetes and hardening of the arteries or poor circulation are at greater risk. Even though I am nowhere near the nerves, just the act of doing the hip replacement can stretch the small blood vessels that feed a nerve, stunning the nerve. Most of the time the function of the nerve will come back, but sometimes the nerve may never come back or require years to come back. You might need to wear a foot and ankle brace for the rest of your life.

The risk of damaging blood vessels is also small. They are in the front of the hip, and I stay away from them. People with arteriosclerosis (hardening of the arteries) and diabetes have a higher risk of injury because their blood vessels are so stiff. In the worst case, you could loose your leg.



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If you have soft or abnormally shaped bones, there is a risk of a bone fracture during surgery. Even if you have excellent bones, there is a chance I will ‘crack’ your thighbone just getting a tight fit for the replacement. Most of these fractures or ‘cracks’ are seen during surgery and fixed. Occasionally they are not discovered until after surgery and may require a return to the operating room. You may have limited weight bearing and range of motion while the bone heals. This can slow down your rehabilitation and return to full activity.

The muscles and ligaments can tear off of the bones during surgery. Generally, it is because the bones are very soft or there is a lot of scarring from previous surgeries, previous hip replacements or injury. Surgery to repair these kinds of complications can be extensive.

Re-do or revision total hip replacements have a much higher risk of bone fractures, torn muscles and nerve injuries. I take every precaution, but you must understand that I have less to work with, and it is in poorer condition than a first time hip.

Benefits

Total hip replacements are successful in approximately 98% of patients. Patient satisfaction is 98%.



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Pain

Most patients note that they have less pain approximately ten days after surgery than they did before surgery. We will eliminate 85-95% of your pain.

Activity

A total hip replacement will allow you to return to most of your daily functions of life without difficulty or restrictions. Higher levels of activity such as aggressive sports can make you loosen your hip, dislocate your hip or make your hip wear out sooner.

Most patients are able to return to doing the activities they love in life—hunting, fishing, hiking, camping, and low-level sports. You just won't be doing as much as you used to do. If you used to walk ten miles elk hunting, you will need to be happy with 1 or 2 miles. If you get an elk, you will need help to get it back. If you stress your hip, it will ache that night, but the next day you will be ready to go again. The hip replacement is metal and plastic or metal and metal not flesh and blood. Remember that it has limits.

Golf, swimming, cross-country skiing, and other such low-impact sports are encouraged. Many patients do play doubles tennis and other more aggressive sports, but they must realize that they may be increasing their risk of dislocating their hip and wearing their hip out at a more rapid rate.



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Pre-surgery Events

Pre-operative Counseling

I like to have a 20-30 minute counseling appointment for the patient and family with me to discuss surgery and total hip replacement options.

Scheduling of Appointments

Our surgery scheduler will schedule most of your appointments and provide you with a calendar of events leading up to your hip replacement. She will arrange for blood donations and assist with such events as a medical clearance, obtaining blood thinners, and insurance pre-authorizations. It takes her over four hours to set up your surgery. You will be notified by the hospital when to arrive the day of surgery. There is a great deal of preparation involved before your surgery, including, in many cases, nerve blocks performed by anesthesia, new laboratory work, and a great deal of paperwork. You need to be there on time or early to allow your surgery to go smoothly.

History and Physical

My physician assistant or nurse practitioner will perform a history and physical exam one or two weeks before surgery. You will need to bring all your medications to this appointment. You will receive prescriptions for pain medications and medical equipment. This is another time for counseling and questions. Don't be afraid to ask "ANY" question. You will also have an



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appointment at the hospital to review anesthesia and any hospital related questions.

Medical Clearance

For medical clearance, if necessary, I will ask your primary care physician to see you before surgery. If you are from out of town, I will also have you see a local physician for a consult. If you have a medical emergency while in the hospital, I need someone to back me up.

Blood Donation/Autologous (your own) Blood

We ask patients to donate approximately two units of autologous blood pre-surgery. While some patients do not require it, we feel it is safer to give patients their own blood if necessary. The risk of AIDS is now approximately 1 in 875,000 from blood bank blood, but the risk of hepatitis is somewhere in the region of 1 in 120,000. Some patients are unable to donate blood because they are anemic or have medical problems. Other patients may need more blood than they can donate. If I have to give a patient blood which is not their own, I don't do it unless there is a life-threatening risk and, if possible, I will discuss it with the patient.

Hospital Course



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Length of Surgery

Once you have been admitted to the hospital, your surgery will take somewhere between two and four hours. Every patient is different and every case is different. Much of the time involved is taken up with the anesthesiologists, preparation for your surgery in the operating room, and then immediate post-care in the recovery room.

Anesthesia

I prefer a continuous femoral nerve block and a general anesthesia/spinal. The nerve block will control most of your pain for 3 days. It does a great job with about 85% of the pain. You will need fewer narcotics with the nerve block, so your chances of nausea, vomiting, pneumonia, over sedation and falling are greatly reduced. Staff will be asking you regularly “what is your pain level (scale of 1-10)”. It is the best way we have of assessing what pain medicines you need. If you are hurting, tell the nurses. I order a variety of different medicines for each patient.

Parts/ Equipment Used

For the thighbone and ball replacement, I use an uncemented or bone ingrowth total hip replacement made by Johnson & Johnson/DePuy Orthopaedics (the largest manufacturer of total joints in the world). It is called the SROM Femoral replacement. It has three parts - the stem, the ingrowth sleeve and the ball.



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The stem and sleeve are made of titanium. The ball is made of extremely finely sized and polished chrome cobalt. It has an extraordinary number of sizes and shapes giving me the ability to recreate just about any hip.

For the hip socket side or acetabulum, I use a bone ingrowth cup with a modular liner made of different materials depending on the patients needs. It is called the Pinnacle Acetabular cup and is also made by Johnson & Johnson/DePuy. The Pinnacle cup is made of titanium. The liners that the ball of the hip will run on are either a super plastic called cross-linked polyethylene or extremely finely sized and polished chrome cobalt.

Uncemented, or bone ingrowth, hip stems are a newer technique than cemented hips, but ingrowth hips promise a longer lasting hip than cemented ones. The hip stem I use has a 99.5% success rate at ten years. Because I use a bone ingrowth system, I need to have a very tight and stable fit of the replacement into the bone. The replacement is actually a little bigger than the bone it is going into. Bone is much like wood and will stretch out around the replacement and then hold it tightly in place. Occasionally, because of soft bone, I have to screw in the cup to hold it snugly in place until your own bone grows into it.

The liner that fits into the metal cup locks in place by an interference fit. It is the surface that the ball of your hip will



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now run on. The plastic liner is made out of high-density polyethylene, the same material that is used to make coalscuttles. If you have ever seen trains unloading coal onto a white shining platform, that is high-density polyethylene. You can pour millions and millions of tons across it every year. However, you are much harder on your hip than the coal is on the platforms. An average person takes somewhere in the area of two to four million steps a year. Eventually, the plastic can wear out, but the design of the hip we use allows us to replace the plastic if necessary. Plastic wear makes small particles that some people's body will attack. This can lead to loosening of your hip or need for revision. Metal liners are made of chrome cobalt. New machining technology has made metal on metal hips a very good option for many people. The machining is so precise and the fit so perfect that the ball floats on a layer of fluid never touching the metal liner. A friend of mine has used metal on metal hips in Switzerland for over twenty years with excellent results. In fact, it is the only type of hip they use. Metal on metal hips wear less than metal on plastic hips and, so, look to last much longer.

With any hip replacement, you will have higher blood levels of titanium, chrome, and cobalt in your blood than a person without a total hip. With a metal on metal hip you will have even higher levels of chrome and cobalt in your blood. Orthopedic surgeons have put chrome and cobalt implants in millions of patients for



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over sixty years. There is no evidence that it causes cancer, dementia or other health problems. There are 21 reported cases of cancer associated with orthopaedic implants. In comparison to the number put into patients over the years, I am unsure what these 21 patients actually represent. You and I will choose which hip is right for you.

Governmental “Privacy” Rules

Because of governmental “privacy” rules, your family will not be able to see you until you have gone to your room, approximately an hour and a half after surgery. That day you will probably be quite sleepy and, in fact, may not remember most of the day. Family should limit their stays to one or two short visits of half an hour or slightly longer.

Seeing Dr. Van Horne in the Hospital

After surgery, I do my very best to speak to family and friends immediately after surgery (generally I write orders first. The nurses get cranky if I don't give them something to do). Rarely, I am unable to find family or am called away to an emergency. In such cases, I leave messages with the operating room staff and try to find the families later. If you have an extended family or people in far places, it helps me if you appoint a specific person for me to communicate with. That way no one feels I am ignoring him or her.



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I will see you each morning and, many times, in the afternoon or evening. Family is welcome. Occasionally, I am away at a conference or giving an out of town talk. On those occasions, my partner will see you. On the weekends, the orthopedists in town share call. Unless there are complications, I may ask them to see you so I can be with my wife and kids. I write all the orders and make all preparations for your care in advance. I almost always have my pager on unless I am out of town.

Length of Hospital Stay

Most patients are in the hospital for a primary total hip three to four days. Depending on how you progress, the physical therapists and I will determine when you are able to go home. My requirements for you to go home are that you are able to:

- 1) Walk 150-250 feet with a walker or crutches.
- 2) Get in and out of bed by yourself.
- 3) Get in and out of your bathroom by yourself.
- 4) Get in and out of your house by yourself.
- 5) Ambulate up and down any stairs by yourself.
- 6) Get in and out of a car by yourself.
- 7) You can perform your exercises independently.
- 8) Your pain is well controlled on medicines by mouth.

If you are unable to meet these requirements, you do not have help at home, or if you and I feel you are unsafe for your home environment, you will need to go to a rehabilitation hospital.



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The average stay at the rehabilitation hospital is approximately one week although some patients need 2 or 3 weeks to be safe at home.

Physical Therapy in the Hospital

Your physical therapy will start in the hospital the first day after surgery. Therapists will be getting you out of bed and start you walking on the first day. We find the sooner we get you out of bed and get you walking, the less chance you have of pneumonia, blood clots, and bed sores. Perhaps, even more important, is the longer you lay in bed, the weaker you get, so the longer it takes you to recover your strength and return to full activities after surgery.

The first ten steps are the hardest. After those first ten steps, each one is easier. You will be surprised, if you push yourself, the great gains you will make with our excellent physical therapy and nursing staff.

Part of your therapy is getting out of bed into a chair for all your meals, starting to take care of yourself and simple activities of daily living such as combing your hair, brushing your teeth, and even giving yourself a bath. All these activities are necessary for you to return to home.



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Your physical therapist will instruct you in a self-exercise program, as well as your restrictions after surgery. You need to start your exercise program immediately. This includes exercises to strengthen your leg and to decrease your chance of blood clots. Your exercises will include training in appropriate walking, getting in and out of bed, strengthening exercises and gentle motion of your legs. The strengthening exercises include straight leg raises, strengthening of your buttock muscles, heel slides, pumping your ankles and lifting your leg to the side. You will be taught how to get your shoes on and dress yourself.

Restrictions and Limitations in the Hospital and Home

Physical therapists will go over your restrictions. These are positions you can't get into, such as crossing your legs, sitting in a chair and bending forward to tie your shoe, or the worse position, pulling your leg behind your hip to put your shoes or socks on. They will be teaching you not to bend your hip more than 90 degrees or turn your foot in more than the neutral position for three months. You will not be allowed to kneel or lie on your stomach for a total of six months.

You should not drive for a total of eight weeks. This is not my rule or the physical therapist's rule; it is because of your insurance company. Many years ago the auto insurances did a study which demonstrated that patients having hip or knee surgery had reduced reflexes for a total of eight weeks after



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surgery. So, if you have an accident, they may say it is your fault. Some time after this eight-week point, you will know when you are safe to drive. We suggest that you try driving in a parking lot before you actually go out on the road. Remember, if you get in an auto accident and kill yourself, I will never forgive you. If you kill someone else, you will never forgive yourself.

Your physical therapist will also demonstrate the use of a knee immobilizer which will prevent you from dislocating your hip during the first 8 weeks after surgery. You will wear the knee immobilizer only at night.

The restrictions your physical therapist teaches you are to allow your hip to heal in tightly. Your physical therapist will also train you in using either your crutches or walker. You will need these for the first 8 weeks after surgery to, once again, protect your hip during its healing phase.

Home and Rehabilitation Hospital

Discharge Planning

The discharge planner at the hospital will be assisting you and your family in making arrangements for home care. I have standard discharge protocols, which the discharge planner will be using.



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Home Physical Therapy

If you are able to go home directly from the hospital, the discharge planner will arrange home physical therapy and/or occupational therapy to come into your house. They generally come for approximately one week.

Your home physical therapist will be reviewing your self-exercise program, making sure your house is safe, and making sure you are safe for your house. They will also be working with you on getting in and out of your car and encouraging you in your exercise program. It will be your responsibility for the first 8 weeks after your surgery to do your exercise program multiple times a day and to walk as much as possible. The more active you are the better your outcome will be at the soonest possible time.

Water exercise is a great way to get back to a high level of activity. I encourage all patients to return to a water exercise program at the 4 to 8 week point after surgery. At the 4 week point, only patients with special needs (returning to work as soon as possible) and patients in excellent physical condition will go to water exercise. I think everyone should go at 8 weeks. For those afraid or uncertain about water exercise, I can get you to a physical therapist with a pool in their office. Medicare and most insurances will only pay for a few visits, and then you have to get into a regular water exercise program. At 4 months, those



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Primer on Total Hip Replacements **An Introduction and Informed Consent**

patients who go to water exercise 3-4 times a week look like
patients 12 months out from surgery

Rehabilitation Hospitals

If you go to a rehabilitation hospital, you will be there for approximately one week to continue your exercise strengthening program or until you are safe for home. Some patients need two to three weeks to be ready for home. Medicare and most insurance will pay for a stay at a rehabilitation hospital if you are not safe to go home or do not have adequate help at home. They won't pay for it if you are.

Home Preparations and Needs

Once you are safe to go home, you don't have to have someone at home with you 24 hours a day. When you first go home, you will need someone around to make sure you are O.K. They should be able to help with such things as putting on your socks and watching you get in/out of the shower. I suggest that you have someone available to check on you several times a day, as well as someone to help with the activities around the house such as washing clothes, cooking meals, cleaning house, and, most importantly, purchasing food and helping you on errands. You will need someone to drive you shopping and to doctor's appointments.



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It will be your responsibility for the first 8 weeks after your surgery to do your exercise program and to walk as much as possible. The more active you are within the limitations of your total hip precautions, the better your outcome will be at the soonest possible time.

At the end of the 8 weeks, we re-evaluate you to see what your muscle strength and gait is like. At that point, if necessary, we will reorder physical therapy for specific training and exercise programs.

Post Operative Office Appointments, Therapy and Exercise
You will have a four-week follow-up with my physician assistant or nurse practitioner for a wound check, review your exercises, and answer questions. At eight weeks, you will have a follow-up appointment with me. I will review your progress and make decisions about activities and, if needed, more physical therapy. Your restrictions are reviewed and your activities progressed. At 8 weeks, I definitely want you back in water exercise. Three or four sessions of water exercise a week for two months will get you back to the activities you love. Water exercise in a formal class seems to work best; however, if you cannot or will not participate in water exercise you need to find another form of regular exercise. Frankly, there isn't much for me to do the first 8 weeks after surgery. I did 5% of the work.



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Now you have to do the other 95% of the work. The therapists have shown you the way, but you have to do the job.

Travel

You will probably set off the metal detectors at the airports. I will give you an identification card about your hip surgery. You have a small increased risk of blood clots for six months. The best things to do when traveling to prevent blood clots are:

- 1) Stand up or get out of your car every one to two hours and walk for 5 minutes.
- 2) Pump your feet up and down while sitting.
- 3) Take one aspirin a day starting several days before your trip.

Dental Work, Operations and Infections

For two years you should take an antibiotic before and after any dental work and before and after some surgeries. Your dentist, surgeon, or I will write a prescription for you. **Always tell your physician or surgeon that you have a hip replacement before any procedure!** Again, your doctor or I will provide you with a prescription. Infections such as bladder infections and festering wounds should also be treated immediately with antibiotics. Viral colds and flus do not require antibiotic treatment to protect your hip.



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Post Operative Pain Medicines

We will give you a prescription for your home pain medicines at the time of your history and physical. When you need refills of your pain medicine call your pharmacy Monday-Thursday between 9am-3pm. If you call Friday, we won't be able to get it filled. Because of many addicts seeking drugs, the doctor on call will not refill your pain medications at night or on the weekends.

You will need pain medication for about 2-6 weeks. Everyone is different. I change your pain medicines because your body becomes rapidly accustomed to narcotics. It is better to switch them every few weeks.



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I have read and understand the Introduction and Informed Consent on Total Hip Replacement and Frequently Asked Questions about Total Hip Replacement, including the risks and dangers. I understand that every possible risk, complication or danger cannot be included, but that Dr. Van Horne has made the best effort to inform me fully. I have been given adequate opportunity to ask questions and have had them answered to my satisfaction.

Patient Signature _____

Date ____ / ____ / ____

Provider Signature

Date ____ / ____ / ____