**Knee replacement FAQ**

Dr Sam Martin
hip and knee surgery

**What is arthritis?**

Osteoarthritis (OA) is wear to, or failure of, a joint lining down to bare bone-on-bone. Many people use the term osteoarthritis to dismiss vague aches and pains that they resign themselves to put up with, but osteoarthritis is something specific and usually treatable. Osteoarthritis can cause pain, stiffness, bony lumps, bow or knock kneed legs and swelling.

Hip and knee replacements are examples of major operations for osteoarthritis, but for other areas in the body smaller operations may be appropriate too. Surgery for osteoarthritis is generally the last resort, and there are many non-operative treatments that can also be discussed with the doctor.

Other types of arthritis, like rheumatoid or psoriatic arthritis, are often treated by a rheumatologist. An orthopaedic surgical opinion may be useful in these cases too, if a lot of damage has been done to the joints.

**What is osteoporosis?**

Osteoporosis is a condition often associated with ageing, in which bones become weaker and break more easily. It is something to ask your general practitioner about, as it is known to be associated with some medical conditions or medications.

If you are middle-aged or older and have broken a bone, it is also something to have checked out. There are tests to rule out important causes and suggest effective treatments. If someone has osteoporosis it doesn't mean they can't have a knee replacement.

Osteoporosis is sometimes confused with osteoarthritis as both of these can be shortened to osteo.

**Can my worn-out knee get too bad for an operation?**

Normally it isn’t possible to let your worn-out knee get too bad for surgery. Actually it is usually in the best interests of your health to put joint replacement surgery off as long as possible.

Your own worn knee is normally tough and won’t disintegrate or grind away to nothing. People also worry about the worn knee joint throwing other joints out and causing damage to something else, but that wouldn't typically be a reason to proceed with surgery. If a joint near or opposite the first one wears out then realistically it was probably going to do so eventually anyway.

In general, the decision to proceed with knee replacement surgery is made when the problem with the specific knee or knees is bad enough that it makes sense to proceed. The surgery is to alleviate current trouble rather than protect against problems in the future.

**Am I too old for a knee replacement? If I put it off will I be too old?**

No one is really too old for a joint replacement. It is important to make a careful and considered decision about proceeding with major surgery in all age groups, and this is especially the case in the very elderly.

A joint replacement is never out of the question as long as your medical fitness allows it. Dr Martin takes time with elderly patients to really get to the bottom of their issues and to help the patient decide whether an operation is right for them or not.

**Am I too young?**

Joint replacements don't last forever and younger people wear them out more quickly. However, the results of surgery in young people are improving, and so there probably isn't a need a for a hard and fast cut off like there used to be.

Despite this there are still good reasons to avoid a knee replacement in a younger person, if at all possible. As a rough guide, Dr Martin would try to avoid doing knee replacements under the age of 50.

If you are young and having a lot of trouble from bad knee arthritis, then it isn't a straightforward situation. That is a good reason to see an orthopaedic surgeon to talk through the different options and associated decision-making.

**How do I know if my knee is bad enough for a knee replacement?**

Firstly an x-ray or scan is necessary to confirm bone-on-bone arthritis in your worn-out knee. A knee replacement is not an option to consider without bone-on-bone wear.

After that it is important to realise that not everyone with a worn-out knee needs a knee replacement. How you know if it is for you basically comes down to whether you are having a bad time with miserable knee pain after having tried the sensible alternatives.

It is major surgery and not something you should undertake for a niggle or so that you can do something very demanding that isn't reasonable for your age group. It is, however, a very good operation for someone that is having significant trouble with day to day things due to knee arthritis.

**How long will the knee replacement last?**

This is a very common question and it's very important to understand the answer but it isn't straightforward. The results of knee replacements are very good and you can expect your joint replacement to last a long time, but this does depend a bit on your age, activity level and the underlying condition that required joint replacement surgery.

For most people the knee replacement would last more than 15 years and chances would be good that it might last as long as 20 or 25 years or more. There is, however, a small risk of failure at any time after knee replacement surgery for various reasons. There is even about a 1 in 100 chance of failure within the first year.

Examples of steps that Dr Martin takes to improve the chances of your joint replacement lasting a long time include the choice of a prosthesis based on The Australian National Joint Replacement Registry results, the use of computer navigation and careful technique during the surgery.

**How long does the operation take?**

A knee replacement usually takes around 90 minutes. Having both sides done at once takes 3 to 4 hours. A patient will often be gone from the ward for 4 hours or more surrounding their operation so do not worry if a family member is having joint replacement surgery and it seems to be taking a long time.

**What sort of anaesthetic can I have?**

Most times the operation can be done under either general or spinal anaesthetic, but there can be situations where the anaesthetist would choose a specific anaesthetic for safety. In routine cases where either is possible, Dr Martin strongly recommends a spinal anaesthetic, as that is overall a bit safer, with a better recovery and importantly better post-operative pain relief.

The trend towards more spinal rather than general anaesthetics has been one of the key things that has helped people recovery more rapidly and comfortably from knee replacement surgery in recent years.

Many people are anxious about having to hear the surgery with a spinal. Be reassured that this isn't a problem, because the anaesthetist can easily make you doze with a spinal on board. If, for medical reasons, it isn't possible to do the operation under spinal, then a general is still fine but if you have the choice go for a spinal.

**How much pain will there be after the surgery?**

The pain associated with major knee surgery isn't nearly as bad as it used to be. This is due to a combination of improvements in technique and pain relief.

Occasionally someone will have significant post-operative pain, but there are always further steps available to get the pain under control to the point where it is manageable. Dr Martin is focused on minimising your pain after the surgery and is constantly striving to improve the experience for patients recovering from knee replacement surgery.

Dr Martin strongly believes you shouldn't need to have an unusually high pain threshold to be able to recover well from a knee replacement.

Examples of the steps that can be taken to minimise pain after knee replacement are the use of a less painful incision (such as the mid vastus) approach, multimodal pain relief, minimised tourniquet time, attention to bandaging and bleeding control, amongst other things.

**How long would I stay in hospital?**

Patients are discharged when they are safe and comfortable to go home. With current techniques this is often as early as 2 days after the surgery. For appropriate patients who would find a very short stay in hospital convenient, Dr Martin can offer a 24 hour stay for the surgery.

If you are planning to go home early after the surgery it is important to have someone at home with you at first.

Dr Martin is continually working towards greater comfort and enhanced recovery for patients after knee replacement surgery. He uses a multi-faceted approach that helps patients get home from hospital quickly, safely and comfortably, where appropriate. This includes the use of a less painful incision, such as the mid vastus approach, multimodal pain relief, minimised tourniquet time and attention to bandaging and bleeding control, amongst other things.

**How long will it take until I am better?**

The recovery from major joint replacement surgery is much faster than it used to be but it is different for everyone and even different from knee to knee for people who have had both done. Some people reach the point where they are back doing what was normal for them with their bad knee before the surgery, as early as 2 weeks after the surgery.

For most people it takes 4 to 6 weeks until they are better than before the operation and reach the point where they are glad they have had the operation.

It is important not to be disappointed if your knee is getting better more slowly than average! Occasionally, people can experience a slower recovery. About 1 in 50 patients might take as long as 6 months until they are pleased with the new knee. From then on the knee would continue to get slowly better until the new knee is fully “bedded in” which can take as long as a year.

Examples of technical steps that can help facilitate an earlier recovery include the use of a less painful incision, such as the mid vastus approach, multimodal pain relief, minimised tourniquet time, attention to bandaging and bleeding control, amongst other things.

**How long until I can drive?**

It isn't recommended to drive until 6 weeks after knee replacement surgery. This is to ensure safety in reaction to an emergency. Patients who can walk well without any assistance and aren't affected by strong pain killers may be safe to drive before 6 weeks, after discussion with the doctor.

**How active can I be after the operation?**

Dr Martin recommends you avoid impact sports including running or jogging after knee replacement. Long walks, bike riding, swimming, golf or doubles tennis would be examples of reasonable levels of activity. If you are keen to undertake impact sports after the surgery it is important to talk that over with Dr Martin.

**Can it be done again?**

In most cases it is possible to re-do a failed knee replacement. In most cases it is even possible to re-do it more than once. This is called a revision. Usually it is a bigger operation with higher risks and worse results than a successful first (called primary) knee replacement. Very occasionally it may not be possible to re-do the failed joint but that really is unusual.

**Does Dr Martin use a prosthesis with good results?**

Dr Martin uses well-established knee replacement prostheses with reliable long term results confirmed in the Australian Joint Registry. He has taken extra steps to track his own results by choosing to be identified in the registry. Dr Martin also requests detailed registry reports regarding knee replacements in different situations, and different patients, to minimise the possibility of failure for each patient.

**How much physio will I need after the operation?**

The recovery after knee replacement surgery is generally much easier than it used to be and Dr Martin is continually fine-tuning his practice to make it as easy as can be. For many people intense physiotherapy is no longer necessary after the joint replacement. This is especially the case for people who have done a physiotherapy course prior to the surgery.

Often, it is now simply a matter of doing some post-operative exercises, as advised by a physiotherapist, and getting on with life. Some patients will require specific attention to some aspect of their recovery and this is something that is dealt with on a case by case basis.

**Can I have both at once?**

It is certainly possible to do both knees at once. This is reasonable in a healthy patient in their 70s or younger who has equally bad knees. The recovery is not much more difficult than one at a time. In general, people might stay in hospital 1 day longer.

Having both done at once is a bigger operation but for the right patient it is probably about as safe as having one side done and the other some time later on. People are choosing to have two at once more and more as the recovery from the operation gets easier.

**Will I need a blood transfusion?**

Blood transfusions after knee replacements are exceedingly rare these days. However, it is important to tell you doctor if you have a bleeding problem. It is also important to discuss all your medications, including over-the-counter medications and alternative treatments, as some of these have a blood thinning effect. Pre-operative self-to-self blood donation is not offered anymore, as blood transfusions are so rare there is no benefit.

**What is it like to have an artificial knee?**

It is very important to have a realistic idea of what to expect out of a knee replacement. For example 1 in 5 people will have some minor ongoing pain for good after knee replacement surgery. This should be minor and manageable with simple pain relief. Severe on-going pain is very, very unusual or there wouldn't be any point in doing the surgery. Numb patches around the incision are very common. These usually become less noticeable with time, but some permanent numbness usually persists.

Some feelings of clunking or swelling are reasonably common and usually settle with time. About 50% of people cannot comfortably kneel or squat after knee replacement surgery. It is normal for the knee to be swollen and warm for some months after the surgery. An artificial knee isn't a super knee. It isn't even as good as the healthy knee of a young person but it is normally much better than a miserable worn-out one.

**Will I trigger an alarm at the airport?**

This depends a bit on what sort of metal you have implanted and what sensitivity the security staff set their equipment to. People ask if they should carry a card or certificate for the joint replacement but that wouldn't make sense because such a document could easily be forged. The airport security staff are used to processing people who have had joint replacement surgery. Enjoy your trip!

**What can go wrong after knee replacement?**

Serious problems after a knee replacement are very unusual and Dr Martin and his team take every step to prevent them. Despite these steps, problems can still occur. For example, infection can cause early failure or on-going pain. A late infection, years after the surgery, is also possible but very unusual. The overall risk of failure due to infection is less than 1%. Failure can also occur due to wear, loosening, breakage of the bones about the knee or for other reasons.

Some degree of minor permanent pain is reasonably common after knee replacement, but on-going severe pain is very unusual, but it is possible if something went wrong. Occasionally the knee might set very stiffly or, conversely, it can be too wobbly. A large part of the surgery is getting this balance right.

Sometime the leg might end up bow legged or knock kneed, but this is also unusual with modern techniques. It is possible, but exceedingly unusually, to have a serious nerve or blood vessel injury during the surgery. In the very worst case scenario this can result in amputation. The risk of that is between 1 in 1000 and 1 in 5000.

Other risks of the surgery include problems like heart attack, stroke or blood clots. It is possible to die from a knee replacement. It is important to talk through the risks and benefits of the procedure and any specific concerns you have when making decisions about the surgery.

**What about partial knee replacements?**

A partial knee replacement is a unicompartmental knee replacement or patellofemoral knee replacement. The results of partial knee replacements can be very good when they are good, but they are also less reliable than total knee replacements.

Recent research has indicated that if a person at any age has a partial knee replacement, they are at increased risk for developing a failed re-do knee replacement by a given age in the future. That is mainly because partial knee replacements have a 2 to 3 times higher failure rate per year than total knee replacements. To minimise the risk of a patient finding themselves in a difficult situation Dr Martin does not do partial knee replacement surgery.

**Are blood clots a worry?**

There are different types of blood clots you can get after a knee replacement but there are good steps that can be taken to protect against them.

A clot in the wound is called a haematoma. That can't spread to the lungs so it isn't dangerous in that way ,but it is an infection risk. Very occasionally a knee replacement might need a haematoma cleaned out in the operating theatre. With current techniques the risk of a bad wound haematoma is very low.

The other sorts of blood clots are ones in the leg veins (DVT) that can clog up the lungs (PE). A PE can be life threatening, but there are a lot of different effective measures that the team of people caring for a knee replacement patient take to make the risk of a dangerous PE very very small.

Bruising-type colours up and down the leg after surgery are not clots. They are usually from some blood that has leaked out of the knee.

**Is infection a worry?**

Infection can be a major problem, so the surgical team takes a number of effective steps and great care to minimise the risk of infection spreading to a knee replacement.

An example of this is pre-operative screening and treatment of people who carry golden staph, whether it is the superbug or more common “garden variety” type. About a third of people in the community carry the “garden variety” golden staph on their skin and special treatment to clear it, or the worse bug, before surgery decreases the risk of infection.

With this and other steps the risk of infection is less than 1%.

Something that patients are not always aware of is that it is also possible for infection to spread to a new knee years after surgery, usually via bloodstream poisoning. Thais is very unusual but it is still worth taking steps to protect against it.

It is important to check with your Doctor if you need antibiotics before other operations or procedures in future. If you are getting a recurrent infection somewhere, such as a kidney infection from a stone, then it is very important to treat the infection and fix the underlying issue to minimise the risk of spread to your knee on each occasion.

**Do injections work for arthritis?**

There are different types of injection available. Any injection has a small risk of infection.

Cortisone injections can give temporary relief. In general, these would be used to help pinpoint which pain was from where, rather than for on-going treatment. There are some lubrication-type injections, however these are reasonably expensive and the research to support them is inconclusive. In practice they are a bit “hit and miss”.

Other injections include platelet-rich plasma or stems cells. These treatments are not yet at the point where they are useful in terms of making cartilage grow back. It is possible that stem cells may be useful in the future, but realistically that is a long way off. There are a lot of things wrong in a worn-out knee that would need fixing (probably also with an operation) for cartilage cells to take.

**What about a keyhole surgical clean out?**

Keyhole knee surgery is called arthroscopy. There are a lot of things that a doctor can do through the arthroscope including ligament reconstruction, meniscus repair or removal, cartilage surgery and removal of loose bits, but making a worn-out knee grow healthy cartilage again isn't one of them. Keyhole surgery used to be done quite a lot for arthritis but research has shown that it isn't reliable. Some people feel better after it and some people are worse. Because of this, arthroscopic surgery for arthritis isn't usually recommended anymore.