HIP REPLACEMENT SURGERY FAQ's

DR SAM MARTIN
SPECIALIST ORTHOPAEDIC CENTRE

1. 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. 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.

2. 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 other 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 there are effective treatments, too. If someone has osteoporosis, it doesn't mean they can't have a hip replacement. Osteoporosis is sometimes confused with osteoarthritis, as both can be shortened to osteo.

3. CAN MY WORN-OUT HIP GET TOO BAD FOR AN OPERATION?

Normally it isn't possible to let your worn-out hip get too bad for surgery. Actually, it is usually in your best interests of your health to put joint replacement surgery off for as long as possible. Your worn hip is normally tough and won't disintegrate or grind away to nothing. People also worry about the worn hip 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 anyway.

The decision to proceed with hip replacement surgery is generally made when the problem with the specific hip or hips is bad enough that it makes sense to progress. The surgery is to alleviate current trouble rather than protect against problems in the future.

4. AM I TOO OLD FOR A HIP REPLACEMENT? IF I PUT IT OFF WILL I BE TOO OLD?

No one is too old for a joint replacement. It is important to make a careful and considered decision about proceeding with major surgery at any age, and this is especially the case in the very elderly. A joint replacement is never out of the question so 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.

5. AM I TOO YOUNG FOR A HIP REPLACEMENT?

Joint replacements don't last forever, and younger people wear them out more quickly. This is more of an issue in knee replacement surgery than hip replacement surgery. The results of surgery in young people are improving, so there probably is no longer a need for a hard and fast age cut off as there previously was. Some young people can end up with a very bad hip. For those people, a hip replacement can be a great solution if they have tried sensible alternatives.

If you are young and having a lot of trouble from arthritis, the solution isn't necessarily straightforward. This is a good reason to see an orthopaedic surgeon who can talk through the different options and assist with the associated decision-making.

6. HOW DO I KNOW IF MY HIP IS BAD ENOUGH FOR A HIP REPLACEMENT?

Firstly, an x-ray or scan is necessary to confirm bone-on-bone arthritis in your worn-out hip. A hip 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 hip needs a hip replacement. How you know if it is for you basically comes down to whether you are having a bad time with miserable hip 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 like sleeping, walking or working, because of a miserable hip.

7. HOW LONG WILL THE REPLACEMENT LAST?

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

8. HOW LONG DOES THE OPERATION TAKE?

A hip 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.

9. 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 have helped people recovery more rapidly and comfortably from hip 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.

10. HOW MUCH PAIN WILL THERE BE AFTER THE SURGERY?

The pain associated with major hip surgery isn't nearly as bad as it used to be. This is due to a combination of improved techniques and pain relief. Occasionally, someone will have significant post-operative pain, but there are always further steps available to get the pain under control. Dr Martin is focused on minimising your pain after the surgery and is constantly working to improve the experience for patients recovering from hip replacement surgery.

Dr Martin believes you shouldn't need to have an unusually high pain threshold to be able to recover well from hip replacement surgery. Examples of technical steps that can help minimise post-op pain include the use of a less painful incision, such as the anterior approach, multimodal pain relief and careful bleeding control, amongst other things.

11. 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 **enhanced recovery for patients** after hip replacement surgery. He uses a multi-faceted approach which helps patients get home from hospital quickly, safely and comfortably, where appropriate. This includes the use of a less painful incision such as the anterior approach, multimodal pain relief and careful bleeding control, amongst other things.

12. 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 hip to hip 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 hip 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 hip is getting better more slowly than average!

Occasionally people can experience a slower recovery About 1 in 50 patients may take as long as 6 months until they are comfortable with the new hip.

Examples of technical steps that can help facilitate an earlier recovery include the use of a less painful incision such as the anterior approach, multimodal pain relief and careful bleeding control amongst other things.

13. HOW LONG UNTIL I CAN DRIVE?

It isn't recommended to drive until 6 weeks after hip 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.

14. HOW ACTIVE CAN I BE AFTER THE OPERATION?

Dr Martin recommends you avoid impact sports, such as running and jogging, after a hip replacement. Long walks, bike riding, swimming, golf or doubles tennis would be examples of reasonable levels of activity. If you are very keen to undertake impact or running sport after the surgery, it is important to talk over the risks with Dr Martin.

15. CAN IT BE DONE AGAIN?

In most cases, it is possible to redo a failed hip replacement. 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) hip replacement. Very occasionally it may not be possible to re-do the failed joint, but that really is unusual.

16. DOES DR MARTIN USE A PROSTHESIS WITH GOOD RESULTS?

Dr Martin uses well-established hip 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 hip replacements in different situations and different patients to minimise the possibility of failure for each patient.

17. HOW MUCH PHYSIO WILL I NEED AFTER THE OPERATION?

The recovery after hip 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.

18. CAN I HAVE BOTH AT ONCE?

It is certainly possible to do both hips at once. That is called bilateral simultaneous hip replacement. This is reasonable in a healthy patient in their 70s or younger who has equally bad hips. The recovery is not much more difficult than one at a time. In general, patients having both done at once 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. More people are choosing to have bilateral hip replacement surgery as the recovery from the operation gets easier.

19. WHAT IS THE ANTERIOR APPROACH/ HIP REPLACEMENT FROM THE FRONT?

There are different ways of getting into a hip joint. It is possible to do a hip replacement from the back, side, front or even top. The main thing is to get the internal components in properly and the approach doesn't matter too much. It is certainly possible to get an excellent result via any of the available approaches. There are pros and cons to the different approaches which you could consider as fine tuning. Dr Martin has decided to use the **anterior approach** as it lends itself to navigation and accurate component position, which probably helps achieve long term reliability. It has a low dislocation rate and achieving equal leg lengths is more accurate. As a side effect, it also has the benefit of less pain and a quicker recovery. In addition, it is excellent for "both sides at once" hip replacement surgery, is a simple position for the anaesthetist, and is appropriate for re-do hip replacement.

20. WHAT ABOUT THE BEARING? IS METAL, PLASTIC OR CERAMIC BETTER?

There are lots of different options for lining the artificial joint. You may have heard of the problems associated with metal poisoning from some large metal hip replacements. Dr Martin does not use linings like that. The other choices are mainly between a metal or ceramic head and a plastic or ceramic socket liner. All those materials have improved a lot in the last decade or so. This has probably been the biggest single recent improvement in hip replacement surgery.

There are pros and cons of the different materials, and it is something interesting to talk over with the doctor. Because of the "across the board" improvement, it is much less of a critical decision than it used to be. It is nearly to the point where which of the available good bearings is used hardly matters.

21. WILL I NEED A BLOOD TRANSFUSION?

Blood transfusions after hip replacements are exceedingly rare these days. However, it is important to tell your 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.

22. WHAT IS LIKE TO HAVE AN ARTIFICIAL HIP?

It is very important to be realistic about what to expect out of a total joint replacement. About 50% of people who have a hip replacement will have a normal-feeling hip afterwards. This is called a forgotten hip, when the hip feels normal to the point you forget you have had the operation. To other people the hip will not feel quite so normal and some will experience on-going aches or pains after the surgery. This should be manageable minor pain, not the severe dreadful pain experienced before the operation.

Numb patches on the skin, relating to the surgery, are also common. These usually get diminish time, but some permanent numbness often persists. Some people have the idea that an artificial joint will be a super hip: better than it ever was. While an artificial hip is not as good as the healthy hip of a young person, it should be much better than a painful worn-out one.

23. WILL I TRIGGER AN ALARM AT THE AIRPORT?

This depends on what sort of metal you have implanted and at what sensitivity the security equipment is set. People often ask if they should carry a card or certificate for the joint replacement, but 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!

24. WHAT CAN GO WRONG AFTER HIP REPLACEMENT?

Serious problems after a hip replacement are very unusual and the team led by Dr Martin go to great lengths to prevent them. Despite this, there are risks of the operation and these include infection, which can cause early failure or ongoing pain. An infection can also spread to the hip later to cause failure, but that is also very unusual. The overall risk of failure due to infection is less than 1%.
Failure can also occur due to wear, loosening or breakage of the bones, or for other reasons, including dislocation. Dislocation usually only occurs in unusual positions that are easily avoided, and the anterior approach also diminishes the risk of dislocation.

Normally the problem can be fixed with a redo operation, but if in the extreme case that that wasn't successful, it is possible to end up with no hip. Sometimes a patient can have a post-operative difference in the lengths of their legs. Usually, a new hip would be less stiff than an arthritic hip, but very occasionally a new hip can set very stiff with bone growth.

Usually, limp would be much improved after hip replacement surgery, but sometimes a limp could persist and very rarely even be worse. It is also possible to still have severe on-going pain after a hip replacement, but that would indicate a failure of the operation. This is very unusual, or we wouldn't perform the procedure in the first place.

Other risks of the surgery include nerve injury and other problems like heart attack, stroke or blood clots. It is possible to die from the surgery. 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.

25. ARE BLOOD CLOTS A WORRY?

There are different types of blood clots you can get after a hip replacement and 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 respect, but it is an infection risk. Very occasionally a hip 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 effective measures that the team of people caring for hip replacement patients always take to minimise the risk.

Bruising colours up and down the leg after surgery are most likely not clots. They are usually from some blood that has leaked out of the hip and tracked along the skin.

26. IS INFECTION A WORRY?

Infection can be a major problem, so the surgical team takes many steps before, during and after surgery to minimise the risk of infection spreading to a hip replacement. An example of this is careful 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 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.

Pre-operative screening of other infections, pre-operative skin preparation, careful technique and great teamwork in the operating theatre and careful post-operative wound care, are also very important.

With these and other steps the infection rate 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 hip years after surgery via blood stream poisoning. That 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 hip on each occasion.

27. 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. 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 expensive and current research to support them is inconclusive. Their success can be a bit "hit or 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 hip that would need fixing (probably also with an operation) for cartilage cells to take.

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