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General Information about your recovery following hip replacement using the
Anterior Approach:

Further details available on website: **www.sydneyhip.com.au**

Before Surgery:

1. Please contact the pre-admission clinic for routine blood tests and a general health check.
2. Purchase an **Antiseptic liquid Body Wash** ***(Microshield 2 Chlorhexidine Skin Cleanser*** **)** and use as a body wash in the shower for 2 days prior and the morning of surgery.
3. Cease all **blood thinning medication** warfarin, aspirin, cartia, plavix, antin-inflammatories, fish oil, glucasamine and herbal medication 1 week prior to surgery. **PLEASE CONFIRM WITH DR SOLOMON EXACT DATES TO STOP.** If you are on long term blood thinning medication I will liase with your cardiologist / GP about the timing as to when to cease these medications and if you need alternative cover.
4. **Diabetic Medication: You need to cease the following medication 3 days before surgery:** Jardiance, Jardiamet, Forxiga, Quern, Glyxambi, Xigduo XR, Stelatro, Segiuromet, Steglujan, Invokana

Ozempic: This must be stopped 4 weeks before surgery

5. If you are due to have dental work, routine colonoscopy or prostate procedures, please have this done at least 4 weeks prior to your hip surgery.
6. **Blood Iron and Vit D Level**: It has been shown that having normal iron levels and vitamin D levels will result in reduced complications. Your blood tests prior to surgery will test for these levels and if they are low, you will need to take a supplement.
7. **Smoking** should be stopped or reduced significantly prior to surgery as smoking has been shown to be associated with increased complications.
8. **Skin/Nasal swab.** As a routine I test for skin organisms. We all carry organisms on our skin. The bodywash pre op is to reduce the skin organism count. Occasionall the pre-op test will pick up a methicillin sensitive staph or a methicillin resistant staph. The DOES NOT mean you are infected but rather these bugs are on the skin. It may be that the hospital will take extra precuations with nursing care. You will be prescribed an ointment for 48 hrs to use in your nose (mupericin) to decolinise the nares.

The Surgery:

1. Admission is on the day of Surgery.

PLEASE DO NOT TAKE ANY BLOOD PRESSURE MEDICATION ON THE DAY OF SURGERY.

2. The Hospital will contact you regarding fasting and admission times.
3. You will meet the **Anaesthetist** and can discuss in detail the modes of anaesthesia and the pain relief protocol with him.

4. I have been working with the same Anaesthetic team and nursing team for over 20 years and everyone is well skilled in their roles.
5. I will always see you prior to surgery (when admitted) and will mark the skin around the hip I am replacing.
6. Surgery usually takes about 60-70 min.
7. Most patients will have a spinal anaesthetic combined with a light general anaesthetic or light sedation
8. A **urinary catheter** is inserted to prevent you having urinary retention from the spinal. The catheter is removed within 12-24hrs after surgery.
9. The spinal will wear off after about 4-5 hrs and you will regain muscle control but still should have good pain relief
10. Local Anaesthetic is injected around the wound providing added pain relief.
11. A surgical **drain** is left in the wound to drain excess blood and the drain is removed 12-24 hrs after surgery.
12. **Intravenous antibiotics** are administered for 24 hrs as a prophylaxis against developing an infection.

13. **Deep Vein Thrombosis Prophylaxis (DVT):**
    Hip Replacement surgery carries a risk of developing a DVT. Patients are given medication to help prevent this complication together with calf compressors and early mobilisation. The type of medication a patient is given will depend on their individual risk profile. Xeralto or Clexane is used as a means to reduce DVT whilst in hospital and then Xeralto for 5 days after discharge followed by Aspirin 100mg daily for a further 4 weeks.

    Calf compressors are applied to your legs whilst you rest in bed to prevent the formation of a DVT. I may ask you to wear a below knee TED stocking to reduce swelling and assist in reducing thrombosis however most patients will use calf compressors and early mobility.

14. **Pain relief:** Some patients may require a PCA (patient controlled analgesia) that allows further boluses of intravenous pain medication after surgery. Most patients seem to manage well with regular oral analgesics. It is best to reduce the strong morphine -based tablets as soon as practical.

15. Constipation (from the analgesics) can occur for a few days and you are encouraged to eat healthy foods. We can supplement this with medication to help the bowls work.

16. **Mobilisation** is the key to reduce complications including DVT and constipation. The physiotherapist will try and get you walking within 6-12 hrs after surgery and I encourage at least two walks a day. When you have the ability to get in and out of bed yourself, you should try and do a few more walks a day.

17. You will initially start **walking** with the physiotherapist who will use a walking frame for support and then when you are confident you will progress within 24-48 hrs onto crutches and then down to one crutch or a cane within 48-72 hrs.

18. **Discharge** to either home or inpatient rehab is dependent on how quickly you mobilise and recover.

    Please bring loose clothing (like a tracksuit or equivalent) to the hospital. The sooner you dress in normal cloths, the better you will feel.

Everyone recovers at a different pace. Most patients are ready for discharge after 48-72 hrs but I never discharge anyone until they are confident and mobile.

19. Patients who prefer to attend **In-Patient Rehab** are discharged as soon as the rehab bed becomes available. This can be anywhere between 3-6 days after surgery as the rate limiting step is the bed availability in the rehab hospital. The **majority** of patients who have had the Anterior Approach prefer **to go home** and have some outpatient physiotherapy.

    There is no advantage to have in-patient vs outpatient rehab and studies have conclusively shown that the outcomes are the same.

20. **Physiotherapy** and muscle strengthening after surgery through the Anterior Approach is not that difficult and many occasions patients are happy with the instructions we give on how to strengthen muscles and do these exercises at home.

21. **Discharge Medication:** Patients are given medication for pain relief when they leave hospital. You will be given a daily Clexane (blood thinner) injection whilst in hospital and upon discharge 5 tablets of Xeralto. After you finish the 5 tablets you MUST take Aspirin 100mg daily for a further 28 days, Mobility is the key to preventing DVT's. If you normally take a blood thinner like eliquis or others, you will start back on this prior to discharge and no need for the aspirin or xeralto.

22. **The Wound:** The surgical wound is closed with absorbable sutures. Keep the wound dressing (Usually changed before discharge) on for a total of 2 weeks from the day of surgery. The dressing is waterproof for showering (not bathing or swimming). At 2 weeks peel the dressing off. You may find steri-strips (wound tape) and these can be peeled off. There is no need for further dressings and you can now wet the wound directly.

    It is normal to feel **numbness** over the lateral aspect of your thigh for up to 6 months and very rarely a little longer. This is simply due to the fact that the anterior approach will always interfere with a very small skin nerve (lateral cutaneous nerve of thigh). In most people, this number and tingling feeling will completely resolved. It is purely a sensory feeling.

23. You can start to apply Vit E cream/ sorbelene or moisturiser 3 weeks after surgery. Patients who have a tendency to form Keloid scars should apply Cicacare (purchased from a pharmacy) when the wound dressing is removed at 2 weeks.

24. **Driving:** You are free to drive as soon as you feel comfortable (Anterior Approach advantage). This usually is around 10 days after surgery. Start off by sitting in the car and ensuring you can use the brake and accelerator comfortably and then do a short drive in your neighbourhood together with another driver. Do not drive if you are taking opiod medication during the day (Palexia or Endone).

25. **Swimming:** You are able to get into a swimming pool 3 weeks after surgery with no wound covering. You can start hydrotherapy 1 week after surgery provided the hydrotherapist (usually inpatient) places extra waterproofing on the wound.)

26. I prefer that you use a **walking stick** or single crutch (in the opposite hand) for 2-3 weeks after surgery to allow the bone to attach securely to the hip prosthesis.

27. **Sports**: You can return to power walking 6 weeks after surgery, golf 6-8 weeks after surgery and tennis, squash and snow-skiing 3 months after surgery. You can run on a treadmill, grass or soft sand 3 months after surgery but do this in moderation. Avoid contact sports

28. **Flying:** Local interstate flying is OK from 5-7 days after surgery. Overseas travel should be delayed for a min of 6 weeks after surgery. I recommend using compression stockings and taking aspirin for 3 days when flying overseas as well as doing foot and ankle exercises during flight.

29. **Airport Security:** Your hip replacement may activate security alarms depending on the sensitivity of the alarm. You need to tell the security staff that you have a hip replacement if it activates the alarm. Unfortunately there is no official documentation that you can carry that airport security believe advising them of your replacement.

30. **MRI scans**: There are no future restrictions on any diagnostic test that you may need for any reason. Your hip implant is " investigation friendly" and you can have any tests you like without damaging the implant.

Rehabilitation following Hip Replacement:
Many patients DO NOT require formal inpatient rehabilitation and can be discharged home with outpatient physiotherapy and a home based exercise program. Studies have conclusively shown that there is NO difference in outcomes between inpatient and outpatient rehab.

There is a false perception that by not going to inpatient rehab your result will be inferior. This is simply NOT TRUE and many published studies have proven that home discharge is as good.
I encourage patients to go home following surgery however there are patients who benefit from inpatient rehab when home circumstances are not ideal or where extra medical attention is required.

ANTIBIOTIC POLICY FOR PROCEDURES FOLLOWING JOINT REPLACEMENT
The risk of getting an infection in your replaced joint is extremely rare following routine procedures such as dental work and colonoscopies.

DENTAL procedures:For routine dental cleaning after joint replacement surgery there is no need to take antibiotic prophylaxis. For major dental work within 3 months after a joint replacement (such as root canal etc) I recommend a single dose of 2gm amoxicillin 1 hour before provided you are not allergic to amoxil. It is not necessary to take antibiotics for any dental work after 3 months provided your health is reasonably good.

COLONOSCOPY, Prostate, Bladder or Gynaecological procedures after joint replacement
Routine colonoscopy without any major biopsies or risk of bleeding do not require prophylactic antibiotic cover.
Surgery to the bladder, bowel, gynaecological and prostate surgery require a single intravenous antibiotic dose that is administered by the surgeon at the time of the procedure. Please advise them that you have a joint replacement.

Risks associated with hip replacement surgery:

Naturally there are general anaesthetic risks which are extremely small and this will be discussed in more detail by your anaesthetist.

Risks specifically related to total hip replacement include the following:

Deep joint infection (less than 1%)
Deep vein thrombosis (1%)
Fracture of the femur or acetabulum (less than 1%)
Dislocation of the hip joint (less than 1%)
Leg length discrepancy (every effort is taken to ensure equal leg lengths. (occasionally one needs to lengthen the leg slightly in order to gain stability but this is extremely rare.)
Loosening of the prosthesis over time (less than 1%)
Chronic pain (less than 1%)
Excessive swelling and stiffness (less than 1%)
Injuries to arteries and veins (less than 1%)
Major nerve injury (less than 0.1%)
Stiffness of the joint (less than 1%)
Extra bone forming around the hip joint (heterotopic ossification, less than 1%)
Reaction to metal on metal bearing (1%)
Wear of the bearing components. We expect the bearings to last at least 25 years or more.

Whilst the above risks are not meant to scare you by any means, any operation always has a small risk attached however, you should be reassured by the fact that over 97% of total hip replacement is successful if done by a skilful surgeon using tried and tested implants.

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Specialising in Surgery of the Hip & Knee

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