Patient Information

Patient information and consent to total hip replacement (arthroplasty)

Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.

- Please read this information carefully, you and your health professional will sign it to document your consent.

- It is important that you bring the consent form with you when you are admitted for surgery. You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.

- Please bring with you all of your medications and its packaging (including inhalers, injections, creams, eye drops, patches, insulin and herbal remedies), a current repeat prescription from your GP, any cards about your treatment and any information that you have been given relevant to your care in hospital, such as x rays or test results.

- Simple painkillers such as paracetamol and ibuprofen may be required after surgery. Simple bowel medication such as senna and lactulose may be required after surgery. It is suggested that you discuss with your pharmacist and have a seven day supply of these medications at home to take as you need according to the instructions.

- Take your medications as normal on the day of the procedure unless you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. If you have diabetes please ask for specific individual advice to be given on your medication at your pre-operative assessment appointment.

- Please call clinic 1 on telephone number 01223 216231 if you have any questions or concerns about your appointment. If you have any questions/concerns about your procedure, call the nurse practitioner hotline on 01223 596183.

After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

Important things you need to know
Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist.

We will also only carry out the procedure on your consent form unless, in the opinion of the health professional responsible for your care, a further procedure is needed in order to save Total hip replacement, CF186, Version 5, April 2018
your life or prevent serious harm to your health. However, there may be procedures you do
not wish us to carry out and these can be recorded on the consent form. We are unable to
guarantee that a particular person will perform the procedure. However the person
undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

About total hip replacement

The operation replaces a worn out hip joint, which has usually been damaged by arthritis, or
occasionally by another cause. The hip joint is a ball and socket joint, formed by a socket in
the pelvis (the acetabulum) and a ball on the head of the thighbone (femur). Over many
years the smooth covering (cartilage) of the joint may be worn away, exposing the
underlying bone and forming an “arthritic” joint. As a result, the joint becomes painful,
movement is restricted and function impaired.

What types of hip replacement are there?

There are many different types of total hip replacement in common use and the principles
are all similar. There are two components, one to replace the worn socket called an
“acetabular cup/socket” and the second to replace the worn ball of the femur described as a
“femoral stem”. Traditionally, hip replacements were held in place with a special bone
“cement”; the acetabular cup was made of high-density polyethylene (a form of plastic) and
the stem was made of metal (usually stainless steel or cobalt chrome) and also held in
place by bone cement.

There are some other alternatives to this that may be used. There might be an acetabular
cup with a metal backing, without cement – an “uncemented” component. This metal
acetabular cup has a porous surface, for bone on-growth to hold it in place, and the cup is
then lined with polythene or ceramic. Often one or more screws are passed though the cup
into the bone of the pelvis, for initial support of the component, whilst the bone grows onto
the socket. Sometimes an uncemented femoral stem may be used and again the bone
grows onto this to hold it in place.

Generally a metal ball will articulate on a polythene surface, to form the new hip joint itself
(the articulation). Sometimes a ceramic ball may be used instead of a metal ball and
sometimes a ceramic lining to the socket is used. Metal-on-metal hip replacements are no
longer used in this hospital.

Intended benefits

The aim of surgery is to improve your quality of life, primarily by relieving your pain. If your
hip is stiff, the range of movement may also improve, but this is not always the case.
Replacement hip surgery is considered by some to be one of the greatest surgical
revolutions in the past few decades. However, no major surgery should be entered into
lightly, so in general terms before you proceed with surgery, your pain should be intrusive
and often troubling you at night, your walking distance restricted, and pain-killers will have
often failed to control your pain. You may already be using a walking stick. You will probably be struggling to manage your everyday activities, work and recreation. You may have tried a course of physiotherapy.

**Who will perform my procedure?**

This procedure will be performed either by a consultant or a designated surgeon either competent to perform the surgery alone or under the supervision of a consultant surgeon.

**Before your procedure**

Most patients attend a pre-admission clinic, when you will meet a nurse and occupational therapist. At this clinic, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. This appointment will give you an opportunity to discuss any queries with the staff present. Various blood tests, a urine test, an electrocardiogram (an ECG or electrical recording of your heart), perhaps a chest or further hip X-ray, etc. will be taken.

Plans for your care at home, after discharge from surgery, will also be discussed.

You will be asked about your home situation, measured for crutches and advised about various aids which may be helpful and where to obtain them. These aids may include a toilet seat raise, bath board, ‘helping hand’, long shoe horn, etc. You may be instructed on the use of crutches. Please bring details of your medication to this appointment.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring all your medications and any packaging (if available) with you.

Some patients will also see the anaesthetist in a separate clinic before surgery, but this is not routine and not always necessary.

If you are a smoker, problems during surgery may be reduced and your recovery after surgery enhanced, if you are able to stop smoking for at least one week before surgery (ideally two weeks, or even permanently!). Smoking can make anaesthesia difficult and leaves you more prone to a chest infection or circulatory problems after surgery.

This procedure involves the use of general and/or regional anaesthesia. Local anaesthesia nerve blocks may also be performed, which reduce post-operative pain. We explain about the different types of anaesthesia or sedation we may use at the end of this leaflet. You will see an anaesthetist before your procedure.

Most people who have this type of procedure will need to stay in hospital two, three, or four days.

It is expected that prior to coming in for surgery, you have made arrangements for your discharge plans and any additional help that you may require whilst you recover.

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It is essential that you have support on discharge from friends and/or family as initially you will need someone to help with domestic duties and shopping.

If your level of dependency changes during your admission, the hospital can help you arrange some support/care for a period of time after surgery.

During surgery, you may lose blood. If you lose a considerable amount of blood your doctor may want to replace the loss with a blood transfusion as significant blood loss can cause you harm. The blood transfusion can involve giving you other blood components such as plasma and platelets which are necessary for blood clotting. Your doctor will only give you a transfusion of blood or blood components during surgery, or recommend for you to have a transfusion after surgery, if you need it.

Compared to other everyday risks the likelihood of getting a serious side effect from a transfusion of blood or blood component is very low. Your doctor can explain to you the benefits and risks from a blood transfusion. Your doctor can also give you information about whether there are suitable alternatives to blood transfusion for your treatment. There is a patient information leaflet for blood transfusion available for you to read.

**Enhanced Recovery Programme**

Patients undergoing hip and knee replacements are automatically entered into the enhanced recovery programme. The organisation will do everything that it can to make certain that your care around the time of your operation will be focused on getting you the best result possible. In return, we require you to ensure you are as fit as possible prior to your operation, to ensure the best possible outcome. This includes regularly performing the exercises as instructed, taking regular exercise, not smoking and weight loss reduction where possible. You will also be provided with some pre-operative carbohydrate drinks by the pre-assessment team which you are expected to drink the day before and morning of surgery. The drinks are designed to maximise your strength and energy levels prior to surgery and to ensure that you recover more quickly post operatively. This will all be discussed and instructions given by the pre-assessment team or orthopaedic nurse practitioner.

**Hair removal before an operation**

For most operations, you do not need to have the hair around the site of the operation removed. However, sometimes the healthcare team need to see or reach your skin and if this is necessary they will use an electric hair clipper with a single-use disposable head, on the day of the surgery. Please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.

**Admission to hospital**

- You will be admitted to hospital the day of the operation, and will be seen by the nursing staff and anaesthetist. Please ensure you bring all your medication in original packs, your toiletries, clothing, etc. You will be unable to eat or drink fluids for six
hours before surgery, unless advised otherwise – the exception may be to allow you to drink still water until three to four hours before the operation but you will receive these instructions when booked for surgery.

- Please make sure you tell your GP you will be in hospital, as they may be able to help you prepare for coming home again and may wish to visit you after discharge.

**Pre-existing medication**

Generally you should continue all your medication until admission to hospital. However, there are some circumstances and other considerations where this may not be the case, and some of these are detailed below:

**i. Non-Steroidal Anti-Inflammatory drugs (NSAIDS).** Drugs such as Brufen or Nurofen ®(Ibuprofen), Voltarol ®(Diclofenac), Naprosyn ®(Naproxen), Celebrex ®(etc. (there are many more) are all similar non-steroidal anti-inflammatory drugs and are used very effectively for pain relief. However, these drugs also affect the way your blood clots during surgery. You will be advised when to stop them at your pre-operative assessment appointment.

**ii. Aspirin.** Some patients take Aspirin for chest pain or to prevent a small stroke or TIA - typically a low dose of 75mg (half a junior Aspirin). If you are taking low-dose-Aspirin, you may continue taking this as usual until the time of your admission and low-dose-Aspirin will probably continue again soon after surgery. If you are on a higher dose of Aspirin (more than 75mg per day), please check in advance or let the nurse know well in advance as this may need to be stopped/reduced around 10 days before surgery.

**iii. Warfarin, Rivaroxaban, Dabigatran, Apixaban, Edoxaban or Clopidogrel , Ticagrelor or blood thinning medication**

Some patients may be taking clopidogrel, typically for a heart problem, and this generally needs to be stopped 7-10 days before surgery. Certain anti-blood clotting drugs may also need to be stopped, so again, please discuss this at your pre-operative assessment prior to surgery.

**iv. Methotrexate and other Rheumatoid Arthritis drugs.** Some patients with rheumatoid arthritis take a drug called methotrexate and this may need to be stopped a week or so before surgery. Other patients take a Cytokine Inhibitor or anti-TNF drug, which may need to be stopped. Generally this will be considered in consultation with your rheumatologist at your pre-operative assessment prior to surgery.

**v. Diabetic Drugs.** Some patients may take medicines for diabetes including tablets and injections. When you attend your pre-operative assessment appointment prior to surgery, a nurse will discuss this with you and give you written instructions to follow.

**vi. Hormone Replacement Therapy (HRT) and the Oral Contraceptive Pill (OCP).** Many types of HRT and OCP contain oestrogen, which can be associated with an increased risk of a thrombosis (blood clot), which is also a risk after hip replacement surgery. It is
generally advised to stop HRT or the OCP four to six weeks prior to surgery and not to recommence these until four to six weeks later (unless the drug is a progesterone only medication). If you have stopped the OCP, then obviously alternative contraceptive precautions are necessary, until the OCP is established again.

**Exercises**

Exercise is important both before and after any operation. To gain benefit from exercise you should gradually increase your activity daily, aim to exercise a little and often.

We recommend that you do not sit still during the day for more than one hour.

**Pre-operative exercises**

- The following exercises are suitable for people to practise before the operation
- Aim to practise your exercises four times a day.
- Build up the repetitions gradually, start with five repetitions of each exercise and increase the number each day, as you feel able, until you can manage 50 repetitions.
- Walking outside is also a good exercise, providing you can do so without increasing any pain.
- Many people benefit from water based activities, we recommend joining a suitable class at your local swimming pool.
- As well as practicing the exercises below, you may start work on the exercises labelled operation to two weeks post operation.

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| 1 | Sit on a firm chair.  
   Sit up tall.  
   Lift one arm as high as you can comfortably,  
   Lower the arm and raise the other arm.  
   Alternate the arm lifts.  
   Start with five repetitions. |
| 2 | Sit or stand.  
   Stretch out your spine.  
   Lift both arms together.  
   Stretch as far as you can comfortably.  
   Start with five repetitions. |
3. Sit upright on a firm chair. Shrug your shoulders up, down, backwards and forwards. Start with five repetitions.

4. Sit near the front of a firm chair. Relax your shoulders, Sit tall, Rest your hands on your knees. Take a deep breath in through your nose. Hold the breath for a count of five. Allow the air to flow freely out through your mouth. Repeat this three times **only**.

5. Lie on the bed, on your back. Bend both knees, rest your feet flat on the bed. Lift your bottom off the bed. Start with five repetitions.

6. If you can manage to lie flat on your front for 30 minutes each day this will help to improve your posture and ability after your operation.

7. Sit in a firm chair, lean back against the back rest. Start with both knees bent and feet resting on the floor. Straighten your knee, keeping your thigh resting on the seat of the chair. Pull your foot up firmly, feel the stretch in your calf muscles. Bend the knee and rest the foot on the floor. Start with five repetitions with each leg.

**During the procedure**

Surgery is performed under a general anaesthetic, or under a regional anaesthetic (epidural or spinal injection in the back) to numb the legs – sometimes a combination of both is used. Medication to help you feel sleepy and relaxed may be given before surgery (a pre-med). This can all be discussed with the anaesthetist when you meet them before surgery. The operation usually takes a couple of hours, but you will be away from the ward for three to four hours by the time you have woken up from surgery and can return to the ward.
wound passes from the upper thigh, over the bony prominence of the hip and then back
towards the bottom.

**After the procedure**

When you first come round after surgery, you will have an oxygen mask on and will be in
the “Recovery Area”, near to the operating theatre. This is to allow close nursing
observation and supervision before you return to the ward. You may have a triangular
shaped pillow between your legs, to help control your legs initially and help keep the hip
correctly in place.

You will have a tube (intravenous drip) in the arm, to give you fluid and antibiotics following
surgery. Sometimes additional pain-relief, or a blood transfusion, is given through this drip.
You may also have one or two tubes (drains) coming from your wound attached to a bottle -
this collects fluid/blood which seeps from the operating site for a few hours after surgery.
Some patients require a urinary catheter (tube into the bladder) for a period after surgery.
Initially you will obviously have some pain from your operation site and this will be controlled
either through the drip, with injections, or tablets once you are able to eat and drink.

Sometimes blood lost during and after the operation can be collected, washed or filtered
and returned to you. However, if the blood loss is too great for this technique, then you may
need to be given a blood transfusion during or after the operation.

**Progress after surgery**

**Eating and drinking.** After this procedure, you should not have anything to eat
or drink until advised - this is usually about one to two hours.

**Getting about after the procedure.** Everybody recovers at different speeds,
dependent on your age, your general health and the nature of your surgery. As
soon as you wake up after surgery and are able to, you should start wiggling your
 toes and feet, bending your foot and ankle up and down, ten times every half an
hour. This helps the circulation in your calf. You can gently try to bend your knee,
rolling your thigh outwards at the same time. You will be allowed to sit up at
approximately 40º in bed. For the first few days, you should do regular deep
breathing exercises, to keep your lungs expanding, and to prevent a chest
infection.

On the day or the day after surgery, some of the tubes attached to you will be
removed. The physiotherapist will see you, assisting you to stand and possibly
walk – where possible patients start mobilising out of bed on the day of surgery.
Everyday in hospital after surgery, the physiotherapist will again assist you with
exercise, and start you walking with crutches.

Soon after the surgery, you be able to get out of bed and sit in a high chair and
use the toilet with a raised seat. It is essential that you do not sit in a chair which
is too low following surgery. Sitting in a low chair will allow your hip to flex (or bend) too far and this can cause a dislocation of the joint. During your stay in hospital, you should keep the pillow between your legs whilst in bed.

With help from the physiotherapist and nursing staff, your mobility will gradually increase and your independence will improve.

**Leaving hospital.** Most patients go home around two to four days following surgery – some may go earlier and others may need a longer hospital stay. Before you come to hospital for your surgery, arrangements can be made for the hire or purchase of certain aids, including a toilet seat raise, shower chair, walking frame, crutches, walking sticks and a gadget to help you put on your surgical stockings and socks. The physiotherapist will discuss this with you.

Please think about your home environment before you come to hospital for your surgery and discuss any problems with the medical staff, nursing staff, or your physiotherapist. You may have stairs at home and the physiotherapist will assist you to safely climb stairs again.

You will be given some surgical elastic support stockings in hospital to help prevent blood clots forming in your legs during and after surgery. You should wear these for six weeks, if you can tolerate them during this period.

If you live alone, you will find it helpful for a friend or relative to stay with you for a short while after you first return home. If your bed is upstairs, you may wish to consider bringing the bed downstairs initially. If access to a toilet is difficult, possibly a commode would be helpful. You will also need someone to help you with domestic chores and you may have difficulty getting to the shops, so will need someone to do your shopping.

Once you are home, continue with the exercise regime you discussed with the physiotherapist. Always try to get out of bed on the same side as your operation for the first six to eight weeks. Also, lie flat on your bed for half an hour twice a day, which will help stretch your hip. Sleep with a pillow between your legs for the first six weeks. When you are sitting, be it on a chair or a bed, never let your knee be higher than your hip. If this does happen, your hip will bend (or flex) too far, and may pop out of joint (dislocate). Likewise, when you get up from a chair, shuffle yourself to the front of the chair and push up from the arms, without leaning forward too far. Again, if you lean forward too far this may flex (or bend) your hip too far and the hip may pop out of joint.

The physiotherapists can advise you about obtaining a toilet seat raise, walking aids, commodes, shoe and stocking gadgets. Some of these they can supply, others you may need to hire from the Red Cross.
Special measures after the procedure: The wound is covered with a white absorbent and plastic dressing. Sometimes fluid accumulates under this dressing, so this may need to be changed. Stitches may be buried underneath the skin and do not need to be removed, or sometimes metal staples are used, which are removed around 12 days after surgery.

It is advisable to go for walks on a daily basis. As the days go by, you will gradually be able to walk a greater distance. For the first six weeks you should expect to walk initially with two and subsequently one crutch for support. Some people are allowed to walk without the support of crutches at an earlier stage; others may need crutches for longer. You will be seen in clinic about six weeks after surgery.

Even in the long-term, many people find a walking stick helpful after a joint replacement and it helps to boost your confidence - you would need to hold it in the opposite hand.

Most patients start driving six to eight weeks after surgery, if they have a manual car. If you have had left hip surgery and drive an automatic car, you may be able to start driving at an earlier stage – two to four weeks. You should let your car insurance company know that you have had a hip replacement.

Even in the long-term, there is a small risk your hip can dislocate and pop out of joint. Remember always to sit on a chair with your hip higher than your knees. Try to sit down with your legs slightly apart. Do not cross your legs. Be careful sitting in a bath and preferably use a shower, especially for the first few months after surgery. Generally, it is safe to bend your hip up and let your thigh turn/roll outwards, but do not bend your hip up and turn/roll your thigh inwards.

Check-ups and results: You will be seen in clinic about six weeks after surgery, when you will be able to discuss your progress and any problems.

As you progress

- Even in the long-term, many people find a walking stick helpful after a joint replacement (which you need to hold in the opposite hand). Continuing to use a walking stick is by no means a disgrace - many people find it helps to boosts their confidence.
- The most difficult part of your recovery is the first few days following surgery. You will also find it difficult for the first few days when you get home. The most rapid improvement is expected in the first six to eight weeks, but you will continue getting an improvement, with your hip feeling more comfortable, your range of movement improving, and your confidence improving, for several months. Many patients report progressive improvement for 12 months or more after the operation.
- Even in the long-term, there is a small risk your hip can dislocate (pop out of joint). Remember always to sit on a chair with your hip higher than your knees. Try to sit
down with your legs slightly apart. Do not cross your legs. Be careful sitting in a bath and preferably use a shower, especially for the first few months after surgery.

**Early post-operation exercises**

After your operation it is important that you start moving as soon as possible. This will help to reduce the risk of blood clots, improve the circulation which helps healing tissues, and reduces the risk of swollen legs and pressure areas.

You will have your first physiotherapy session within 18 hours of your operation; this may be on the same day as your operation. You will be assisted to sit on the side of the bed and take a few steps. Most people are able to place weight on the operated leg straight away, but will require the help of some aids, such as crutches.

If you are finding it difficult to move your feet, this may be due to the type of anaesthetic you have received, discuss this with your nurse or therapist and they will be able to explain any numbness.

Aim to practise some exercises every hour that you are awake. A little and often is better than exercising a lot once a day. Each day increase the number of repetitions by one until you can comfortably manage the maximum suggested.

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<tr>
<th>No.</th>
<th>Exercise Description</th>
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<tbody>
<tr>
<td>1</td>
<td>As soon as you wake up after your operation, start moving your feet in circles. Aim for at least 10 big circles with each foot.</td>
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<tr>
<td>2</td>
<td>Move your feet firmly up and down from the ankle. Feel the stretch in your calf muscles as you pull your foot up. Repeat 10 times with each foot.</td>
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<td>3</td>
<td>Lie or sit in a relaxed position. Relax your shoulders. Take a slow deep breath in through your nose. Hold the breath for a few seconds then release the breath through your mouth. Repeat three times every 30 minutes when you are awake.</td>
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</tbody>
</table>
| 4 | Lie on your back on the bed you may have pillows under your head for comfort.  
Keep your heel on the bed.  
Bend your knee up sliding your foot towards your bottom.  
If this exercise is difficult, place a large plastic bin liner under your foot, this will reduce any friction and make the movement easier.  
Start with five repetitions and increase until you can manage 20 repetitions. |
|---|---|
| 5 | Lie on your back on the bed, you may have pillows under your head for comfort.  
Keep your knees straight.  
Slide one leg out to the side towards the edge of the bed. Slide the leg back to the middle.  
If this exercise is difficult, place a large plastic bin liner under your foot, this will reduce any friction and make the movement easier.  
Start with five repetitions and increase until you can manage 20 repetitions |
| 6 | Lie on your back on the bed, you may have pillows under your head for comfort.  
Bend both knees and place your feet flat on the bed.  
Push on your feet and your shoulders.  
Lift your bottom off the bed.  
Start with five repetitions and increase these until you can manage 10 repetitions |
| 7 | Sit in a firm chair, lean back against the back rest.  
Start with both knees bent and feet resting on the floor.  
Straighten your knee, keeping your thigh resting on the seat of the chair.  
Pull your foot up firmly, feel the stretch in your calf muscles.  
Bend the knee and rest the foot on the floor.  
Start with five repetitions with each leg. |
| 8 | In standing, hold a firm support.  
Stand up tall and straight, with both feet fully on the floor.  
Keep your knee straight and lift the operated leg behind you.  
Keep your head and shoulders still – do not lean forward.  
You should feel the muscles in your bottom tighten up.  
Start with five repetitions and increase these until you can manage 20 repetitions. |
In standing, hold a firm support.
Stand up tall and straight, with both feet fully on the floor.
Keep your knee straight and lift the operated leg to the side.
Keep your toes pointing forward.
Keep your head and shoulders still – do not lean to the side.
You should feel the muscles at the side of your hip tighten up.
Start with five repetitions and increase these until you can manage 20 repetitions.

Practise walking with your elbow crutches.
Aim to stand and walk every hour during the day.
Stand tall, head up.
Move both crutches forward.
Take the operated leg to rest on the floor between the crutches then step through the crutches with the un-operated leg.
Aim to walk 10 meters on the first day and increase the distance every day.

To walk downstairs.
Hold the rail with one hand.
Hold a stick or crutch (aid) in the opposite hand.
Take the aid down one step.
If you are still using two sticks or crutches, hold the spare aid with the other aid, hold the spare aid horizontally. You will be shown how to do this, by the physiotherapist, when in hospital.
Take your operated leg down the first step, bring the un-operated leg down to the same step.
Repeat all the above for each step until you reach the bottom.
Then use your aids as normal.

To walk upstairs.
Hold the rail with one hand.
Hold a stick or crutch (aid) in the opposite hand.
If you are still using two sticks or crutches, hold the spare aid with the other aid, hold the spare aid horizontally. You will be shown how to do this, by the physiotherapist, when in hospital.
Take the un-operated leg up one step.
Take your operated leg up the first step, to join the un-operated leg.
Then bring your walking aid(s) up to the same step.
Repeat all the above for each step until you reach the top.
Then use your aids as normal.

To get into a car.
Ask the driver to park away from a kerb.
Sit in the front seat.
Open the door wide.
Ask the driver to slide the seat back to give maximum leg room.
Sit onto the side of the seat.
Slide your bottom across the seat towards the hand break.
Lift your legs into the foot well, over the sill and turn to face forwards.
To get out of the car.
Park away from the curb.
Open the door wide.
Lift your legs out of the car onto the path.
Slide your bottom towards the side of the seat.
Stand up. It may help to hold the side of the car to assist in the stand.

Significant, unavoidable or frequently occurring risks of this procedure

A hip replacement is a major surgical operation and usually a very successful operation. Over 90% of people come into hospital, have the operation, go home again and recover with no particular problems. Surgery should not be undertaken lightly and it is inevitable that with major surgery that there are some risks. A small proportion of patients do have lasting symptoms, which are difficult to account for or explain/rectify.

The common risks are discussed below. These are risks you should be aware of, but of course try not to worry about them too much. Remember again that over 90% of people are very pleased with their hip replacement, their pain is relieved, and their quality of life is dramatically improved.

1. Infection. With careful surgical techniques and antibiotics, infection is a rare complication. It is, however, a very serious complication and on a few occasions the artificial joint replacement needs to be removed to control the infection.

2. Blood Clots. Blood can clot in the legs following surgery, causing a ‘thrombosis’. To try and prevent this, various measures are taken whilst you are in hospital and you are given special elasticated stockings to wear. Occasionally a blood clot can break off and go to your lungs (a pulmonary embolism), causing severe breathing problems, or even death. To reduce the risk of a blood clot developing whilst in hospital, the majority of patients are given a daily injection of a drug to thin the blood. On going home you will need to continue with these injections for four weeks; these may be given by yourself or a relative. Most patients find this much easier than they had expected.

3. Chest and Urinary Tract Infections. These are common to all surgical procedures. You can try and prevent a chest infection with breathing exercises.

4. Dislocation. This is most common in the early period following surgery and may be caused by crossing your legs, twisting badly on your leg, or sitting in a low chair. Usually a brief anaesthetic is required to get the hip back into joint. On rare occasions the hip may need to be revised (further surgery) to control this problem.
5. **Leg Length.** We always try to give you equal leg length following surgery, but some variation is common and sometimes the leg is lengthened. Usually this is not noticeable, but on rare occasions, the heel and sole of one or other of your shoes may need to be raised. Even before surgery, some patients have had unequal leg length for many years and become accustomed to this, often without even noticing it.

6. **Nerve damage.** There are major nerves around your hip and these can occasionally be stretched or damaged, leading to profound weakness and loss of feeling in your thigh, leg or foot, which can sometimes be painful.

7. **Stroke and major chest problems, such as a heart attack.** These are very occasional but catastrophic consequences of any major operation. Whilst extremely unlikely to happen, when an operation is recommended, this is always a consideration. Very rarely, someone can have a major heart attack, major stroke, or other medical problem, from which they do not recover. There is a very small mortality rate (risk of death) with such major surgery.

8. **Loosening, wear and long term failure.** It is inevitable that all hip replacements wear with the passage of time. Failure of a hip replacement is usually caused by loosening. It is very rare that components themselves break. Loosening is a progressive problem, over many years. As a rough guide, 10% of hip replacements will fail by 10 years, but around 80-85% of hip replacements are still in place and functioning well 15 years after surgery. On rare occasions there can be problems in the early period after surgery, necessitating further surgery.

9. **Swelling.** It is common for your leg and ankle to be a little swollen for some time after surgery. This gradually improves over a period of months. If you are concerned about this after discharge from hospital, you should see your GP or specialist again. It may help to elevate the foot of your bed by 10-15cms, or put some old duvets/blankets under the mattress, for a few weeks after surgery.

10. **Other medical problems.** Major surgery can sometimes be followed by other unexpected medical problems. These could include poor kidney function with reduced urine output, the gut temporarily failing to function, constipation, poor bladder function, a chest infection, etc. To try and prevent constipation, which can be exacerbated by the pain killers required after surgery, laxatives are often prescribed.

11. **Anaesthesia,** both general and regional, for any operation carries risks of its’ own. These risks are small, but can be significant, and will be discussed with you by the Anaesthetist when they see you before the operation.

12. **Trochanteric Bursitis.** Some patients develop discomfort/pain/tenderness after surgery, over the hip wound and bony prominence of the hip, described as ‘Trochanteric Bursitis’, which can cause irritation for some time in a minority of patients. Generally this settles with time, facilitated by physiotherapy and/or an injection to the tender area, but occasionally persists and rarely can be difficult to resolve.
Other points to remember

1. **Sitting.** As already mentioned, avoid sitting in low chairs. When you stand up from a chair, keep your operated leg in front of you and take the weight through your unoperated leg. You should shuffle forwards to the edge of the chair before attempting to stand and push up with your arms. Sitting down is the reverse process of standing, gently lowering yourself to the front of your chair, taking weight through your unoperated leg. Remember not to cross your legs when sitting.

2. **Sleeping.** Sleep on your back for the first six weeks following surgery, keeping the pillow between your legs at night during this period. Later on it is usually better to sleep on your operated leg.

3. **Getting out of bed.** Get out of bed on the same side as your operation for the first few weeks, if possible. Again, standing up from bed is similar to standing up after sitting in a chair. If your bed is very low, you may need to have a higher bed.

4. **Driving.** When you are driving, if possible use a two-door car and have the seat as far back as possible. Gently lower yourself into the car, taking weight through your unoperated leg, keeping your operated leg straight in front of you. You can start driving again, usually six to eight weeks following surgery, unless you have had a left hip replacement and have an automatic car. You must be able to do an emergency stop and should inform your insurance company before you start driving again.

5. **Sexual intercourse.** You can soon enjoy normal sexual activity following surgery. Remember that you must not bend your hip further than a right angle, or 90º, but it is usually safe to let your knees roll out. Initially it is best for you to be on your back, but as time goes by, you will be able to become more adventurous.

6. **Toilet seat raise.** You should continue to use this for 6-12 weeks after surgery.

7. **Socks and shoes.** If you have difficulty putting on shoes or stockings, use a long shoe horn, or a special gadget which is available from the Physiotherapist to help.

8. **Sports and hobbies.** Unless you have particular problems, you can re-start hobbies such as gardening, bowling, gentle dancing, golf and cycling around three months after surgery. You can start swimming three to four weeks after surgery, once the wound is well healed. Contact sports should be avoided, as should vigorous exercise. If you are swimming, it is traditional to recommend avoiding breaststroke as some patients loose the rotational kick required, but many can still manage breaststroke. Many patients return to playing doubles tennis. Some patients return to skiing, horse riding, or other more extreme activities, but rather at their own peril.
Revision surgery

As already mentioned, a few hip replacements do run into early problems. Some hip replacements wear out or loosen and become de-bonded from the bone at a later date, requiring a re-do of the replacement. Further surgery is described as “Revision Surgery”.

Revision surgery is complicated and the nature of surgery required is different in every case. However, the general principles of surgery are exactly the same, although the duration of surgery and the post-operative recovery is more prolonged. Different or more specialised implants are required to reconstruct the hip, sometimes using bone graft. The general plan of post-operative mobilisation, care and precautions are often identical. Sometimes it is necessary to avoid weight bearing for the first few weeks and keep you walking with crutches for longer. Unfortunately, as a revision procedure is a more major operation, the potential complications are also greater.

Alternative procedures that are available

An alternative to this surgery is a decision not to have surgery. To get some symptom control you may use pain-killers, physiotherapy, walking stick or wheelchair. We will discuss with you the implications of deciding not to have surgery.

Information and support

The occupational therapists and physiotherapists can advise you about obtaining a toilet seat raise, walking aids, commodes, shoe and stocking gadgets.

Useful contact numbers:

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic 1</td>
<td>01223 217231</td>
</tr>
<tr>
<td>Nurse Practitioner Hotline</td>
<td>01223 596183</td>
</tr>
<tr>
<td>Waiting list</td>
<td>01223 349390</td>
</tr>
<tr>
<td>Red Cross, Cambridge</td>
<td>01223 357 376</td>
</tr>
<tr>
<td>Homecraft Supplies Ltd</td>
<td>01162 375 955</td>
</tr>
<tr>
<td>Bee Mobile</td>
<td>01223 246 425</td>
</tr>
<tr>
<td>Keep Able Ltd</td>
<td>01933 679 426</td>
</tr>
</tbody>
</table>

Anaesthesia

Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. **The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness.** Sometimes different types of anaesthesia are used together.

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:
• your general health, including previous and current health problems
• whether you or anyone in your family has had problems with anaesthetics
• any medicines or drugs you use
• whether you smoke
• whether you have had any abnormal reactions to any drugs or have any other allergies
• your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

Pre-medication
Occasionally you may be prescribed a 'premed' prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. *Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.*

Moving to the operating room or theatre
You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia**, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

General anaesthesia
During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.
Regional anaesthesia

Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic.

Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

Local anaesthesia

In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted. Some sensation of pressure may be present, but there should be no pain. Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthetic will be given by the doctor doing the operation.

Sedation

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a ‘sleepy-like’ state. Sedation may be used as well as a local or regional anaesthetic. The anaesthesia prevents you from feeling pain and the sedation makes you drowsy. Sedation also makes you physically and mentally relaxed during an investigation or procedure which may be unpleasant or painful (such as an endoscopy) but where your co-operation is needed. You may remember a little about what happened but often you will remember nothing. Sedation may be used by other professionals as well as anaesthetists.

What will I feel like afterwards?

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

What are the risks of anaesthesia?

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or...
performed in an emergency.

**Very common (1 in 10 people) and common side effects (1 in 100 people)**
- Feeling sick and vomiting after surgery
- Sore throat
- Dizziness, blurred vision
- Headache
- Bladder problems
- Damage to lips or tongue (usually minor)
- Itching
- Aches, pains and backache
- Pain during injection of drugs
- Bruising and soreness
- Confusion or memory loss

**Uncommon side effects and complications (1 in 1000 people)**
- Chest infection
- Muscle pains
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)

**Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications**
- Damage to the eyes
- Heart attack or stroke
- Serious allergy to drugs
- Nerve damage
- Death
- Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.

For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)
Information about important questions on the consent form

1  Creutzfeldt Jakob Disease (‘CJD’)

We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2  Photography, Audio or Visual Recordings

As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

3  Students in training

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4  Use of Tissue

As a leading bio-medical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.
Privacy & dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are now a smoke-free site: smoking will not be allowed anywhere on the hospital site.
For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:

If you would like this information in another language, large print or audio, please ask the department where you are being treated, to contact the patient information team: patient.information@addenbrookes.nhs.uk.
Please note: We do not currently hold many leaflets in other languages; written translation requests are funded and agreed by the department who has authored the leaflet.

Document history
Authors: Trauma and orthopaedics department
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Version number/Ref: 5 / CF186 / Doc id 31656
A total hip replacement is intended to allow the hip to function in a similar way to the natural joint by reducing hip joint pain and improve mobility.

Common (2-5%): pain, swelling (including in the ankle), bleeding and bruising, stiffness, altered leg lengths, joint dislocation, blood clots (deep vein thrombosis or pulmonary embolism) and long-term wear requiring revision surgery.

Less common (1-2%): infection.

Rare (<1%): persistent on-going pain, permanent muscle weakness around the hip causing a limp, fracture of the bones around the hip, nerve damage and foot drop, stroke, heart attack and death (0.1%).

The operation and anaesthetic together take around 2.5 hours, but sometimes longer. There is an incision, typically in the side of the hip area. A typical length of stay in hospital is two to four days. Alternatives to this surgery include: losing weight, stopping strenuous exercises or work, physiotherapy and gentle exercises, medicines (eg anti-inflammatory drugs: ibuprofen or naproxen) or using a stick or a crutch.
Total hip replacement

**d)** any extra procedures that might become necessary during the procedure such as:
- Blood transfusion
- Other procedure (please state)

2 The following information leaflet has been provided:
Total hip replacement (arthroplasty)

Version, reference and date: **CF186 version 5 April 2018**

or □ I have offered the patient information about the procedure but this has been declined.

3 This procedure will involve:
- General and/or regional anaesthesia
- Local anaesthesia
- Sedation
- None

Signed (Health professional):  
Date: __________

Name (PRINT): ____________________________  
Time (24hr): __________

Designation: ____________________________  
Contact/bleep no: ____________________________

**C** Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.  
**Important:** please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

1 **Creutzfeldt Jakob disease (CJD)**
Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.
- □ Yes
- □ No

2 **Photography, Audio or Visual Recording**
   a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.
   - □ Yes
   - □ No
   
   b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.
   - □ Yes
   - □ No

3 **Students in training**
   I agree to the involvement of medical and other students as part of their formal training.
   - □ Yes
   - □ No

Patient safety – at the heart of all we do

Addenbrooke's Hospital | Rosie Hospital

File: in the procedures and consents section of the case notes

CF186 version 5 April 2018
Use of Tissue

a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.

I have listed below any procedures that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): ___________________________ Date: ____________ / __________ / __________
Name of patient (PRINT): ___________________________ 

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.
Signed: ___________________________ Date: ____________ / __________ / __________
Relationship to patient: ___________________________

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.
Signed (Witness): ___________________________ Date: ____________ / __________ / __________
Name of witness (PRINT): ___________________________
Address: ___________________________

For staff use only:
Hospital number:
Surname:
First names:
Date of birth:
NHS no: __________ / __________ / __________
Use hospital identification label
Consent Form

Total hip replacement

D Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): .................................................. Date: ...D.D./M.M./Y.Y.Y.Y.

Name (PRINT): ................................................................. Job title: .................................................................

Please initial to confirm all sections have been completed:

E Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): .................................................. Date: ...D.D./M.M./Y.Y.Y.Y.

Name (PRINT): .................................................................

Or, please note the language line reference ID number:

F Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): ................................................................. Date: ...D.D./M.M./Y.Y.Y.Y.

Signed (Health professional): ........................................... Date: ...D.D./M.M./Y.Y.Y.Y.

Name (PRINT): ................................................................. Job title: .................................................................