

## Anterior Approach Hip Replacement Information Sheet

“My goal is to provide my patients with a hip that gives them a lifetime of good function with minimal or no pain. All the decisions I make during the planning and performing of a hip replacement, including surgical approach and implant selection, are done with the best interests of my patients in mind. I want to do as minimally invasive an operation as I can do, but still adhere to the surgical principles that are required to make a hip replacement function well for many years. Another main goal is to avoid any complications that can prolong your recovery. The following is a brief summary of the hip replacement experience. Any questions that arise can always be answered in person. Thank you for your trust and allowing me to help you improve your quality of life”

-Alexander C. Gordon, MD

Total hip replacement is one of the most successful operations ever developed. Hundreds of thousands of patients each year benefit from the pain relief and improved function obtained from replacing their damaged hip joint. Although it is a commonly performed surgical procedure today, it has taken decades to develop the principles and implants that allow hip replacement to be a successful operation. It is beyond the scope of this letter to describe all of these principles. Any questions that come about after reading this can be addressed in person.

### **Pain Management**

This is one of the most concerning areas for patients. Hip replacement has typically been thought of as a painful operation and recovery. We are doing several things to alleviate the pain associated with the operation.

### **Pre-medication**

Often, we will use medications before surgery to start the pain management program. This can consist of medications called Celebrex, Opana, and/or Oxycodone.

### **Anesthesia**

Spinal and epidural anesthesia block the nerves that transmit pain signals to your brain. This can last from many hours to days.

### **General Anesthesia**

There are several factors that determine what the best anesthesia for a given person is.

Some studies have shown that a spinal and/or epidural anesthetic are very effective in relieving pain and assisting in a faster recovery after hip replacement surgery. These so-called regional anesthetics can also lead to decreased blood loss during surgery and may lessen the need for a transfusion.

### **Post-operative**

Narcotic medications, like morphine and similar substances, are the traditional ways to manage pain post operatively. We use these medications frequently, but they do have side effects such as nausea and drowsiness. If we can minimize the use of these medications and still manage your pain well, it can help in a faster recovery.

Usually by 2-3 days after surgery, oral medications like hydrocodone are effective in managing pain. These are used for 3-4 weeks after surgery, with a transition to non-narcotic medications after that. Hopefully, by 6 weeks after surgery, you will not need prescription pain medication.

### **Pre-surgical medication use**

If you take pain medication prescribed by a physician prior to hip replacement, it may make it difficult to manage your pain after surgery. Please let us know any and all medications, as well as doses and frequencies, you are taking.

### **Anterior Approach Hip replacement surgery**

The operation itself is performed in about 90 minutes.

There is an incision over the front of the hip joint (Anterior Approach)

The “ball” of the femur is removed and the bone is shaped to accept a titanium implant. This will be the anchor for the new ball. The hip socket (acetabulum) is then prepared for a titanium implant as well. A new liner is then inserted into the implant which acts as the new cushion for the hip joint. Dr. Gordon has intimate knowledge of the principles and practice of hip replacement surgery. This includes surgical technique and implant selection.

The incision is closed with dissolvable stitches and the skin is closed with a skin adhesive.

After 60-90 minutes in the recovery room, you will be taken to your room.

### **Hospital Room**

Once in your room, you will be in your bed. There should be an overhead frame to help you maneuver in bed. There will be pulsing booties on your feet. These simulate the pressure in your feet while walking and are meant to help prevent blood clots. If you need to get up or move in your bed, please call the staff. Trying to get out of bed by yourself can be dangerous and could lead to a fall.

You will have blood drawn each morning to check your blood counts and blood thinning levels. More blood draws may be necessary depending on the situation.

### **Hospital Stay**

You will be started on blood thinning medication to help reduce the risk of blood clots. The most typical medication we use is Coumadin, also called warfarin. This is given once a day, usually in the evening. This will be continued for 3 weeks and will need to be monitored by blood tests at least twice a week. In certain circumstances we also use an injectable blood thinner called Lovenox (enoxaparin).

The bandage will be changed on the second day after surgery. You will get 2 therapy sessions each day. I usually do not restrict the amount of weight you can put on your hip, even immediately after surgery. Therapy starts with simply getting out of bed into a chair and progresses to walking in the hallway within

2-3 days. Monitoring of your vital signs, blood counts, and pain levels is done throughout the hospital stay.

By the second or third day after surgery, most people are ready for discharge.

### **Recovery**

The time-frames discussed below are guidelines and are not absolute landmarks. The range of normal is quite wide and we will discuss your progress at each visit.

#### **3 weeks**

You should be walking into the office. Some people are using no support, some are using canes, and others using walkers. This depends on many factors

You will stop your Coumadin after this visit.

#### **6 weeks**

Hopefully your walking be improved so that you can almost walk normally

You should no longer need prescription pain medication

This is the point at which many people can return to work in some capacity. Return to work is different for each individual and should be discussed prior to surgery.

#### **12 weeks**

Therapy should be done or almost completed

Pain should be minimal

You're hip may not be totally "normal" by this point, but you should be able to perform most activities.

You will be discharged from your post surgical follow-up period, with annual checkups thereafter.

Complications and other factors affecting hip replacement

### **Infection**

Infection is a serious complication that can occur after hip replacement. We take many steps to prevent infection after surgery including the use of pre-operative skin cleansers, appropriate antibiotics, and a sterile operating room environment. Despite these precautions infection can occur in some cases. The risks are dependent on many factors. If an infection does occur, timely and aggressive treatment is necessary. Often times more surgery is needed, and in some cases removal of the hip replacement is necessary. Poor circulation, diabetes, and poor nutrition are some conditions that increase the risk of infection.

### **Wound healing problems**

Problems with wound healing are rare, but serious. Conditions such as diabetes and obesity put people at increased risk for this complication. Previous non-hip surgery with previous incisions on the hip are also a risk factors. This can necessitate further surgery and sometime major reconstruction if it occurs.

### **Nerve or blood vessel injury**

Injury to nerves or blood vessels around the hip can occur with knee replacement. The best prevention is good surgical technique. These are extremely rare complications, but can be very disabling if they do occur. Diabetes, poor circulation, hardening of the arteries, and significant deformity are some of the factors that increase the risk of this happening.

With the anterior approach, however, numbness in the lateral thigh is a very common occurrence. This has to do with the Lateral Femoral Cutaneous Nerve and its location near the hip joint. While many patients have numbness, studies have shown that this does not affect function or the outcome of a hip replacement.

### **Blood clots**

Blood clots in the veins, called deep vein thrombosis, can occur commonly after hip replacement surgery. We use Coumadin, also called warfarin, to prevent blood clots. This is a pill taken once a day and must be monitored by blood tests. Other agents such as an injection may be used if you are at increased risk. Blood clots may be silent or may lead to swelling of the leg. In some instances, the blood clots break loose and travel to the lungs. This is called a pulmonary embolism, and in some cases may be fatal. Your surgical team is very aware of this possible problem and we take many steps to address it. Risk factors include a personal or family history of blood clots, cancer, obesity, and certain other medical conditions.

### **Revision Surgery**

Despite the use of the most up-to-date surgical technique and implants, a hip replacement may fail to function well for the rest of your life. This may require re-do, or what we call revision, surgery. Historical data shows that the most common reasons for revision are implant loosening from the bone, dislocation of the ball and socket, and wear of the plastic. The risk of revision surgery is probably about 10-15% in the first 20 years after a hip replacement.

### **Obesity**

Obesity is defined as a body mass index greater than 30. Much research has been done to determine if obesity is a risk factor for complications after hip replacement. The data is not conclusive, but there is a suggestion that obese patients are at higher risk for a number of different complications after hip replacement and their outcome may not be as good as non-obese patients. Patients with a body mass index over 40 are at particular risk.

This is not a comprehensive list, but does highlight some of the risks surrounding hip replacement surgery. Any questions should be directed to Dr. Gordon or his staff.