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Hip Replacement

Anterior Approach

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Total Hip Replacement Patient Guide

This handbook was written in an effort to provide you with as much information as possible in consideration of a hip replacement. Through the process of gaining knowledge about the procedure, it is our hope that you will become better informed to make the best decision for your own health and comfort. You will be provided with information regarding a healthy vs. diseased hip, how a hip is replaced, and a step-by-step guide of what to expect before, during and after surgery.

If you and your doctor have decided that hip replacement is right for you, a team of healthcare providers will participate in your surgical and recovery process, helping you return to your normal level of activity. Our staff has one goal: getting you back on your feet so that you can return home safely and back to your usual activities as quickly as possible. Your active participation during your recovery period will aid in your rehabilitation. By knowing what to expect during and after your hospital stay, you can be a more active participant.

The handbook is just a guide. Your physician, physician assistant, or therapist may add to or change some of the recommendations. Always use their recommendations and ask questions if you are unsure of any information. Communication is essential to this process. Should you have any questions after reading this pamphlet, we would be happy to discuss them with you: (310) 829-2663.

Healthy vs. Diseased Hip

Your hip is a ball and socket joint. The "ball," is the round upper end of thigh bone, or femur, which is medically termed the femoral head. The "socket", which the ball fits into, is medically termed the acetabulum, which is part of the pelvis. The femoral head is held in position by muscles and ligaments located around the socket; the entire surface is covered with a 1/8" thick, smooth white substance called articular cartilage. The articular cartilage does not have nerves and as such, cannot transmit pain.

In a healthy hip, the surfaces are smooth and allow for painless and even distribution of body weight with movement. In a diseased hip, the articular cartilage has worn away. Eventually the ball can wear against the socket and the involved bone becomes pitted and rough; the roughness causes pain and stiffness as the hip moves. Other hip pathology can occur as well such as labral tears. You may occasionally hear a grinding, creaking or even

clicking. A decrease in flexibility may make it hard to walk up and down stairs, participate in activities such as yoga, tie your shoes, or even get in and out of sitting in low/soft chairs or cars.

The causes for such hip diseases are many and varied, however the most common is Osteoarthritis. **Osteoarthritis** is degeneration of the articular cartilage. It can be caused by congenital (birth) defects such as hip dysplasia or impingement, a trauma or injury to the joint, previous surgery to the joint, or just plain degeneration without reason. Another hip disease that can necessitate a hip replacement is Avascular Necrosis (**AVN**). AVN is a condition where blood supply to the femoral head is disrupted causing that portion of the bone to die. Secondarily, the bone collapses creating degenerative disease. The most common causes for AVN is the oral intake of steroids (e.g. prednisone/Medrol) or excessive drinking of alcohol. Rheumatoid Arthritis can also affect the hip joint.

No matter the cause, if one or more of these afflictions affect and restrict the normal use of the hip, a hip replacement may be necessary.

Initial Consultation

The initial visit involves a discussion with the doctor. **X-rays are always needed** and will be taken in our office in the absence of any films brought with you. Any other diagnostic studies taken previously, such as MRI's or X-rays, can also be helpful with diagnosis and signs of progression. Please bring any previous studies with you to the visit. Bring a **list of medications** that you are currently taking, along with all dosages. We welcome any spouses and other family members who wish to participate in the discussion of your treatment.

Non-Operative Treatment for Hip Disease

- **Decreased in activities:** Since hip pain can be increased by walking, a simple decrease in activities can result in less hip pain. You can avoid or limit your walking by taking elevators or driving whenever possible. You should **avoid strenuous activities** such as running, jogging and other high impact sports that can be replaced by non-jarring exercise.

- **Pain medication:** You may also, upon a doctor's recommendation, take an Analgesic such as **Tylenol**, Tramadol, or Non-Steroidal Anti-Inflammatory Drugs

(**NSAIDs**) (Advil, Aleve, Aspirin, Motrin, Naprosyn and Celebrex). These medications can decrease the inflammation of the arthritic joint. As everyone differs with pain and tolerance, different medications may work with different patients. NSAIDs are not habit-forming; but they can cause stomach upset and should be taken with food, milk, or an antacid. NSAIDs also have the potential to cause an increase in blood pressure, edema, swelling and affect the liver. It should be noted that the **maximum 24 hr dose of Tylenol is 3,000mg.** More than 3,000 mg of Tylenol daily can have a serious effect on the liver.

- **Injections: Steroids** combined with Xylocaine are occasionally given to the affected hip by a doctor and can relieve pain and inflammation on a temporary basis. Additionally, viscosupplement injections/hyaluronic **lubricant injections** (e.g. Monovisc, Orthovisc, Synvisc, Euflexxa, Gel-One) are also available; these may aid in assisting the body to reproduce better lubricants that over time have been lost in the joints of the body. It should be noted that hyaluronic injections are effective at best in only 50% of the patients and are not FDA approved in the hip but are used "off label"; as such, they are not covered by most insurances.

- **Weight Loss:** As extra body weight usually aggravates hip pain, patients who struggle with hip pain may consider a weight-loss program to help make them more comfortable.

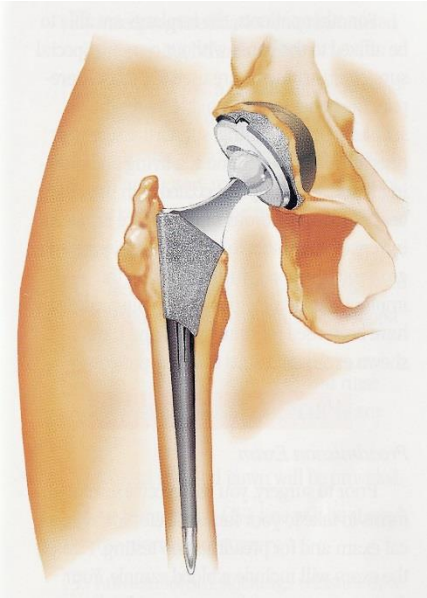
- **Walking aid: A cane** may aid in providing some pain relief and comfort. It is important, however, that the cane be sized for your height and should be held in the hand of the *opposite* side of the affected joint.

- **Exercise:** a good tool for overall conditioning of people with hip disease provided it is a ***low impact*** exercise. Swimming provides the buoyancy of the water and relieves stress on the affected joint and riding a stationary bike is usually tolerated well by the hip patient.

Operative Treatment for Hip Disease

The procedure of hip joint replacement is called a **Total Hip Replacement** (THR) or **Total Hip Arthroplasty** (THA). The surgery involves replacing the damaged portions of the hip joint with a prosthetic device. The goals of this procedure are to end pain and stiffness, thereby improving function and quality of life. Total hip replacement is usually an elective surgery and like all surgeries, comes with certain risks. Total hip replacement should only

be considered when the pain and disability from the hip are negatively affecting your lifestyle. If you feel your pain is a minor inconvenience and you are able to walk without a limp or the use of a cane, you are probably not ready for a total hip replacement. If you feel that your **pain is significant and your lifestyle has changed** considerably, you are probably **a candidate for the replacement surgery**. We encourage you to gather as much information as possible from your family, orthopedic doctor, family physician, and/or seek second opinions prior to your making the decision to proceed. **Our goal is to improve your quality of life.**



The total hip replacement prosthesis is made up of 4 parts: 1) Titanium cup 2) acetabular liner made from either polyethylene (a hard plastic) or ceramic 3) titanium femoral stem 4) ceramic femoral ball.

-First, the titanium cup is placed into the acetabulum (socket) of the hip to replace the worn socket. Then the liner is fitted inside the titanium cup. After that the titanium stem is inserted down inside the canal of the femur for added stability. And finally, the femoral head is replaced with the new ceramic ball. The new ceramic ball now moves smoothly inside the polyethylene or ceramic liner providing significant pain relief.

-The structural components of the prosthesis, the titanium cup and the titanium stem, are porous and rough which allow the bone to grow into the prosthesis and permanently bond to it. This process takes 3 months to complete.

-The weight bearing component of the prosthesis, the ball and liner, is either ceramic on ceramic or ceramic on polyethylene.

Weight bearing stimulates in-growth of the bone into the prosthetic cup and stem and **will be allowed from Day One**. The Anterior vs. Posterior approach as well as the prosthetic type will be discussed with you at that time. You and Dr. Gerhardt will both decide what is best for you and your health. In most all case, Dr. Gerhardt uses the Anterior approach.

Risks and Potential Complications

Hip replacement surgery has a **95% success rate** and although complications are rare, it is important that you know what risks and complications are possible.

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Infection: Although the chance of infection is **less than 1%**, it is possible. **Antibiotics** are administered through an IV **at the time of surgery** to prevent infection. However, infection can be introduced at any time after your total hip surgery including several years later. Infection can be spread from another part of the body to your hip. If your hip replacement becomes infected it is very difficult to fight, even with antibiotics, and as such, the prosthesis may need to be removed. Although this remains a rare circumstance, we go to great lengths to prevent infection. Usually viral infections such as colds and fungal infections are not a problem with your hip; however, it is best to seek treatment from your family physician to put your mind at ease.

Dislocation: Dislocation of new hips occurs approximately less than **1% of the time**. The risk of dislocation is reduced with the anterior approach, as compared to the posterior approach. Dislocation is when the ball comes out of the socket. The ball is held in place by muscles, so if you have **poor muscle tone**, you will be **more likely to suffer a dislocation**. During the first few weeks after surgery, as the scar tissue forms and before your muscle strength returns, the hip is more prone to dislocate.
Should your hip dislocate, you will need to go to the nearest emergency room where it is usually a simple matter, after administration of sedation, your hip will be relocated. Occasionally, if you have repetitive dislocations further surgery may be required.

Thromboembolism (Blood Clot): Inflammation, swelling and immobility of the hip increase the risks of forming a blood clot in a vein in **1/500 people**. The danger of a blood clot is that it can travel to the lungs and cause problems with the pulmonary system. To decrease your chances of this occurring to you, we administer an anticoagulant medication you will take x 3 weeks after surgery. You will also wear **anti-embolism (TED)** hose for 2 weeks after your surgery. Additionally, you will have **pneumatic compression devices** squeezing your calves while you are hospitalized to further prevent any blood clots.

Loose Prosthesis: Loosening of the prosthesis from the bone is a major long-term problem. However, with current technology the chance of the prosthesis loosening is rare.

Leg length: Leg lengths can be slightly changed by surgery though it is usually insignificant. X-rays are taken at the time of surgery which aid the surgeon in eliminating any differences.

Nerve Damage: Nerve damage occurs in **less than 0.5% of the time**. The most commonly damaged motor nerve is the sciatic nerve that brings the foot up towards the

face. Over the period of several months this nerve slowly recovers in the vast majority of cases.
Occasionally, numbness or tingling of the outer thigh skin can occur as a result of compression of a sensory nerve, the lateral femoral cutaneous nerve. This most commonly resolves with time. If the numbness/tingling is bothersome post-operatively you may be prescribed a nerve medication to alleviate this.

Stiffness: Rarely some extra bone, called heterotopic bone, forms around the hip joint and may cause hip stiffness.

Fracture: This is extremely rare, but the femur can fracture with the insertion of the stem of the hip prosthesis.

* The chances are very small that any of these complications will occur. Having major surgery does carry some risks, however, and you should weigh the risks versus benefits of the surgery. We will do everything possible to minimize your risks, reduce any significant pain you are experiencing and make a dramatic improvement in your lifestyle.

Surgery Scheduling

If you decide to proceed with surgery, we will schedule you at the first available date that works with your schedule. The surgery will be performed at **St. John's Health Center** or **Marina Del Rey Hospital**.

Pre-Op Clearance: Once a surgical date and time have been determined, we will ask you to schedule a visit with your internist for "preoperative clearance." Edith, our surgical coordinator will contact your physician's office to request specific tests, labs and other clearance prior to your appointment.

Please note it takes a great deal of coordination to schedule your surgery so once a date and time have been set, we ask that you do not reschedule unless absolutely necessary.

Hospital Pre-Operative Course for Total Joint Replacement:
St. John's Health Center offers a course for patients undergoing total joint replacement. The course is held **2-3 times a month**. An orthopedic nurse, a physical therapist and occupational therapist provide preoperative education for all total joint surgery patients. This includes a variety of postoperative information, including what to expect once your

surgery is completed. Issues discussed include general information about your surgery and techniques on how to ensure you and your joint remain stable and healthy.
For more information please call **888-432-5464**.

Marina Del Rey hospital offers a similar total joint replacement pre-op education class the 2nd and 4th Thursday of every month. To register, call the orthopedic patient care coordinator at: 310-823-8911 Ext 85229 or email: Valerie.wong@cshs.org. Registration is required.

Before Surgery

Pre-Op Visit with Dr. Gerhardt

You will be given a scheduled appointment with Dr. Gerhardt or Tanya, our physician assistant, prior to surgery to check to make sure all things are in order. We will give you your final instructions for surgery at that time. We will also arrange for you to have all necessary equipment ready for post-operative use in the hospital and at home. All pre-certification with insurance companies will be performed by our office in advance of this appointment to avoid any undue stress on you or your family. Please **bring any questions** to your pre-operative appointment.

Stopping NSAIDs and ASA prior to Surgery

Depending on the patient we will ask you to stop taking any kind of anti-inflammatory medication such as ibuprofen, Naprosyn, aspirin, Celebrex, and other blood thinners 7 days prior to your surgery.

Reducing Infection prior to Surgery

Peri-prosthetic joint infections are one of the most serious complications in joint replacement surgery. We work diligently to lower the incidents of infections around prosthetic joints but despite these efforts, they still occur. While the percentage of prosthetic infections is low, we would like to continue to reduce that number as best as possible.

To help prevent infection, three consecutive days prior to surgery you will be asked to apply an antibacterial ointment called **Mupirocin or Bactroban** into the nose with a Q-tip. In addition, we would like you to use **Hibiclens** (an antibacterial soap), in the area of the surgery three consecutive days prior to surgery. A prescription and specific instructions on the use of these items will be given to you at your pre-operative visit. Finally, **do not share towels or**

soaps with other people. It is hoped that these additional steps will continue to decrease infectious rates and decrease the risk of developing a peri-prosthetic infection.

Getting your Home Ready

There are several things you can do before your surgery to make your return home easier:

- Prepare food ahead of time.
- Move frequently used pots, pans and dishes for easier access.
- Remove loose throw rugs so that you will not trip.
- Make necessary arrangements for pet and child care.
- Place grip strips in the shower stall or tub so you will not slip.
- Remove electrical and phone cords out of walking areas.

Your Hospital Stay

Pack a small bag for your hospital stay. This should include: **non-slip shoes** (e.g. tennis shoes or loafers) and one pair of loose fitting, comfortable clothing (e.g. **shorts/sweats**).

The hospital can provide you with the **basic toiletries,** but you may bring your own (i.e. razor, make-up, shampoo, toothbrush etc). All rooms are private and equipped with a television and telephone. Cell phones are allowed in the hospital.
* Do not bring medications, jewelry, credit cards, or large amounts of money with you.

The Night prior to Surgery

Bathe or shower (including Hibiclens) in your normal routine. You should be **NPO (no food or drink) after midnight the night prior** as food in your stomach may cause anesthetic complications. Occasionally your doctor will advise you to take your normal medications the morning of surgery with just a sip of water.

Hospital Admission

Please verify your scheduled time of surgery on your pre-op visit and plan on being at St. John's Health Center or Marina Del Rey hospital **two hours prior to the scheduled surgery time**.

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At the Hospital

An Orthopedic Nurse Coordinator will…

Perform your pre-operative nursing assessment.
Be actively involved in your care and treatment during your hospital stay.

An Orthopedic Nurse and Certified Nursing Assistant will…

Help keep your pain under control and help make you as comfortable as possible. Help you get in and out of the bed, transfer to a chair, assist with daily bathing activities, and walk to the bathroom. Watch for any changes in your condition and coordinate your care during your hospital stay. Act as a liaison between you and your physician.

A Physical Therapist (PT) will…

Teach you how to get in/out of bed, walk with the appropriate ambulatory device, get into/out of a chair, and negotiate stairs.
Teach you the movement precautions and weight bearing restrictions if any.
Teach you exercises to increase hip motion and strength.
Recommend and order the appropriate equipment for ambulation.
Educate and instruct family or caregivers that may be assisting you after discharge.

An Occupational Therapist (OT) will…

Teach you safe techniques for dressing and bathing activities. Teach you how to transfer in/out of the shower stall or bath tub. Teach you how to transfer on/off the toilet or commode.
Recommend and order the appropriate equipment to perform your self-care activities.
Educate and instruct family or caregivers that may be assisting you after discharge.

A Case Manager will…

Arrange home health services as ordered by the physician. Work with your insurance company or workers compensation insurance to obtain authorization for services and/or equipment ordered by the physician.

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The Procedure

A total hip replacement procedure takes about 1 ½ hours of actual surgical time; however, the time in the operating room could be much longer considering preparation, anesthesia, etc. A hip revision may extend this period an additional hour.
Anesthesia is either **spinal or general**. Spinal anesthesia placed within the spinal fluid may decrease post-operative pain for 24 hours. This will be discussed with you by your anesthesiologist. Antibiotics will be given intravenously to help prevent infection prior to the surgery. An oblique incision is made across the antero-lateral surface of the hip, exposing the joint. The incision length is typically 9cm (about 3.5 inches) for females and 10cm (about 4 inches) for males. The incision may be longer for revision surgeries. The worn bone and cartilage of the femoral head and within the hip socket are removed. The prosthetic joint is then implanted. The incision is then closed with absorbable sutures and a surgical glue. A waterproof bandage placed over the closed incision. **Dr. Gerhardt does perform minimally invasive surgery.**

Post-Operative Hospital Stay

Hospital stay: most patients prefer to leave the day after surgery.

Pain Control

You will be given pain medication as needed to control post-operative pain.

Anti-coagulant therapy

You will take a coated aspirin, 325mg, once a day x 3 weeks post-operatively. This medication is used to thin your blood and reduce the risk of blood clots. If you have a personal history of a blood clot or cancer you will be placed on a different blood thinning medication, Xarelto or Eliquis. Ideally you will have this medication filled and ready for your arrival back home.

TED hose and Pneumatic Compression Device

While in the hospital you will be wearing knee high "TED hose" or **white compression stockings**. When you are discharged to home you will continue to wear the compression stockings during the day x 2 weeks. You may take the compression stockings off at night. If you have continued swelling after two weeks continue to wear the compression stockings an additional week.

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Showering

Most patients will be ready and able to take a shower before they are discharged from the hospital. **Showering is allowed so long as a water-proof dressing is being utilized**. Do not scrub the surgical site. Allow the water to gently roll over the incision area with the waterproof bandage in place and pat dry.

Use of Pillows

Pillows can be utilized to improve your comfort, but they are NOT necessary. If you are noticing swelling in the leg/hip area it can be helpful to elevate the leg on several pillows while at rest, especially the first two weeks post-op.

Elevated Bedside Commode

elevated bedside commode may be requested but is not necessary.

Getting out of Bed

Most patients sit and stand by the edge of the bed on the day of surgery and will take a few steps with the nurse or therapist. As the days continue, you will progress to walking around the room to walking down the hall allowing full weight bearing.

Physical Therapy

Without complications, a therapist will meet with you the day of your surgery and begin exercises and ambulation. The physical therapist will **teach you exercises** and will show you how to walk correctly and safely with crutches, walker or cane. They will instruct you in **climbing stairs** as well.

Assistive Devices

Most patients will be **discharged with a walker** but may progress to a cane or crutches. The walker offers support and protections especially when in public. The walker also aids the patient with balance and distribution of weight. Some patients use crutches especially if the use of a walker becomes too cumbersome. The use of a cane for support and protection from falling or losing balance in public is also a common practice. The physical therapist will advise you on which assistive devices will be best for your use.

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Post-Operative Care

What to watch for: If you notice any of these signs or symptoms, please call our office or your primary doctor.

- **Infection:** Signs include fever, red streaking from incision, large increases in amount of pain and/or drainage from incision.
- **Blood Clots:** Signs include increased pain, swelling or redness of your lower leg.
- **Incision:** Look for drainage from the incision, areas of the incision that are not sealed over, red pimply areas on or near the incision, redness along the incision.

Recovery Timeline: The first **2 weeks** is the most difficult timeframe where you will likely need narcotic pain meds. After 2 weeks, swelling and pain improve progressively. At **6 weeks**, you will no longer use a walking aid and may only need an over the counter pain med such as Tylenol as needed. You will likely still feel stiff especially when first getting up out of a chair/car to walk. By **3 months** post-op most patients can participate in their desired activities without thinking too much about their replacement. However, in some cases the hip may remain swollen, warm and stiff up to **6 months**. This is a normal surgical phenomenon. You may have numbness over the hip for up to **one year** until skin nerves regenerate.

Ice/Heat: Icing is especially important the first 2 weeks post-op. You may apply ice for 20 minutes 2-3 times per day, particularly after exercising. You may use a heating pad on thigh and hip for 20 minutes before exercising to relax muscles.

Medications:

- Anti-coagulant: You will also be prescribed a medication to prevent blood clots as described above. This is the *most important medication* you will be taking post-op. If prescribed Aspirin, you may also be prescribed a proton pump inhibitor/PPI medication such as Protonix, to protect your stomach from the aspirin. If Protonix is expensive under your prescription plan, Prilosec over the counter is a good alternative.
- Pain medications:

- *Non-narcotic pain medications*: You will typically be prescribed: Tylenol (x 2 weeks), Celebrex (x 2 weeks), and Gabapentin (x 5 days).
- *Narcotic pain medications:* such as Oxycodone, are only to be taken as needed. You are encouraged to utilize the non-narcotic pain medications and only take the Oxycodone if the non-narcotic meds are not enough to completely manage the pain.

- Over the counter stool softeners may be used to prevent constipation which is a common side-effect of narcotics.

Wound Care: The incision will be covered with a waterproof dressing, Mepilex, during your entire hospitalization. Upon discharge the nurse will provide you with 2 additional Mepilex bandages. You should keep your incision covered for a total of 2 weeks. Keep your original bandage in place x 4-5 days, then change the Mepilex every 4-5 days (for a total of 2 bandage changes). Remove the bandage completely after 2 weeks.

When removing your bandage, you may notice the surgical glue along the incision. It has a purplish cast to it, and sometimes wrinkles. **Do not put any ointment, alcohol, peroxide, or Betadine on the surgical glue/incision** as it will breakdown the glue before intended. After 2 weeks the glue will start to peel or flake off on its own. Do not pick this off.

Hygiene: Most patients will take a shower prior to discharge from the hospital. You may shower with the Mepilex water-proof dressing x 2 weeks post-op. After two weeks you can shower without a dressing on the wound, but do not scrub the surgical site. Just let the water run over it gently, then pat it dry after you shower.

No soaking the incision in a bath, pool, hot tub/jacuzzi for 3 weeks! Once you are 3 weeks post-op you may begin to swim or participate in pool therapy if you can enter safely (handrails, ramp, steps etc). **Wait until the incision is well healed before entering the pool**. Limit the time in the pool to 10 - 15 minutes in order to monitor your response and incision healing.

Scar Treatment: Do no place any product on the incision site x 1 month. After 1 month, you may use a scar treatment of your choice. Products with silicone work best. Silicone scar sheets, such as Mepitac, work well under clothing.

Bruising: Bruising of the operative leg, especially the thigh, is common after surgery and may take several weeks to resolve.

Diet: There are **no restrictions** to your diet. Eat a normal diet as you did before surgery. Make sure you eat plenty of fruits and vegetables and drink 6-8 glasses of water a day. This will help prevent constipation.

Driving: You may drive as quickly as two weeks post-op if you are comfortable, not in pain, and NOT requiring day time narcotic analgesics. If you had surgery on your right hip, you must have good control of your leg to work the gas and brake pedals.

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Handicap Parking: You can obtain an application for a handicap-parking placard from the clinical assistant at our office. Your doctor or PA will sign the form. You must fill out your portion of the form, and then take it to either the DMV or AAA. Temporary handicap-parking placards are issued x 3 to 6 months, depending on the severity of your case.

Travel: You may get out of the house **as soon as you feel up to it**. Use the handicap bathroom stall. If you are in a hotel, request a handicap accessible room. If you must fly, request bulkhead seating or first-class seating if possible.
There is a small increased risk of blood clot in the first few weeks after surgery when flying, but you will already be on a blood thinner which will help protect against the development of a blood clot. However, please be sure to stretch frequently on your flight and consider wearing your compression stockings on the flight. If you do go on a long flight (5 hours or longer) within the first 3 months post-op and you are no longer taking the anti-coagulant, do take a full aspirin the day of the departure and return flight.

Sexual Activities: You may resume sexual activities as soon as you feel able and after your incision is healed. Your therapist or doctor can answer other questions you may have.

Prophylactic Antibiotics: You will be asked to refrain from any non-urgent dental work, including cleanings, x 3 months following surgery. We no longer require prophylactic antibiotics prior to dental procedures, urologic, or GI procedures based on the current guidelines from the American Academy of Orthopedic Surgeons. It is only necessary if required by the treating dentist or MD for that treatment. For example, if you do have an urgent issue within the first 3 months, such as a dental abscess, this should be treated with antibiotics per the dentist's recommendation.

Blood Transfusions: With a normal blood count, the possibility of needing a post-operative transfusion IS RARE. On the face of this, we no longer encourage autologous blood donations which may actually weaken the patient prior to surgery.

However, should the patient elect to donate their own blood, services for such are available through the Saint John's Hospital Blood bank. This is the safest blood available and therefore carries the least degree of risk. Given that the blood comes from the patient, there is virtually no risk of infectious disease or allo-sensitization. The only risks arise from the donation process and the remote possibility that some form of contamination or mishandling of the unit can lead to a problem.

If you are scheduled for a revision surgery where a greater blood loss could be expected, we will have Cellsaver available during the surgery. This is a process where your own blood is collected during the surgery and, if enough blood is lost, you will be transfused a portion of your own lost blood at the end of the case.

Walking aid: Use walker, crutches or cane until hip feels secure when walking.

Restrictions: With an Anterior Approach hip replacement you do not have any restrictions on how you move or hip precautions. You may move you hip in any way that is comfortable post-operatively. You can even sleep on the operative side once you feel comfortable to do so.

For the first 3 months post-op, avoid all activity with a potential for a hard impact at a high-speed. Examples are: downhill skiing, horseback riding, running, outdoor bike riding, surfing. Once you are 3 months post-op, the bone is fully bonded with the bone and you will be allowed to engaged in any activity you choose!

Physical Therapy

During your hospital stay, the physical therapist will instruct and provide you with a home exercise program. You may do these exercises 2x/day the first 2 weeks post-op. In addition to the exercises, gradually increase your daily walking. **Walking is the best exercise in the early post-op period.** Try not to over exert yourself. If you have increased soreness or swelling, decrease your activity, ice, and elevate your leg above your heart. Mild discomfort is acceptable and expected.

At the 2 week mark you may start outpatient physical therapy. We recommend PT x 4-6 weeks or longer should you desire. A good goal is to no longer need the cane 3 or 4 weeks from your surgery date.

If you are discharged to a **Skilled Nursing Facility** (SNF), you will have therapy while you are an inpatient there. Once discharged to home, you may start outpatient therapy starting at 2 weeks post-op as well.

Your **insurance carrier determines which physical therapist you will be able to see**. The physical therapy office you wish to go to will let you know if they accept you insurance. Our office can give recommendations for physical therapy sites if you need. It is best to choose a site that is easy for you to drive to and that takes your insurance.

Leg muscles are often very weak due to under use both prior to and after the surgery. Therefore, it is important to strengthen the quadriceps and surrounding muscles. Walking

and exercises such as the stationary bicycle or elliptical machine are excellent for rehabilitation.

*Total recovery time may take up to 1 year however most patients are better at one month post op than they were prior to surgery.

Follow-Up Visits

Your post-operative visits, in general, will be scheduled as follows:

1) **2 weeks** from surgery, typically with the Physician Assistant, Tanya
2) **8 weeks** from surgery, typically with Dr. Gerhardt
3) **1 year** from surgery

Your progression, ambulation, range of motion and any complications will be discussed at that time.

X-rays of your hip will be taken at the post-operative visit and then again at 1 year out from your surgery to track the healing progress.

* The timing of these visits is a guideline; we may ask to see you sooner or more frequently depending on your individual recovery and circumstances.

Your Healthcare Team

Clinical Assistant (Edith) 424-314-5043
Coordinate scheduling of your surgery.
Arrange for you to have paperwork and all necessary forms filled prior to your surgery.
Arrange your prescription for post-operative medications.
Help with obtaining necessary equipment and handicap placard.
Answer questions relating to office visits and general post-operative issues.

Administrative Assistant (Desiree) 424-314-5000 ext. 45035
Scheduling of pre- and post-operative appts.
Answer questions relating to office visits and occasionally general post-operative issues.

Administrative Assistant (Yesenia) 424-314-5000 ext. 45034
Answer questions relating to office visits and occasionally general post-operative issues.
Assist with disability paperwork.

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A Physician Assistant (PA) (Tanya Cariveau, PA-C) or Orthopedic Fellow
Assist with your surgical procedure.
See you on daily rounds.
Change your dressing and check your incision.
Help manage your hospital care.
See you in the clinic for the follow-up or pre-op visits, as directed by Dr. Gerhardt.

Important Numbers

Main Line (answering service after hours) _____(424) 314-5000

Appointments
New patients _____(424) 314-5000

Medical Staff
Tanya Cariveau, PA-C (Physician Assistant) _____ (424) 314-5000
Desiree Walstrom (Administrative Assistant) _____ (424) 314-5000, ext 45035
Edith Rodriguez (Medical Assistant) _____(424) 314-5043
Yesenia Rodriguez (Administrative Assistant) _____(424) 314-5000, ext 45034

Medication Refills
Edith Rodriguez (Medical Assistant) _____ (424) 314-5043

Billing and Insurance
Main Line (ask for Billing Dept).____ (424) 314-5000, ext 60874

Disability Forms
These forms may be obtained online or from your employer. Please fill out the forms completely and then turn them in at the concierge's desk for Yesenia. Online filing is also an option and can be completed at **edd.ca.gov**. If filing online, be sure to provide Yesenia with the receipt number so that she can complete your claim. It typically takes 24-48 hours for claim completion once our office receives the necessary paperwork/receipt number.

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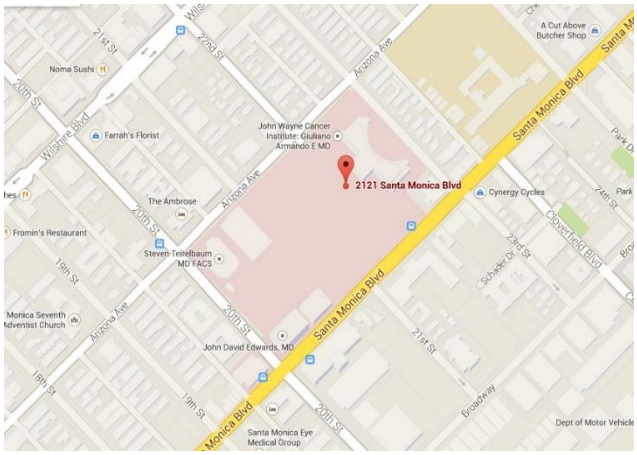
Information for St. John's Health Center

2121 Santa Monica Blvd. Santa Monica, CA 90404. The Orthopedic unit is located on the 3rd floor. The telephone number is 310-829-5511.

The hospital does not validate parking. The maximum daily rate is $13.00. The main entrance is located on Santa Monica Boulevard, between 20th and 23rd Streets. All parking is by valet only, no self-park lots are available. There is also metered street parking on adjacent neighboring streets.



Information for Marina Del Rey Hospital

4650 Lincoln Blvd
Marina Del Rey, CA 90292
(310) 823-8911

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TOTAL HIP REPLACEMENT HOME PROGRAM

This section will cover step-by-step instructions on how to perform your activities of daily living once at home. The physical and occupational therapist will teach you these activities during your hospital stay.

BED MOBILITY

Getting out of bed:

Scoot to the edge of your bed by using your non-operative leg. (Figure 1)

Angle your body so that your legs are nearing the edge of the bed and touch down with your non-operative leg. (Figure 2)

Push up onto your hands, so that your hands are positioned behind your hips, and rotate your operative leg off the bed. (Figure 3)

Use your hands to help scoot your hips forward to the edge of the bed. (Figure 4)

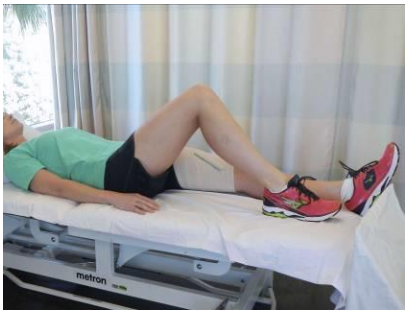

Figure 1

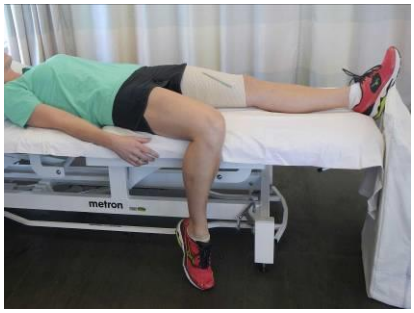

Figure 2

Figure 3

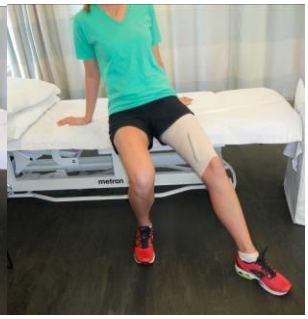

Figure 4

Getting into bed (the reverse process):

Sit on the edge of the bed and position your hands behind your hips.

Slide your buttock backwards while supporting yourself with your arms.

Begin to rotate your body towards the head of the bed.

Continue to scoot back using your non-operative leg to help until both legs are onthe bed.

Sleeping:

You can sleep on your back or side. Some patients prefer to sleep a pillow placed between their legs for comfort. (Figure 5)

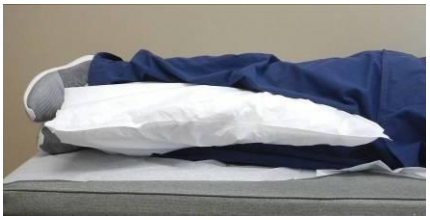

Figure 5

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SITTING

Figure 5

Find a firm, sturdy chair with an armrest when sitting (e.g. dining room chair).

Sitting Down:

Back up to the chair until you can feel it with the back of your legs.
Place your cane/crutches aside.
Reach back for the armrest.
While holding firmly to the armrest, lower yourself Slowly (Figure 6)
You may sit up straight with your hips scooted back into the chair and knees bent underneath you. (Figure 7).

Standing Up:

Scoot forward in the chair while extending and un-weighting your operative leg.
With most of your weight on the non-operative leg and your hands on the armrests, push up against the armrests.

TOILETING

You may use a raised toilet seat for comfort.

DRESSING

You may bend over to put on your shoes and socks, as long as you work in between your legs. Make sure to point both knees and toes outward and **un-weight** your operative hip when reaching down. (Figure 8)
You may bring the foot of your operative leg and rest it on the non-operative knee to put your shoes and socks on. (Figure 9)
If you experience difficulty or were unable to put your shoes and socks on prior to surgery, you may temporarily need to use adaptive equipment to assist you. Adaptive equipment includes a long handle reacher, long handle sponge or brush, long handled shoehorn, and/or a dressing stick.

Figure 8

Figure 9

BATHING

Most patients will shower in the hospital prior to discharge. The occupational therapist will help to determine if any at home bathroom equipment is needed for safety.

STAIR CLIMBING

Going Up:

Remember to step up with the non-operative leg (or the "good" leg) first.

Use a handrail if available. (Figure 10)

Going Down:

Remember to step down with the device and operative leg (or the "bad" leg) first.

Use a handrail if available. (Figure 11)

"Up with the good, down with the bad"

Figure 10

Figure 11

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GETTING IN/OUT OF THE CAR

If possible, park the car away from the curb allowing entry/exit from a level surface.
Maximize leg room by reclining the seat and positioning it as far back as possible.
With help from your cane/crutches, back up to the front passenger car seat.
Slide your operative leg forward and reach back for the seat. (Figure 12)
Lower yourself slowly onto the seat, keeping the operative leg extended.
Scoot back onto the seat. (Figure 13) and
Back into the seat in a semi-reclining position.
Pivot into the seat, bringing your legs into the car, and face forward. (Figure 14)

Figure 12

Figure 13

Figure 14

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TIPS FOR WALKING WITH THE CANE OR CRUTCHES

Do not be afraid to put weight on your operative leg (unless you have been instructed otherwise).

Take even stride lengths to emphasize a normal heel-toe walking pattern.

Do not lean over on the cane or crutches. Remember to stand straight.

If you are ready to progress to one crutch or to a cane, use the device on the opposite non-operative side (e.g. Place the device in the left hand if the right hip was replaced). (Figure 15-16)

Figure 15

Figure 16