San Antonio Orthopædic Specialists

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Frequently Asked Questions about MIS Total Hip Arthroplasty

Congratulations!

You have elected to receive a total hip arthroplasty via Minimally Invasive, Tissue Sparing techniques. These groundbreaking techniques allow for much more rapid relief of pain and return to function than previous, more standard techniques. Dr. Harris is the first in South Texas and in South Louisiana to offer these procedures, and has taught these techniques across the country.

The "rules" for your rehabilitation may be very different from hip replacements done by other techniques. Not all therapists understand this in advance, and may not believe the rehabilitation orders. Please read this information carefully and share it with your family and your therapist. Please call the office with any questions.

Your Hospital Stay

You will be admitted to the hospital on the day of your surgery. The hospital stay is usually one or two nights. The length of your stay depends on many things. The better general condition that you are in before the surgery, the shorter your hospital stay is likely to be. Those with single-level houses and supportive families will also have shorter stays. Those living by themselves or with "obstacles" at home (such as a large number of stairs) tend to stay longer.

The exact length of the stay is, in a sense, a "game" where the rules are made by the government and the insurance companies. You must stay in the hospital until you are medically stable. You cannot go home until you are safe to go home to your home environment. In general, if these two points are separated by a day, then you can stay an extra day in the hospital, then go home. If they are expected to be separated by several days, then you will be transferred to a rehabilitation facility. Experience with this procedure is that for those under eighty years of age, a rehab stay has been needed less than one per cent of the time. Most of those over eighty do require a rehabilitation stay.

The hospital stay is not a recipe where the patient is merely an ingredient. People respond to the surgery differently. Most get up quickly, but some go a little more slowly. It is NOT possible to predict who will “bounce” and who will need some more time. The length of the stay cannot be absolutely predicted before the surgery. The length of the stay is determined after the surgery. Dr. Harris will do what best fits each individual patient.

What can I do before to minimize my risk of infection?

First, the record of known infectious complications in this office is better than published reports. Unfortunately, the so-called “super bugs” have become very common in the community in some studies representing 30% or more of organisms cultured off otherwise healthy skin. Therefore, a shower or bath

with a Chlorhexidine based soap (Hibiclens and others) may reduce your risk. **Please be careful though! Some people are allergic to this soap.** If you plan to wash the night before the surgery with Chlorhexidine, please try the soap a week or more before to be sure that you tolerate the soap. Rashes or blisters near the incision area will force postponement of the surgery. Chlorhexidine soaps are available at most drug stores, and many groceries.

Next, while losing weight is a good thing if you're overweight, don't scrimp on protein in the few weeks before the surgery. Adequate protein levels are important with regard to wound healing. For the most part, short term increases in cholesterol or lipids intake will not be significant in the long run. If you have concerns about "eating meat" please bring them up to your primary care physician. It is outside the realm of this office to make specific nutritional recommendations, only the general

Tell Dr. Harris about any remote (away from the surgical area) infections. Boils, open wounds, and decaying teeth are a few examples. Check with your primary care physician about urinary tract and sinus or respiratory infections. Check with your dentist to be sure that you have no active infections in your mouth.

Lastly, if you shave in the area of the surgery on a regular basis, please don't do so for seven to ten days before the surgery. Remember, that the hip surgery incision may be placed in the groin area. Many surgeries have been postponed for infected cuts and scratches in area of the surgery.

Discharge Plans:

Like the stay itself, the plans for care after the hospital stay vary from patient to patient. In most cases, the ideal situation is for the patient to go home and from there go to outpatient physical therapy. It is simply not practical to do this for each and every patient. That which may work for one patient won't work for the next. A key determinant here is the function that is gained during the hospital stay. Discharge plans are made as you progress with the therapy in the hospital after the surgery. Dr. Harris will do what best fits each individual patient.

Your Weightbearing Status

The vast majority of patients are "weightbearing as tolerated." The emphasis here is on the "as tolerated." Don't be a hero or a couch potato. Please wean from assistive devices as rapidly as it is safe to do so. Some patients have used supports for only one day. Unless you have heard specifically from Dr. Harris otherwise, you can be weightbearing as tolerated. If anybody suggests otherwise, please call the office to confirm.

If you are one of the less than 5% who require some protection, your rehabilitation will start as "touch-down weightbearing." This means that you may rest your leg on the ground, but not add the weight of the body to this. The object is not whether you place your foot flat on the ground, or only your toe. The issue is that you should not put more than the weight of the leg on the ground. This is slightly different from "toe-touch weightbearing" that is frequently taught by therapists. If you think about it, walking on one's tiptoes is both "toe-touch" and "full weightbearing."

Hip Restrictions:

Patients undergoing primary, or first time, total hip arthroplasty will not require hip restrictions! Many therapists won't believe this one. If the therapist starts teaching you about where you can or can't put your foot or leg, show them this note!

Hip Restrictions (revision cases):

Most, but not all patients undergoing revision arthroplasty will have hip restrictions. *(These are position restrictions – where your leg is in space, not motion restrictions – how you move your leg.)* These restrictions last for only 8 weeks.

1) You may not cross your legs. The concern here is moving the knee across the midline of the body to the other side.
2) You may not flex your hip more than 90°. The position of 90° is sitting straight up in a standard chair. The position of the knee is not important.
3) You may not pivot on your hip. Pivoting maneuvers include turning corners, particularly at landings between flights of stairs, a full swing in golf, and many dancing maneuvers.

Wound Care

Your surgical dressing should be removed two to three days after the surgery. It is common for the wound to ooze a few drops for a few more days. Until it is completely dry, do not put water on the wounds. Clean the wound(s) with sterile normal saline, dry them carefully, then apply a new dry dressing. Do this once or twice per day. You may shower but cover the wounds with an occlusive dressing while you are in the shower. Two common occlusive dressings are Op-Site and Tegaderm. Both are available over the counter. They look a little like Saran Wrap™ with one sticky side. Remove the waterproof dressings immediately after the shower. Then replace the regular gauze.

After the wounds have been absolutely dry for 48 hours, you may shower without protection over the wound(s). At this point, dressings are not necessary in or out of the shower. After the shower, be sure to dry the wounds completely. Water can accumulate under the pieces of tape (if you have them), effectively soaking the wounds. Bathtubs, pools, or any other forms of "soaking" are to be avoided. Stay out of tubs or pools until the wound is at least three weeks old.

You may want to cover the wounds to protect them from rubbing against clothing or to keep them dry, as the groin can be a damp place. Please wear clothing that does not allow sweat to accumulate on the wounds. A thin film of antibiotic ointment is not harmful. Often, the tape needed to keep dressing on causes more trouble than the incisions themselves.

Blood Thinners:

Without some protection, after joint replacement, there is a significant risk that you'll develop an abnormal blood clot in your leg. These clots can break off and cause all sorts of trouble, particularly in the lungs. Before rapid mobilization and routine prophylaxis for these clots, 1% of elective patients died from this complication. With prophylaxis, the rate is around 0.02% in most studies. Therefore, after your joint replacement, you will be placed on a blood thinner.

For most patients, Dr. Harris follows the recommendations of the American Academy of Orthopaedic Surgeons, and uses aspirin. A few patients will be better served by alternate drugs, and you may be asked to participate in a study looking for simpler and potentially safer medications for the same purpose. The duration of the therapy may range from 10 days to 6 weeks.

You should refrain from using other types of blood thinning drugs while you're on the prophylactic medicine. For example, anti-inflammatory medications are, like aspirin, platelet inhibitors. If you are using aspirin for prophylaxis, you may use non steroidal anti-inflammatory medications (NSAIDs), but not Vitamin E, Glucosamine, Garlic, etc. If you're on a heparin like drug, you should not use NSAIDs, or coumadin. This can be confusing. If you have any questions, please ask before adding a drug that could make your blood too thin.

Dental Work and other procedures after Hip Replacement

Many things that we do during ordinary activities will cause some bacteria to float around in our blood system. Simple acts, like brushing your teeth will cause a detectable rise in the number of bacteria in the blood. For these ordinary activities, some very very sensitive tests are needed to detect the levels. For some activities, such as dental hygiene at the dentist's office will spill a larger number of bacteria into the bloodstream. These bugs can take up residence on the metal of your prosthesis, and cause all sorts of problems.

Therefore, for these procedures, we suggest that you take a single dose of antibiotics 30 to 60 minutes before the procedure. Your dentist can give you the prescription, your primary care can also give the prescription, as can this office. I don't care where you get the prescription, so long as you get and take the medicine.

Other procedures that stir up bugs probably include colonoscopy and endoscopy. Larger procedures, such as "standard" surgery should be accompanied by preoperative antibiotics anyway, and no special additional medications are needed to protect your prosthesis. These "extra" antibiotics immediately before dental and similar work are needed for only 2 years, unless your immune system is not up to snuff.

If there is any question, during the first two years, ask the provider of the "other procedure" if he or she would give prophylactic antibiotics if you had a mechanical heart valve. If the answer is yes, then you should also have prophylactic antibiotics.

When can I drive?

This is the Number One, most commonly asked question. PLEASE read this section! Between the patients and their family, this question is usually asked two to three times! Please communicate with your family.

Dr. Harris is conservative on this point. The issue is not driving in empty parking lots or abandoned streets. Nor is the question of driving related to the distance that you plan to drive. Most accidents happen close to home, or in neighborhoods. The key issue is whether you'd think twice about your hip in an emergent situation. There is no good assessment of who is truly safe to drive, and there are many people on the road now that are not safe to drive. They have not had surgery! There are no studies about reaction times after this new hip surgery. With standard approaches, reaction times are not normal until six weeks after the surgery, without regard to which hip had surgery. Technically, Dr. Harris cannot give his formal blessing to your driving for six weeks. Having said that, many patients do drive much earlier than that. If you plan to drive before this time, you're an adult and are responsible for your own decisions. If you plan to drive before two weeks, call Dr. Harris at home, so that he can keep his kids and pets inside.

When should the stitches be removed?

In many cases, there are no stitches above the skin. The wound is closed under the skin. When the tapes across the wound look as if they are no longer helping after about ten to fourteen days, then help them off. If you have staples, they should be removed in the office about two weeks after the procedure.

How long do I have to limit my motion?

MOST PEOPLE DON'T! The whole concept of hip restrictions is a holdover from traditional techniques and earlier designs of implants. Patients who have their first hip surgery with either the direct anterior tissue sparing approach or the two incision approach do not have hip restrictions.

That being said, most people who have second time surgeries will still require hip restrictions. In this setting, the restrictions last eight weeks. When given freedom to increase your range, Dr. Harris does not suggest that you test it in detail immediately. You should gradually increase your activity and range.

How much pain medication should I take?

You should have a prescription for a narcotic pain medicine. Use these as you *need* them. Some patients need nothing but plain Tylenol after a few days, others will need three to six pills a day for a few weeks. In general, if you feel that you need more than six pain pills per day, then Dr. Harris needs to know about that.

If you have pain, take the medicine. It is legitimate to use pain medicine before physical therapy sessions. Otherwise, don't take pain medicine "in case you might have pain." Narcotic pain medicines are often not that effective against "soreness." If you primarily have only soreness, try plain Tylenol instead of narcotics.

The common prescriptions after surgery all also contain Tylenol. (APAP is an abbreviation for acetaminophen, which in turn is generic for Tylenol.) Please also be careful about the "non-aspirin pain relievers" during the first six weeks. Most of these contain antiinflammatory medications. These are also blood thinners and can interact with the blood thinner that your receive. Others contain plain Tylenol. Stay within the over-the-counter limits for total Tylenol per day which is 4 grams (4,000 mg).

If there is sudden onset of dramatically increased pain, call Dr. Harris immediately. Truly emergent problems that require a late night trip to the emergency room are rare.

What about antiinflammatory drugs (NSAIDs)?

Dr. Harris prescribes an antiinflammatory drug on the day of the surgery and for two days after that. Thereafter, the use of NSAIDs will depend upon the type of blood thinner that is used. NSAIDs themselves are blood thinners. They belong to the category of thinners known as platelet inhibitors. If you are on aspirin after surgery, it is also a platelet inhibitor. You may mix platelet inhibitors, and use NSAIDs in addition to aspirin.

However, if you're on a different blood thinner, you shouldn't mix two different types of blood thinners. In that setting, NSAIDs should be avoided.

How long do I take Blood Thinners?

There is no more consensus as how long blood thinners should be used after hip surgery than there is which method is best. Currently, Dr. Harris recommends six weeks of therapy. For most patients, plain aspirin is used as the blood thinner.

If you are on Coumadin, then one doctor should manage your Coumadin. Problems arise more commonly if the responsibility for anticoagulation management shifts back and forth. Dr. Harris will initiate the therapy. Thereafter, the doctor managing your Coumadin may change once during your treatment. If another doctor is current managing yours, then ask that physician. If on Coumadin, you will require periodic blood tests to measure the effect of the drun on your system. Dr. Harris tries to limit the number of times that he sends the "vampires" to your bedside. But as your activity increases and your diet changes, your requirement for Coumadin changes. If your levels are reasonably steady, he'll check once a week. If they are not, he may need daily labs for a few days.

When do I start physical therapy?

The day of surgery! If you're awake enough, it is still daylight hours, and the therapist has not been by, please bug the nurse to call the therapist. During the first week or two, you should have therapy every day or more often. Thereafter, the demand for therapy varies greatly from one patient to the next. In rare circumstances, insurance will place severe limits on physical therapy. In these cases, Dr. Harris may "hold on to physical therapy days" and restart therapy at a later date. Otherwise, your therapy should not be interrupted. Complain to your insurance company or as appropriate to your primary care physician to be sure that your therapy continues. Alternately, if you feel that you've accomplished all of the goals of physical therapy, discuss stopping early with Dr. Harris.

When may I roll onto the surgical side in bed?

The issue here is potentially twofold. Many people are uncomfortable doing so for a few weeks. For most patients, and for all first time hip surgery patients, comfort is the only issue.

For the few patients who have hip restrictions, the key is the hip motion restrictions. Dr. Harris really doesn't care if you sleep on your head – so long as you don't violate the hip restrictions. Particularly in a soft bed or waterbed, rolling onto the surgical side will violate the hip restriction of crossing your legs. If you have a hard mattress and can follow the hip restrictions, make yourself comfortable on your side. Enjoy.

What about sex?

There are a few potential issues here. The first and most important potential limit is comfort. It may be several weeks until you are comfortable enough to engage in this activity. For most patients, and for all first time hip surgery patients, comfort is the most important issue. The second issue is hip position. Though most patients don't have hip restrictions, it is probably not a great idea to have an enthusiastic spouse put or push your legs into extreme positions.

For those patients with weightbearing or position restrictions, a bit more planning is needed. Some people forget that touchdown weightbearing makes it very difficult, for example, to get onto both knees. It is common for a woman in particular, to flex a hip more than 90° during sex. The man may hyperextend the hip (by arching the back with the legs extended), which may be equivalent to "pivoting" on the leg. Spend some time thinking about positions and restrictions and talking about them with your partner ahead of time.

What should I do about drainage?

A small amount of drainage is not unusual. In general, more than a drop or two of drainage should not persist beyond a week from the time of the surgery.

What about the color of the drainage?

Normal drainage is clear, clear-yellow, slightly pink, or clear and blood stained. If the drainage is cloudy, green, or malodorous, call the office. Drainage that has been sitting on the dressing for a while may change colors on the dressing or become malodorous. The concern is the color of the active drainage, if any.

The wound is red or hard. What should I do?

It is common for the wounds to be a little pink after the surgery. If the wound is red, hard, painful, or tender, then you need to be evaluated in the office. Call now!

I have a fever of 100°. What should I do?

A low-grade temperature is common after any open orthopedic surgical procedure. This is a result of some blood getting in between the muscles and the body trying to absorb the blood. Temperatures in the 99 to low 100's are not considered fevers. Temperatures over 101° may represent a problem, particularly if you feel "ill" at the same time. A measured oral temperature over 102° should prompt an immediate call to the office.

When should I call the office?

If there is something that you don't understand, or if you have a concern not covered in these pages, please call. Dr. Harris is a firm believer that there are exactly two types of "stupid questions." There are those that you don't ask, and there are those that you ask five times. Everything else is legitimate. These frequently asked questions are updated periodically. If there is a topic that you think should be covered and is not, please let us know.