

SAN ANTONIO ORTHOPÆDIC SPECIALISTS

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Frequently Asked Questions About MIS Total Knee Arthroplasty

Congratulations!

You have elected to receive a total knee replacement or unicompartmental knee replacement by Dr. Harris using minimally-invasive techniques. The techniques employed are all tissue sparing though the details may vary slightly from one patient to the next. These techniques do not cut into the muscles or tendons as do the standard techniques that have been employed by most surgeons since the 1970's.

This page is designed to provide information about the surgery and postoperative care and feeding, and to answer the most common questions that most patients have. Please share this with your family and your therapists. If everyone is "on the same page," then your course through the surgery and rehabilitation should be smooth.

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.

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Your Hospital Stay

You will be admitted to the hospital on the day of your surgery. The hospital stay is usually two to three days thereafter. Most people are able to go directly home after the hospital stay. The length of your stay depends on many things. The better your general condition before the surgery, the shorter your hospital stay is likely to be. Those with single-level houses and supportive and available families also will 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 the expectation is that safety for discharge will follow medical stability by several days, then you will be transferred to a rehabilitation facility.

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.

Physical Therapy

Physical therapy starts the day of or the day after the surgery. The goals of the therapy are twofold. The first goal is to make you independent. The second is to help you gain the maximum range of motion of your new knee. As there are a great many therapists, signal can occasionally get crossed. Please share this information with your therapist. Unless you hear from Dr. Harris personally that he has changed the plan for your knee, this pamphlet describes your therapy protocol.

In general, Dr. Harris prefers that patients attend outpatient physical therapy as opposed to inpatient rehabilitation or home health. While this program does not fit every patient well, there are good reasons for this preference. Good studies have shown that patients experience less pain at home than they do when they are in any inpatient facility. Further, while at an inpatient facility, if you want a drink of water, you hit a button at the bedside, and someone brings it to you. At home, you're likely to get up and walk to the kitchen yourself. This is also part of your therapy. As far as home health is concerned, the better therapists, in general, work for outpatient centers. Unfortunately, many home health therapists charge for the transit time, and patients get 10-15 minutes of therapy instead of an hour or more. (Exceptions do exist in both directions.)

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

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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.

Range of Motion

The work on range of motion is aimed at maintaining both extremes of motion. On one end is a completely straight knee (extension); on the other is a maximally bent knee (flexion). Both of these goals are obtained in the operating room. After the anesthetic wears off, motion may be painful. How painful will vary with many things, but you will be given plentiful pain medication. However, the more that you move your knee early in “the game”, the less it will hurt to move your knee.

The character of the pain should be different. Most people can tell the difference between post-surgical pain and the arthritic pain before the surgery. The relief of the arthritic pain has led some people to be very happy with the initial pain relief but avoid the post-surgical pain by not moving the knee. In the first few weeks after the surgery, gaining motion is much more important than cutting down on pain medication. In short – take the medicine and do the exercises.

Gaining range of motion is divided into two parts. When you’re in bed, do not prop your knee with pillows. Use this time to work on extension. Perhaps place the pillows under your heel, and allow gravity to help straighten your knee. When in a chair, do not prop up the surgical leg on a pillow or ottoman. Instead, place the heel of your opposite leg in front of the ankle of your surgical leg and use it to push the knee into greater flexion. The tendency is to do exactly the opposite, supporting the knee in mid-flexion with the ankle of the opposite foot. Again, please take the medicine and do the exercises.

Many patients ask about continue passive motion machines. Most surgeons in this area use them. There may be some very short-term benefit to these machines. The long-term benefit of continuous passive motion is by no means proven. The machines hurt, and patients on these machines need more pain medicine than those who don’t use them. Those who advocate their use claim that the need for forceful manipulation is decreased. Dr. Harris’ patients very rarely need manipulation—even without the use of the motion machine.

Weightbearing and Assistive Devices

Unless Dr. Harris has specifically told you otherwise, you may bear weight on your surgical leg as you tolerate it. Use a walker, crutches, or a cane as you need to, to keep yourself from falling over. Use these devices only as long as you need them, not one day longer. On the flip side, no patient has Dr. Harris's permission to fall and break anything. He does not give out airline miles for your returning to the hospital with something broken.

Wound Care

Your surgical dressing may be changed before your discharge from the hospital. If you stay less than two days, the dressing should be changed before three full days after the surgery. Whether you go to rehabilitation or you go home, please change the bandage at least once per day. You should clean the

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wound with sterile normal saline or dilute hydrogen peroxide (one part hydrogen peroxide to three or four parts water or saline). *Please do not use full strength hydrogen peroxide or alcohol to clean the wound.* These do more harm than good, particularly if used repeatedly. A thin film of antibiotic ointment is not harmful. Sterile normal saline can be purchased at most drug stores. Saline is also used for cleaning contact lenses. If you want a larger bottle, you may need a prescription. If so, please ask the pharmacy to call this office.

Before the wound is "bone dry," you may shower. To do this, get OpSite or Tegaderm and cover the wound. These are waterproof dressings that are available over the counter. They look a little like Saran Wrap™ with one sticky side. After the shower, removed the waterproof dressing and replace the regular gauze. Stay out of tubs and pools until the wound is at least three weeks old. Once you're more than a week beyond the surgery, no more than a few drops of a mix of blood and clear liquid are expected,.

After the wound has been "bone dry" for 48 hours, then no dressing is needed, in or out of the shower. Running water is good for the wound. You may want to keep a lightweight dressing over the wound to protect it from rubbing against clothing.

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 Knee 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 should the stitches be removed?

In rare cases, there are no stitches above the skin. The wound is closed under the skin. Generally, patients who receive total knee arthroplasties will have staples in the skin. IF there are only tapes, then, 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.

When can I drive?

This is the number one, most commonly asked question. PLEASE read this section! Between the patient 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 are no studies about reaction times after this new hip surgery. Further, there is a great deal more to driving than reaction times. There are probably many people out there right now who have no business driving and have not had recent surgery. A "formal blessing" would have to be based on the available literature. Technically, Dr. Harris cannot give his formal blessing to your driving for six weeks. My greatest concern about driving is your ability to react appropriately in an emergent situation. If there might be any hesitation in an emergent situation, don't get behind the wheel in the first place. When my kids were younger, I'd tell my patients that if they were going to drive early, call me at home so that I could keep them inside. 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.

How much pain medication should I take?

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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.

Conversely, don't try to wean from pain medicine too soon. It is important that you do the exercises and get your range of motion. If it hurts to do the exercises, take the pain medicine, and do the exercises. Don't fall into the trap of trying to get off the medicines too soon by not doing the exercises.

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 you 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. Most patients will receive either ten days of Coumadin followed by aspirin, or plain aspirin for the whole duration.

If you are on Coumadin at any point, 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, if you are to receive Coumadin for the entire duration, the doctor managing your Coumadin may change once during your treatment. If another doctor is currently managing yours, then ask that physician. If on Coumadin, you will require periodic blood tests to measure the effect of the drug on your system. Dr. Harris tries to limit the number of times that he sends

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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 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.

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. It is probably best that the "involved partner" not be "on top" for three weeks. This is a minimum amount of time for the wound to mature enough for direct weight bearing or rubbing that may be associated with sex.

A very few patients whose surgery involved a "re-do" of a previous arthroplasty, AND who have weight bearing restrictions, then a bit more planning is needed. Some people forget that touchdown weightbearing makes it very difficult, for example, to get onto both knees. 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?

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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.

The bottom line:

If you don't understand something, please ask. Dr. Harris is a firm believer that there are only two types of "stupid" question. One is the question that you don't ask. The other is the question that you ask five times. Pretty much everything else is legitimate.