Spire Healthcare

Knee replacement

A complete guide to your operation and recovery following knee replacement surgery

Contents

About this booklet

This booklet has been written to give you a better understanding of knee replacement. It contains advice on what you can do to help your operation and recovery go as smoothly as possible. To help you know what to expect, it also explains some of the care you will receive while you are in hospital.

Please read this booklet together with the Spire Healthcare hospitals leaflet, *Having a knee replacement*.

There is a glossary of terms at the back of the booklet. The words included in the glossary are printed in bold the first time they appear in the text.

Throughout the booklet, the illustrations show the operated leg coloured green.

Please bring this booklet with you when you come to the hospital for your operation.

About your care

Care pathways

A care pathway is a plan of expected care for all patients in Spire Healthcare hospitals having a particular type of operation. It lists all hospital care, from the **pre-operative assessment** (see page 13) until the time you go home. The aim is that every patient having a knee replacement follows the same pattern of care. This helps to make sure that Spire Healthcare hospitals are offering the same high quality care, based on the best available evidence, to all patients.

Your care pathway document is kept in your room.

Care pathways are used:

- as a guide to your expected pattern of recovery
- to record information that will help staff to prepare for your procedure and make arrangements for when you go home
- to make sure the hospital has a complete record of the care that you receive

The care you receive may sometimes be different from the standard care pathway, depending on your individual needs. Any variations in your care will also be explained in your own care pathway document.

Some of the advice and exercises included in this booklet may not be appropriate for you. Your surgeon, **physiotherapist** or **occupational therapist** will let you know when they want you to do anything differently.

Any member of staff caring for you will be happy to answer any questions you have about your care pathway, or any part of your treatment.

Your role in your treatment

It's important to realise that the operation itself is just part of your treatment. Preparation beforehand and rehabilitation afterwards are just as important. Throughout your treatment, from before the operation until after you go home, hospital staff will ask you to take an active role in helping to speed up your recovery.

About knee replacement

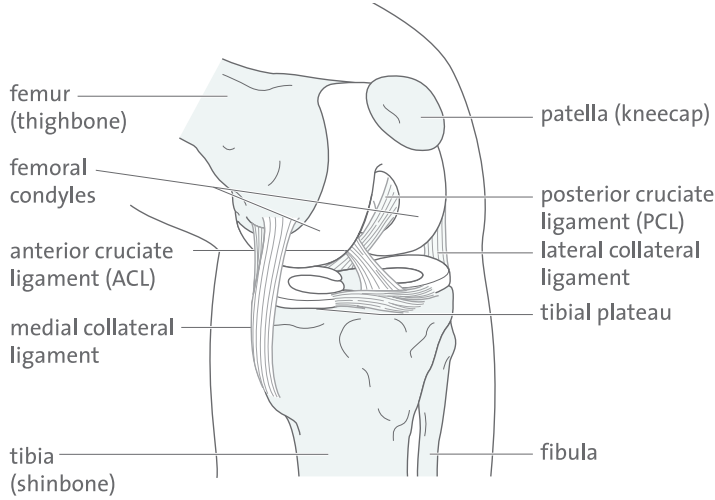
The knee joint

The knee joint is one of the largest and most complex joints in the body. It is a major weight-bearing joint, and is involved in bending, straightening, twisting and turning.

The knee joint is formed by the lower end of the femur (thighbone) and upper end of the tibia (shinbone), known as the **tibial plateau** (see figure 1). The surfaces of the bones that form the joint are covered with a smooth, shock-absorbing layer called **articular cartilage**. At the front of the knee lies a small bone called the kneecap (patella).

Strong ligaments support the knee joint. On the sides of the knee there are **medial** and **lateral collateral ligaments**. Within the knee, the **anterior** and **posterior cruciate ligaments** cross from the front to the back of the knee to give it stability.

Figure 1



The left knee joint

Why have a knee replacement?

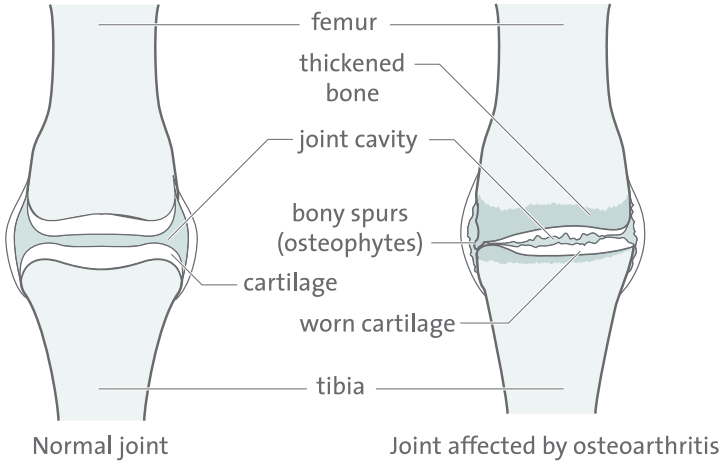
A knee replacement is an operation to replace a knee joint or part of a knee joint that is worn or damaged.

Your surgeon will usually only suggest the operation if other treatments, such as painkilling medicines, physiotherapy or walking aids, are not effective at controlling your symptoms. Your surgeon will decide which type of operation is best for you depending on how severe your symptoms are and your general health. But the final decision about whether to have surgery is yours.

The most common reason for having a knee replacement is a type of arthritis (joint damage) called osteoarthritis.

Osteoarthritis happens when the articular cartilage around the joints wears away, exposing the bone underneath (see figure 2). This leads to roughening of the bones and distortion of the joint, causing pain, stiffness and restricted movement. Bony protrusions called osteophytes may appear at the edges of the bone.

Figure 2



The knee joint affected by arthritis

About the operation

Knee replacement is an operation to replace parts of the knee joint that have been worn away or damaged. The damaged bone is replaced with a **prosthesis**.

Types of knee replacement

There are several different types of knee replacement, which are fitted after the damaged cartilage and bone are removed. A total knee replacement (TKR) replaces the end of the femur and the top of the tibia.

The end of the femur is usually replaced with a smooth metal surface, which fits onto a tibial plate. This plate is normally made of a type of plastic, which may be supported by a metal backing (see figure 3, page 8).

The two components may be fixed to the bone with surgical cement. Alternatively, components may be coated with a chemical called hydroxyapatite, which encourages bone to grow into them to help hold the components in place.

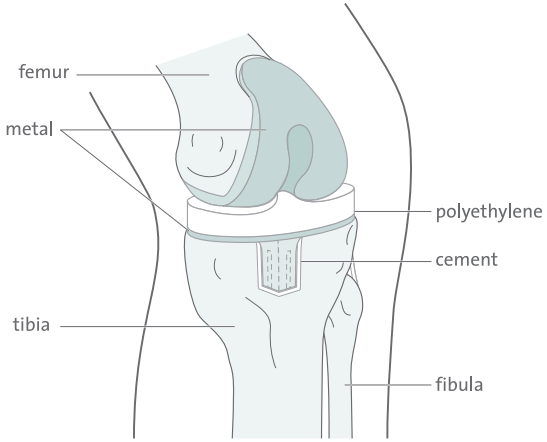
Sometimes osteoarthritis only affects one side of the joint, and it may be better to replace just this side. This is called a uni-compartmental knee replacement (see figure 3, page 8). It usually involves replacing just the inner (medial) part of the joint, leaving the undamaged part of the joint alone.

However, if there is a risk that the arthritis may have affected more of the joint, the surgeon may decide on a total rather than a uni-compartmental replacement. This decision may be made at the time of surgery, once the surgeon has seen the state of the joint.

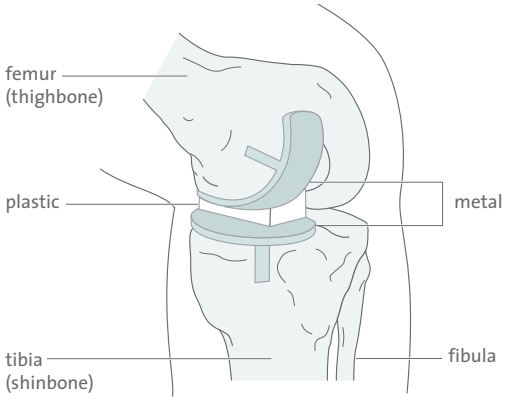
The anterior cruciate ligament is usually removed for a total knee replacement, and left in place for a uni-compartmental replacement. With some knee replacements, the posterior cruciate ligament is removed and with others it is left in place.

Figure 3

The knee joint after a total knee replacement



The knee joint after a uni-compartmental knee replacement



the left knee joint

During the operation, the kneecap is moved to the side and then put back over the prosthetic knee at the end of the operation. Sometimes the back of the kneecap (the part that is in contact with the new knee joint) is also replaced with a plastic prosthesis. This is called patellar resurfacing.

Your surgeon will discuss with you the exact type of knee replacement you are having.

Side-effects and complications

A knee replacement is a commonly performed and generally safe surgical procedure. However, all surgery does carry an element of risk. This can be divided into the risk of side-effects and the risk of complications.

Side-effects

These are the unwanted but mostly temporary effects of a successful procedure. An example is feeling sick as a result of the general anaesthetic and painkillers. After a knee replacement operation, the knee may be swollen and sore to move for up to three months. The skin over the knee is likely to feel numb. Sometimes this is permanent.

Your bowels may take a while to become active again and there may be difficulty passing urine on the first day or so. Some patients need to have a urinary catheter (a thin tube) inserted into the bladder. This drains urine into a bag beside the bed. A catheter is only used if you cannot empty the bladder normally.

Complications

This is when problems occur during or after the operation. Most people will not be affected.

The main possible complications of any surgery include an unexpected reaction to the anaesthetic or excessive bleeding during or soon after the operation. A blood transfusion may be required to replace the lost blood.

There are specific complications that can happen after a knee replacement:

- the wound or joint can become infected. Antibiotics are given during surgery to help prevent this.
- the incision may not heal properly because the thin skin over the knee doesn't have a very good blood supply.

- for up to six weeks after the operation, there is an increased risk of developing a blood clot (**deep vein thrombosis** or **DVT**) in the veins in the leg. This clot can break off and cause a blockage in the lungs. In most cases this is treatable, but it can be a life-threatening condition. Compression stockings and bloodthinning injections or tablets are used to reduce the risk of DVT.
- the new joint may be unstable due to stretching of the ligaments. In some cases it's not possible to make the new knee fully stable. It's possible for the kneecap to become dislocated. Further surgery is sometimes needed.

The chance of complications depends on the exact procedure you are having and other factors such as your general health. Ask your surgeon to explain how these risks apply to you.

Common questions

How long will I be in hospital?

You will be in hospital until you can walk safely with the aid of sticks or crutches, and carry out normal daily activities such as washing on your own. For most people this is three to five days, though it may be slightly more or less depending on the speed of your recovery. Some hospitals operate rapid recovery programmes which means it is more likely you will be discharged within 3 days of your operation. Please ask your surgeon for further details.

How long does it take to recover?

The external wound usually heals in seven to ten days, but it will take several weeks for the muscles and ligaments around the knee joint to heal. It will probably be six to twelve weeks before you are back to your usual activities.

Your surgeon will give you more advice about this. The table on page 20 summarises the progress most people make in the days after a knee replacement.

The time it takes to recover after a knee replacement depends on the exact type of surgery you have, your general health and how well you follow the guidelines you are given for recovery.

Being fit and healthy

Exercise

Being as fit and healthy as possible before your operation will help you recover quickly afterwards and reduce the chance of complications.

Physical activity is useful to help strengthen your legs, heart and lungs. Strong leg muscles will help to keep your new knee stable after the operation. Try to find an activity suitable for your level of mobility and fitness. For example, in the weeks leading up to your operation, try to walk a short distance each day if pain permits. Or you could find a suitable keep-fit class.

The most important muscles to strengthen before your operation are the **quadriceps** (thigh muscles), which straighten your knee and the **hamstrings**, which bend it.

Many of the exercises recommended after your operation work on these muscles (see page 22 to 25). If pain permits, try to do these on both legs three to four times a day.

These are just some examples. Your physiotherapist may give you a sheet with similar exercises. Your physiotherapist may recommend using a weight on your ankle. Ankle weights are available in sports shops.

In addition to these exercises, you may be advised to make sure you can straighten your legs as fully as possible before your operation. One way to do this is to lie on your front on a bench or bed, with your knees near the edge and your feet over the edge (see figure 4, page 12). Let the weight of your feet straighten your knees. This position may not be suitable for everyone, so check with your physiotherapist before you try it. He or she will tell you how often to lie like this.

After the operation, you will need to use your shoulders and arms more than usual, for example to move in bed. To exercise your upper body, push down on the arms of a chair and try to lift your bottom using your arms, continuing to take some weight on your feet.

Figure 4

Lie face down with your feet over the edge of the bed

Smoking

There are many reasons to stop smoking before your operation. If you smoke, try to give up as soon as you can.

A healthy weight

Being overweight or underweight before your operation can increase the risk of complications. Try to maintain a healthy weight for your height. You can ask your GP or practice nurse for advice.

Arrangements for afterwards

After a knee replacement you will be able to carry out most of your usual activities at home, and probably won't have to make many changes to your living arrangements.

However, this varies from person to person. You'll attend a pre-operative assessment before your operation, and your nurse or physiotherapist will be able to give you more advice. Some people need to make small changes, such as getting a chair that's a bit higher than their usual armchair, because it may be difficult to stand up from low chairs to begin with.

You will need to make sure someone is available to drive you home from the hospital, and should have a friend or family member to stay with you for a few days afterwards. If no one is available you may need to make alternative care arrangements.

Crutches or sticks

The hospital will supply you with sticks or crutches. You may need to pay for these.

Your hospital care

Pre-operative assessment

Before your operation, you'll have a pre-operative assessment at the hospital. The aim of this appointment is to check that you are fit enough to cope with the operation and to discuss what will happen when you come to hospital and whether you need to make any preparations.

A nurse will ask you about your previous medical and surgical experience, including any allergies you have and any medicines you are taking.

The nurse will record your blood pressure, temperature, pulse and weight. Samples of your urine and blood will be taken to check that your liver and kidneys are working. The nurse may do an ECG (electrocardiogram) test to check your heart for problems such as abnormal heart rhythm. A blood sample will be taken. This is checked in case you need a blood transfusion during or after your operation. The nurse will measure your legs for compression stockings.

Your nurse, physiotherapist or occupational therapist will also ask you questions about your living arrangements. He or she can then help you decide whether you need to make any arrangements.

The operation

An incision around 15 to 30cm (six to twelve inches) long is made down the front of the knee. When the joint has been replaced, the surgeon closes the incision with stitches or clips. The operation usually lasts up to two hours, or longer if both knees are treated.

For more details about the operation, please see the Spire Healthcare hospitals leaflet, *Having a knee replacement*.

Back on the ward

You won't have to spend a long time in bed. The amount of time you spend in bed depends on the exact operation you have, but it is usually less than 24 hours.

You may be wearing compression stockings or have a pump (called a **compression pump**) that inflates special pads to apply pressure to your lower legs. These help maintain the circulation in your legs to reduce the risk of blood clots forming (DVT).

If used, a compression pump is usually used for up to three days after the operation, but you will need to keep wearing compression stockings after you go home.

You will have a fine plastic tube running from the operation site into a bag beside your bed to drain fluid and blood from the operation site. Drains are normally removed the day after the operation. Sometimes special drains are used that allow your own blood (autologous blood) to be collected, filtered and returned to you.

You can help the nursing staff move you in bed by using your arms, your unoperated leg and the **monkey pole**, if your bed has one. It's best not to become too reliant on the monkey pole though, as you won't have one when you get home.

The nursing and physiotherapy staff will help you to the toilet, so you may not need to use a bedpan or bottle.

Pain relief

You'll have some pain, swelling and bruising in the soft tissue around your knee. The hospital staff will give you medicines to keep pain to a minimum. There are various methods available for controlling pain immediately after the operation.

Injections into the knee

Your surgeon may inject a painkiller directly into the knee area at the end of the operation. This provides pain relief for several hours. After this, you may be given more pain relief injections and/or tablets.

Injection into the spine

Your anaesthetist may give you an **epidural** or a spinal injection. An epidural allows the medicine to be topped up through a fine plastic tube (cannula). A spinal is a one-off injection. These injections work by blocking the pain nerves. They can also cause a temporary numbness and weakness in your legs. This is nothing to worry about and usually wears off after several hours.

If you have an epidural, you will normally have a urinary catheter put in place, which is removed after the epidural is taken out – usually less than 24 hours after the operation.

After the epidural is removed, or the spinal anaesthesia wears off, your nurse will give you painkiller tablets or **suppositories**, or both.

Patient-controlled pain relief

You may have a **patient-controlled analgesia (PCA)** pump. This is a pump that you operate, which delivers painkilling medicine into a vein, usually in the back of your hand. This means you can give yourself pain relief when you need it. It is designed so that you can't give yourself too much medicine. PCA is usually used for the first 12 to 24 hours. After this, your nurse will give you painkiller tablets or suppositories, or both.

The nurses will assess you regularly to find out how comfortable you are. Suffering from pain can slow down your recovery, so tell your nurses if you are in pain. While your pain level may be acceptable when resting it will increase when you move, so it's important to keep taking pain relief medicine regularly.

For more information about pain relief, please see the Spire Healthcare hospitals leaflet, *Pain relief after your operation*.

Eating and drinking

You'll be encouraged to drink normally, especially water. This will help prevent dehydration and constipation. You may be able to have something light to eat on the same day as your operation if your operation was early in the day. By the day after your operation you'll probably be able to eat a light diet.

Nausea and sickness are quite common side-effects of the general anaesthetic and painkillers, but medicines are available to help reduce these symptoms. Being unable to eat may slow down your recovery, so it's important to let the nursing staff know if you feel sick.

Starting rehabilitation

Recovering from your operation is a vital part of your treatment. It begins immediately after your operation and continues in the months after you return home. You will need to take an active role in your rehabilitation. It involves exercises or other interventions that help to:

- maintain good circulation of blood in the legs
- strengthen the leg muscles
- minimise swelling, which can cause stiffness
- minimise the build up of scar tissue in the joint, which can cause stiffness

Recovering from anaesthesia

Having a long anaesthetic can cause mucus (fluid) to build up in your lungs. You should try to breathe deeply and cough to help clear your lungs and prevent a chest infection. Your physiotherapist will talk to you about this. You'll start these breathing exercises as soon as you return to your room.

Maintaining circulation

Steps to help the blood circulate and reduce the risk of DVT may include:

- exercises and walking
- compression stockings
- compression pump
- injections of anticoagulant medicine just below the skin or taking oral anticoagulant medicine

Circulation exercises

These exercises help the blood to circulate in the legs and so reduce the risk of DVT. You should start these exercises as soon as you return to your room, and do them approximately every hour. You don't need to wait for your physiotherapist to visit.

- Wiggle your toes.
- Squeeze your buttocks together and hold for a count of three.
- Keeping your legs straight on the bed, point your toes up to the ceiling, and then point your toes and feet downwards as far as possible.
- Keeping your legs straight, rotate both feet at the ankle in each direction.

Getting your knee joint moving

Moving your knee will help to strengthen your leg muscles, minimise pain, stiffness and swelling and help to prevent scar tissue building up in the knee.

It's important to work on straightening your leg fully after the operation. Unless your surgeon gives you different advice, you should also be able to start to bend your knee immediately after your operation.

Active exercises

Regular exercises are a vital part of rehabilitation. Don't forget to exercise your unoperated leg too.

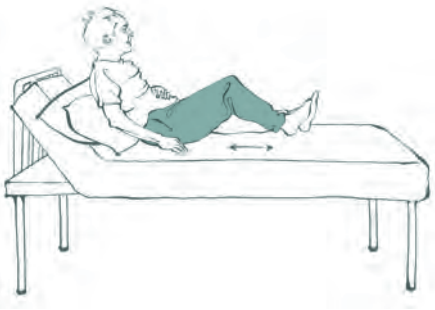
Your physiotherapist will explain some exercises you can do in bed the day after your operation. These may include those shown in figures 5 to 7. Your physiotherapist will tell you how often to do them and how many repetitions to do. This will gradually increase each day.

You should do these exercises independently, not just when your physiotherapist visits.

Figure 5

With one knee bent, push the back of the other knee down into the bed and pull the foot towards you. Hold and release.

Figure 6



Slide your heel up the bed towards your buttocks to bend your knee as far as you can. Keep your toes and knee pointing to the ceiling. A sliding board (or a tray or a magazine) may help.

Figure 7

Place a rolled up towel under your knee and raise your heel up off the bed until the leg is straight. Lower slowly.

Reducing swelling

- Ice
  You may be fitted with an ice cuff that fits snugly around your knee. This also applies some compression to reduce swelling.

- You may be advised to continue using ice at home. If so, you can use a bag of frozen peas wrapped in a tea towel. Take care not to apply ice directly to the skin.

- Cooling your knee with ice reduces pain and prevents swelling, which can cause stiffening and reduce mobility. Your nurse or physiotherapist will tell you how long to ice your knee for and how often to do it.

- Putting your leg up
  When resting, put your operated leg up from time to time to help prevent swelling. Your foot needs to be higher than your hip. However, you should not sit like this for long periods. Your physiotherapist will give you more advice about this.

Getting up and about

Usual recovery times

The following table summarises the minimum progress you can expect to make in hospital after your operation if you are in good health and there are no complications.

Activity	When
Get out of bed to sit in a chair, using a frame and with help from your physiotherapist	Same day or next day
Walk with a frame in the corridor, with help from your physiotherapist	One to two days
Walk with a frame on your own	One to two days
Walk with crutches or sticks with help from your physiotherapist	Two to three days
Walk with crutches or sticks on your own	Two to three days
Shower in a walk-in shower on your own	Two to four days
Walk up and down stairs, with supervision	Two to four days
Go home	Two to five days

Your physiotherapist will teach you how to stand, get in and out of bed, sit down, walk, and go up and down stairs. Your occupational therapist or physiotherapist will advise you on the best way to bath or shower and to get dressed. You'll be confident with all these activities before you go home.

The amount of weight you can put on your operated leg depends on many factors, including the type of operation you have had and your health. Your physiotherapist and surgeon will explain how much weightbearing is appropriate for you.

Standing up

You will probably get out of bed, take a few steps and sit in a chair on the same day or the day after your operation.

When you stand up for the first time, your physiotherapist will help you, and you will have a walking frame. You may feel slightly light-headed. This is common immediately after surgery, but it usually disappears quickly.

Walking

You will usually be able to put your foot on the ground and take weight on your new knee. Your physiotherapist will give you walking aids and teach you how to use them. You will probably start walking using a frame, and progress to crutches or sticks before you go home. The walking sequence should be:

- walking aid
- operated leg
- unoperated leg

If you have had both knees replaced in the same operation, your physiotherapist will give you advice that is appropriate for you.

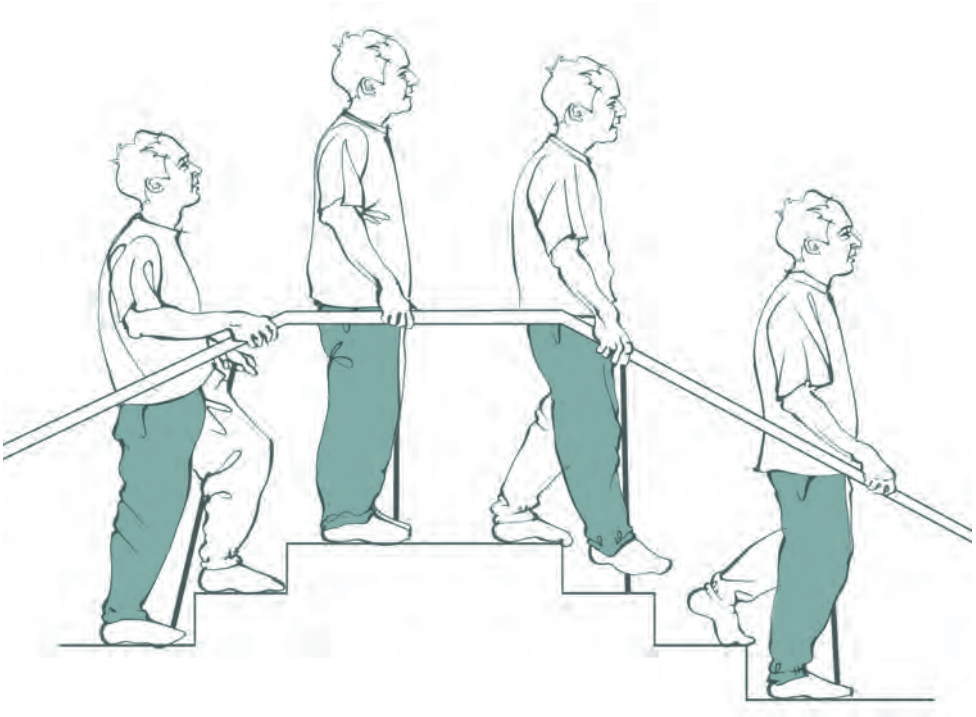
Using stairs

Your physiotherapist will show you how to go up and down stairs (see figure 8 next page). Use your free hand on the banisters, if there are any. You'll be shown how to hold your other crutch or stick.

Remember:

- going upstairs, unoperated leg leads, followed by operated leg and walking aid together on to the same step
- going downstairs, operated leg leads, together with walking aid, followed by unoperated leg on to the same step.

Figure 8



Going up and down stairs

More exercises

Seated exercises

Once you are moving around more easily, your physiotherapist will show you some more exercises. These may include those shown in figures 9 to 12.

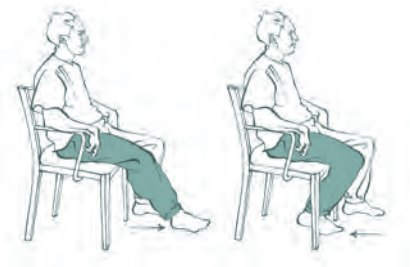
Figure 9

Sit and allow your knee to stretch for five to ten minutes, three to four times a day.

Figure 10

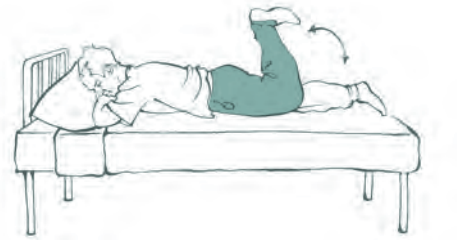
Keeping your thigh in contact with the chair, lift your lower leg and straighten the knee. Lower slowly.

Figure 11



Sitting in a chair, straighten your leg out in front of you by sliding the heel forwards, then bend the knee back as far as possible until you feel a stretch over the front of the knee.

Figure 12



Lie on your front. Bend one knee at a time, trying to move your heel towards the buttock. Lower slowly.

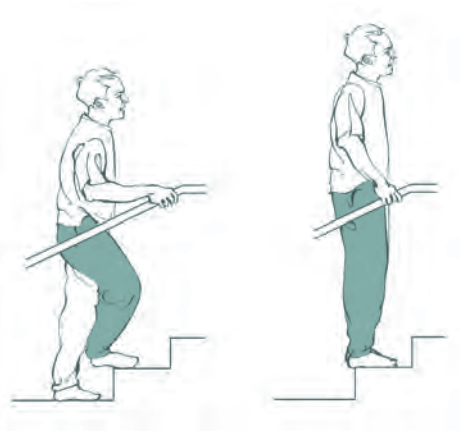
Standing exercises

Your physiotherapist will show you some exercises that you can do while standing. These may include those shown in figures 13 and 14. Try to do these every day and continue with them at home.

Figure 13

Holding on to a firm surface, stand up on your tiptoes. Then squat until your knees are bent to 60° to 90°. Stand up again, using as little help from your arms as possible.

Figure 14



Holding on to the banisters, step up with your operated leg on to the bottom stair (about 15cm or 6 inches). Slowly step down, using your operated leg.

Daily activities

Your occupational therapist or physiotherapist will make sure that you can manage normal activities safely on your own before you go home.

Showering and bathing

Many people are worried about washing themselves after their operation, but your nurse, physiotherapist or occupational therapist will show you how to do this.

For the first few weeks, it's best to shower rather than have a bath. A walk-in shower is easiest. Make sure you always use an anti-slip mat in the shower.

If you don't have a walk-in shower, you can use a bath board over a bath – your physiotherapist or occupational therapist will show you how to use this.

It's best not to sit in a bath until your wound is fully healed (around seven to ten days). But if you want to have a bath, try to keep your surgical wound out of the water.

Dry the wound by patting it with a clean towel.

Getting dressed

If you plan to wear a dressing gown in hospital, make sure it's not too long. Wearing slippers with backs to them will also reduce the risk of falling.

You'll be encouraged to get dressed as normal. It's a good idea to wear loose-fitting clothing as this will be most comfortable.

You may need to wear compression stockings for around six weeks after the operation to reduce the risk of DVT. If you do, then you will need someone to help you dress because they are difficult to put on.

Going home

Most people go home three to five days after their operation, but this varies for each person. If you are on a rapid recovery programme you are more likely to go home within 3 days of your operation.

You'll need to arrange for someone to collect you in a car and drive you home. If possible, arrange for someone to stay with you at home for at least a day or two, until you settle back in at home.

Getting into a car

When getting into a car at first, it's easiest to sit down on the seat first and then lift your legs in. It may be helpful to put a plastic bag on the seat to help you slide on to it. If you do use a plastic bag, take this out before you set off to prevent you slipping forwards as the car slows down.

When getting into the car, you may find it helpful to hold on to the doorframe or the seat back for support. If you use the door for support, make sure that someone is holding it open for you.

Getting active again

Your rehabilitation continues at home. It's important to continue with your exercises every day, as they will help you become active more quickly. It's best to alternate your activity between moving around (doing your exercises or walking) and resting (sometimes sitting, sometimes lying down, using an ice pack as advised).

Try to increase your activity gently, walking a little further each day. Don't do anything that involves standing or sitting for a long time.

If you are using one stick, hold it in the opposite hand to the operated leg. When you are no longer really using your stick and you are not limping, you can start to walk unaided. It's still a good idea to take the stick with you, especially if you are walking longer distances or in crowded places. Your surgeon or physiotherapist can provide further advice.

Driving

You can normally drive again after about six weeks, depending on your surgeon's advice. This also depends on which leg is operated on.

You should not drive until you feel you have the speed and mobility to drive safely, including being able to perform an emergency stop. You may not be insured to drive until your surgeon has advised you it is safe to do so.

Sex

Sexual intercourse can usually be resumed whenever you feel ready, provided your surgeon hasn't given you any different advice.

Sports and hobbies

After around three months you may be able to return to active or sporting hobbies, such as gardening, swimming or golf. Your surgeon can give advice about your specific activities.

You will be unable to kneel back on your heels, but you can usually kneel as long as you keep your knees at an angle of 90° or more. If you do want to kneel, for instance when gardening, use a kneeler stool that has handles to help you get up.

Travel

If you plan to travel a long distance in the first 12 weeks or so, talk to your surgeon first because of the risk of DVT. It may also be helpful to ask the travel company to make arrangements for assistance or extra legroom.

If you plan to fly, bear in mind that your prosthesis may be picked up by airport metal detectors, so it's advisable to carry written proof of your knee replacement. Your surgeon or GP can give you more advice about this.

Work

The time it takes before you can return to work (if applicable) depends on how physically demanding your job is. Your surgeon will advise you about this.

Follow-up appointments

Your surgeon will normally review your progress between two and six weeks after you go home.

In the meantime, if you have any questions please call the hospital. The contact numbers are on page 32.

Continuing physiotherapy

You may be invited to visit the physiotherapy department as an out-patient until your knee has regained as much movement as possible, and the muscles are strong enough to support your knee without the use of the stick(s). You will be asked to arrange your first out-patient appointment before you go home.

Infection

The risk of infection after your knee replacement is very low. However, you should contact your surgeon if you get any signs of infection, such as a high temperature, redness around the joint or an increase in pain. You may need a course of antibiotics.

You may need to inform your dentist about your knee replacement, especially if you get a tooth abscess. Most dentists routinely ask about joint replacements before starting any treatment.

In the long term

Health and fitness are important. To minimise stress on your new knee joint, try to keep to a weight that is appropriate for your height and stay as active as possible. Your surgeon will discuss any activities you may need to avoid to prolong the life of your new knee.

A first knee replacement usually lasts for at least ten years. After this, it may need to be replaced in a revision operation.

Glossary

Anterior
Towards the front of the body.

Articular cartilage
The shock-absorbing substance that protects joints and helps them move smoothly.

Bath board
A board that fits over a bath for you to sit on while washing.

Collateral ligaments
Ligaments on each side of a joint, in this case the knee joint.

Compression pump
A pump that helps blood to circulate in the legs. Pads are wrapped around your feet or calves and these inflate with air alternately. This squeezes the bottom of each foot or the leg, which helps to keep your blood moving.

Compression stockings
Sometimes called TED (thromboembolic deterrent) stockings, these are tight elastic stockings that help blood circulate in the lower legs. They help prevent blood clots in the deep veins (DVT).

Cruciate ligaments
Two ligaments inside the knee joint that cross over. These help to support the knee joint.

Deep vein thrombosis (DVT)
A blood clot in a deep vein, most commonly in the leg. The risk of DVT is increased after major surgery, leg operations and when immobile for long periods of time. For knee surgery, preventive measures are used. These include medicines to reduce blood clotting (anticoagulants), compression stockings and/or a compression pump.

Epidural
An injection given into the epidural space – an area around the spinal cord. A fine tube (cannula) is left in place so the medicines can be topped up. This provides pain relief and may numb the legs and abdomen. An epidural infusion can be used for anaesthesia during surgical procedures or for pain relief after surgery.

Hamstrings
The muscles at the back of the thigh, which bend the knee.

Hydroxyapatite
A compound that may be used to coat components in an uncemented knee replacement. It encourages bone to grow into it to hold the components in place.

Lateral
The side of the body that is furthest from the middle. In the case of the knee joint, this means the outside of the knee.

Medial
The side of the knee that is nearer to the middle of the body. In the case of the knee joint, this means the side of the knee closest to the other knee.

Monkey pole
A bar suspended above the bed that you can use to lift yourself slightly and move around in bed.

Occupational therapist
A healthcare professional trained to show you ways to manage daily activities more easily. As not all hospitals have an occupational therapist, this role may be filled by a physiotherapist.

Patient-controlled analgesia pump (PCA)
A device that you operate, that delivers a dose of painkilling medicine into a vein.

Physiotherapist
A healthcare professional trained to show you how best to move around and advise you on exercises.

Posterior
Towards the back of the body.

Pre-operative assessment
A hospital appointment a week or so before the operation, when you will talk to the nurses and physiotherapists about your health, medicines you may be taking, and any arrangements you may need to make for after the operation. The nurses will do some tests to make sure you are fit for surgery, such as a blood test, an ECG (electrocardiogram) and a urine test.

Prosthesis (plural prostheses)
An artificial substitute for a body part.

Quadriceps
The muscles at the front of the thigh, which straighten a bent leg.

Sliding board
A smooth board that can be placed under the foot and leg to reduce friction, so that sliding the leg in bed is easier.

Suppository
A small bullet-shaped plug of medicine designed to be inserted into your back passage.

Tibial plateau
The flattened part of the tibia, at the top of the bone, which forms the joint with the femur.

Total knee replacement (TKR)
An operation where the whole joint is replaced with a prosthetic knee.

Uni-compartmental knee replacement
A half-knee replacement, which may be used if only one side of the joint is affected by the disease.

Urinary catheter
A fine plastic tube that drains urine out of the bladder and into a bag beside your bed.

More information

Please ask your nurse for the Spire Healthcare hospitals patient information, *Having a knee replacement* and *Pain relief after your operation*.

Arthritis Research Campaign
Telephone 0870 850 5000
www.arc.org.uk

British Orthopaedic Association
Telephone 020 7405 6507
www.boa.ac.uk

Contact details

Your surgeon

Contact number

Your nurse

Contact number

Your physiotherapist

Contact number

Your occupational therapist

Contact number

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