Spire Healthcare

Hip replacement and resurfacing

A complete guide to your operation and recovery following hip replacement and resurfacing surgery

Contents

About this booklet

This booklet has been written to give you a better understanding of hip replacement and hip resurfacing. It contains advice on how to help your operation and recovery go as smoothly as possible. It also explains some of the care you will receive while you are in hospital.

If you are having a total hip replacement, please read this booklet together with the Spire Healthcare hospitals leaflet, *Having a hip replacement*.

There is a glossary of terms at the back. The words you will find 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.

There is space on page 34-35 for you to write down any questions or notes that you think of as you read through the booklet.

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

About your care

Care pathways

Each patient has a planned pattern of hospital treatment, called a care pathway. 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 12) until the time you go home. The aim is that every patient having a hip replacement follows the same pattern of care. This helps to make sure 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.

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 one 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 do things, such as exercises, to help speed up your recovery.

About hip replacement and resurfacing

The hip joint

The hip is a ball and socket joint. The ball is formed by the head of the thighbone (femur), which fits snugly into the socket of the pelvis (acetabulum) (see figure 1 on page 6). The surface of these bones is covered with a smooth, shock-absorbing layer called articular cartilage.

Why have a hip replacement or resurfacing?

Hip replacement and resurfacing are operations to replace a hip joint that is damaged or worn.

These operations are usually only suggested if other treatments, such as painkilling medicines, physiotherapy or walking aids, are not effective at controlling your symptoms. Your surgeon will advise 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 go ahead with surgery is always yours.

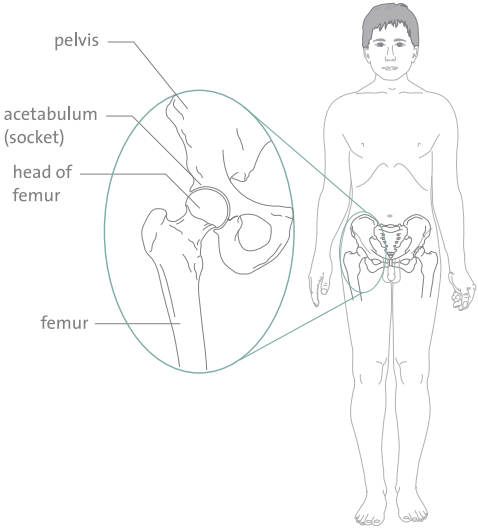
The most common reason for having a hip replacement or resurfacing is to treat a type of arthritis (joint damage) called osteoarthritis.

Osteoarthritis happens when the articular cartilage around joints wears away, exposing the underlying bone (see figure 2 on page 6). This leads to roughening of the bones and distortion of the joint, causing pain, stiffness and restricted movement. The hip joint is commonly affected by osteoarthritis. The leg on the affected side may become shortened, muscles may become weaker and a limp may develop.

Other conditions that might lead to a hip replacement include:

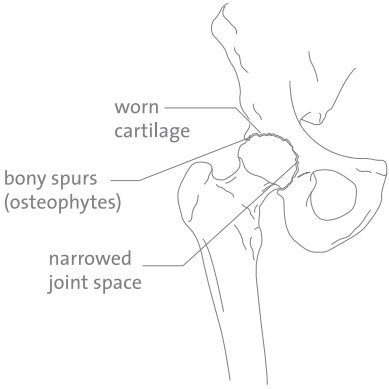
- other types of arthritis – eg rheumatoid arthritis
- childhood hip problems
- injury
- cancer

Figure 1



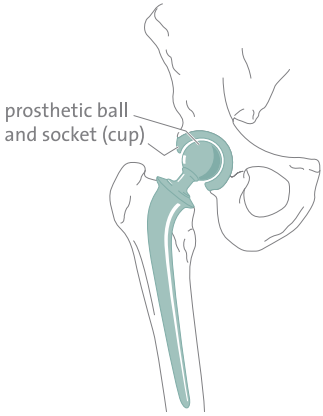
Location of the hip joint

Figure 2



A hip joint affected by arthritis

Figure 3



A hip joint after a total hip replacement

About the operations

Hip replacement and hip resurfacing are operations to replace parts of a hip joint that have been worn away or damaged. The damaged bone joint is replaced with a **prosthesis**.

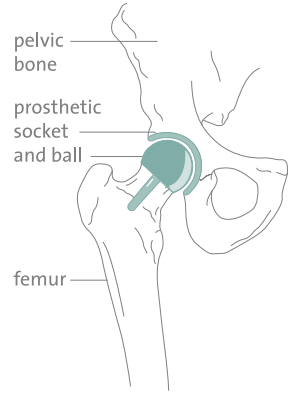
A total hip replacement replaces the worn head of the femur with a metal or ceramic ball on a stem, which is inserted into the centre of the bone. A cup is fitted into the acetabulum (see figure 3 on page 6). This is made of a tough plastic or a ceramic material. These two components may be fixed to the bone by special surgical cement. Some components are coated with a compound that encourages bone to grow into them to hold the component in place. This means cement does not need to be used.

With hip resurfacing, the components, which are usually made of metal, are smaller and just cover the surfaces of the head of the femur and the hip socket (see figure 4). This means that more of the original bone can be left in place.

Both procedures are designed to relieve pain and may also improve joint movement. Total hip replacement can sometimes correct any leg shortening, although it is not always possible to make the legs the same length.

Hip resurfacing is not suitable for every patient. Your surgeon will decide which type of prosthesis is most suitable for you. The decision about which type of prosthesis to use depends on many factors, such as your age, health and symptoms.

Figure 4



A hip joint after hip resurfacing

Methods of surgery

There are various ways to do a hip replacement or resurfacing. The cut that allows the surgeon access to the hip joint can be made in different places.

The site of the cut and the way the surgeon carries out the operation can make a difference to how you can move after the operation. Certain methods mean that you will need to restrict how you move to prevent the hip from dislocating (see page 15).

These precautions are not needed with some types of hip replacement or with hip resurfacing. The exact choice of surgical method is down to the surgeon. Your surgeon will explain the method he or she will use and whether the precautions apply to you.

Side-effects and complications

A planned hip replacement or resurfacing is generally a safe surgical procedure. For most people, the benefits are greater than the disadvantages. 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 hip replacement, the area is likely to be uncomfortable for several weeks. There may also be some temporary pain and swelling in the knee and it is quite common to have a swollen ankle for up to three months afterwards. 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 also complications specific to a hip replacement or resurfacing operation:

- an infection of the wound or joint may develop. Antibiotics are given during surgery to help prevent this.
- for up to six weeks after the operation, it is possible to develop 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, an intermittent compression pump, blood-thinning injections or tablets may be used to reduce the risk of DVT.
- occasionally, small cracks in the bone result in a hip fracture during the operation. This can be treated but may slow down your recovery.
- the nerves controlling the leg can be damaged. This is usually mild and temporary.
- after a total hip replacement, the new joint may dislocate. This is most likely to happen immediately after the operation and is straightforward to deal with. Very occasionally, dislocation happens repeatedly, requiring further surgery. Following any precautions your surgeon recommends (see page 15) will help to reduce the risk of dislocation.
- the operated leg may be a slightly different length. This may improve over the three months after the operation, as the new joint settles into alignment and gains strength. But sometimes a raised shoe on the shorter side is necessary.

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 are able to walk safely with the aid of sticks or crutches. 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 scar usually heals in seven to ten days, but it will take several weeks for the muscles and ligaments around the hip 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 18 summarises the progress most people make in the days after a hip replacement.

The time it takes to recover after a hip 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.

Preparing for your operation

Being fit and healthy

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

Exercise

Walking is excellent exercise for your legs and is also good for your heart and lungs. In the weeks leading up to your operation, try to walk a short distance each day if pain permits. Increase the distance slightly each time. Attending a physical activity or keep-fit class appropriate for your level of mobility and fitness would also be useful.

There are some exercises that you can do at home to strengthen your muscles and make your joints more mobile. Similar exercises will be recommended after your operation. This page includes some examples. Your physiotherapist may give you a sheet with similar exercises.

- Sitting in a chair, slowly rotate each foot clockwise and anticlockwise.
- Sitting in a chair with your feet on the floor, pump your feet up and down by bending your ankle upwards and pointing your toes downwards.

- Sitting in a chair, raise your foot from the ground as far as you can so that your leg straightens out. Keep your thighs on the chair. Hold for a few seconds and slowly lower your foot. Repeat with each leg (see figure 14, page 22).
- Standing up, hold on to a firm surface with one hand and slowly swing your leg forwards and backwards, keeping your leg straight. Do not lift your leg more than 45° (see figures 16 and 17, page 23 to 24).
- After the operation, you will need to use your shoulders and arms more than usual, for example, to sit down. 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.

Smoking

There are many medical reasons to stop smoking before your operation. If you smoke, try to give up as soon as you can. Ask your GP for advice or ring Quitline on 0800 00 22 00.

A healthy weight

Being overweight or underweight before your operation can increase your risk of complications. Try to maintain a weight that is appropriate for your height. You can ask your GP for advice.

Arrangements for afterwards

You can make things easier for yourself when you get home. You may need to make some changes to your living arrangements.

There are a number of aids available to help with everyday activities. These include a **"helping hand"** and a long-handled shoehorn. Your physiotherapist may recommend other aids, depending on your height and the type of operation you are having. These might include a raised toilet seat, a **toilet frame**, a **bath board**, a trolley and a high stool for kitchen work. Aids are available from the hospital, or you can buy or hire them yourself. The British Red Cross has a medical loan service (see page 33 for contact details).

You will need to make arrangements for family or friends to stay with you after you go home. Make sure they will be available from two to three days after your operation. If this is not possible, you may need to make alternative care arrangements. Discuss this with your nurse or physiotherapist at your pre-operative assessment (see page 12).

Crutches

The hospital will supply you with sticks or crutches. You may need to pay for these. They cost about £15.

Your hospital care

Pre-operative assessment

Before your operation, you'll have a pre-operative assessment at the hospital. At this appointment 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. Your blood group 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 questions about your living arrangements, such as how high your usual armchair is. He or she can then help you decide which aids you might need and advise you on how to organise them.

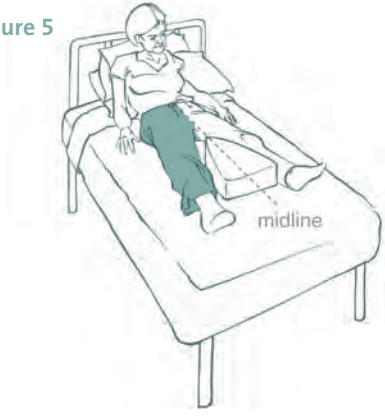
The operation

For total hip replacement, an incision, usually around 10 to 15cm (four to six inches) long is made along the hip and thigh. This will be longer for hip resurfacing. When the joint has been replaced or resurfaced, the surgeon closes the incision with stitches or clips. The operation usually lasts about an hour. You'll spend some time in a recovery room after the operation before returning to your room, so you will be away from your room for two to three hours.

Back on the ward

You won't need to spend a long time in bed. The amount of time you spend in bed depends on the exact operation you have and your general health, but it is usually less than 24 hours. If you are following the precautions on page 15, your legs may be positioned slightly apart with a triangular wedge or pillow (see figure 5), or with your operated leg resting in a foam trough to hold it in place. This prevents your legs crossing the **midline** and minimises the risk of dislocation.

Figure 5



Lying in bed with a wedge pillow

You may be wearing compression stockings or have an intermittent compression pump to apply pressure to your lower legs. These help maintain the circulation in your legs to reduce the risk of blood clots forming (DVT).

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 may need to lie on your back rather than your side at first to help prevent your leg from crossing the midline. After around six weeks, you may be able to lie on your operated side – check this with your surgeon or physiotherapist.

You can help the nursing staff to 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 rely too much on the monkey pole though, because you won't have one when you get home.

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

Eating and drinking

You'll be encouraged to drink plenty, especially water, to help prevent dehydration and constipation. By the day after your operation you will probably be able to eat a normal diet.

Nausea and sickness are common side-effects of general anaesthetic drugs and painkillers, but medicines are available to help reduce them. Being unable to eat may slow down your recovery, so it's important to tell your nurses if you feel sick.

Pain relief

You'll have some pain, swelling and bruising in the muscles and ligaments around your hip. The hospital staff caring for you will give you medicines to keep any pain to a minimum. There are various methods for controlling pain immediately after the operation.

Injections into the spine

Your anaesthetist may give you an epidural or a spinal injection. For an epidural, the medicine can be topped up through a fine plastic tube (cannula). A spinal injection is a one-off injection. These injections work by blocking the pain nerves. They can also lead to 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 or so. After this, your nurse will give you painkiller tablets or suppositories, or both.

Your 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 separate Spire Healthcare hospitals leaflet, *Pain relief after your operation*.

Precautions

You'll be able to move around soon after your operation and will not be in bed for longer than one day (see table on page 18). In some cases, patients are encouraged to move around on the day of their operation.

But after a hip replacement the new joint is not well supported by muscles and ligaments at first. This means it can become dislocated more easily than usual. So you will need to be careful how you use your hip for six to twelve weeks.

After some types of hip operation, there are specific precautions you need to follow. These can include those shown here and on the following page.

After a hip resurfacing, the joint is less likely to dislocate, so your surgeon may not ask you to follow these specific precautions. However, he or she may ask you to take care how you move your hip joint.

Your surgeon and physiotherapist will tell you which, if any, precautions apply to you.

Figure 6

Don't bend the hip joint more than 90°

Figure 7

Don't let your operated leg cross past the midline to the other side of your body

Figure 8

Don't twist the operated leg

Figure 9

Slide your heel up the bed towards your buttocks. Keep your toes and knee pointing to the ceiling. Stop at a distance that's comfortable, with your hip bent less than 90°. Then slide it back.

Bed exercises

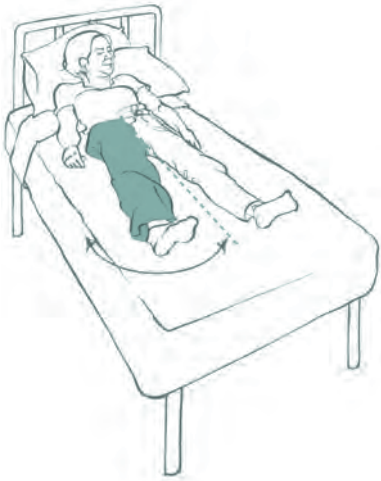
Leg exercises are very important because they minimise the risk of blood clots forming, strengthen your muscles and keep your joints moving.

Your physiotherapist will explain some exercises to do in bed. You should do these exercises regularly. You don't need to wait until your physiotherapist visits you.

- Breathe deeply and cough – this helps to prevent chest infection.
- Wiggle your toes.
- Pump your feet up and down and rotate them to move your ankles.
- Tighten your thigh muscles by pushing your knee down into the bed.
- Squeeze your buttocks together, hold and release.

As you progress, your physiotherapist will show you more exercises (see figures 9 to 11).

Figure 10



Depending on the type of operation you have had you may be able to slide your leg slowly out to the side a short distance. Keep your toes and knee facing the ceiling. Then slide it back.

Figure 11

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

Getting up and about

Usual recovery times

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

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 of 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

The day after your operation, you will probably get out of bed, take a few steps, and sit in a chair.

When you stand up for the first time, you'll have support from your physiotherapist, plus a walking aid – usually a frame. You may find you feel slightly light-headed. This is common immediately after surgery, but it usually disappears quickly.

Activity	When
Get out of bed and sit on a chair	Day of operation or after one day
Walk with a frame in the corridor, with guidance from your physiotherapist	One to two days
Walk with sticks, with guidance from your physiotherapist	One to three days
Walk with sticks or crutches on your own	One to three days
Go up and down stairs	Two to four days
Go home	Two to five days

Getting in and out of bed

You will be told how to get in and out of bed, and you may need help for the first few days (see figures 12a to 12c).

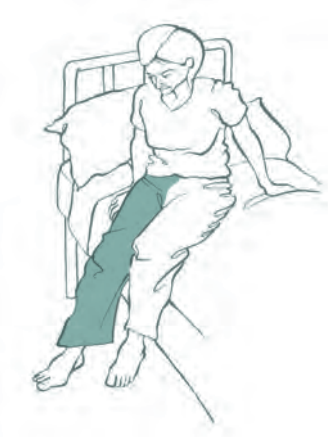
If you have been advised not to let your operated leg cross the midline, you will find it easier if you try to get in and out of bed on the same side as the operated leg. If this is not possible at home, your physiotherapist or occupational therapist will discuss other ways to get in and out of bed.

Your bed should be firm and high enough so that when you sit on the edge of it your knees are lower than your hips.

Figure 12a

Getting out of bed – move the operated leg out of the bed first, making sure your operated leg does not cross the midline

Figure 12b



Then put your feet on the floor

Figure 12c

Then stand up with the help of a walking aid

When getting into bed, step backwards until your legs are touching the bed. Sit down as described below.

Sitting

To sit down:

- lean your crutches or sticks to one side, within easy reach
- feel for the chair or bed with the back of your legs (see figure 13a)
- feel for the arms of the chair with your hands (see figure 13b)
- lower yourself down, keeping your operated leg about 15cm (six inches) out in front of you, taking the weight on your good leg (see figure 13c)

It is best to sit in a firm, upright chair with arms (see figure 13d). Sitting in a high chair will help to stop you over-bending the hip joint, if you are following the precautions on page 15. Check that your thighs slope downwards, so your knee is always lower than your hip. This may mean you won't be able to sit in a low armchair or sofa for six to twelve weeks after your operation.

Don't cross your legs, as this would bring your operated leg past the midline. It's probably best not to sit on swivel chairs, but if you do, take care not to twist your hip.

Your physiotherapist will show you exercises you can do when sitting (for example, see figure 14, page 22).

Figure 13a

Feel for the chair arms with your hands.

Figure 13b

Feel for the chair or bed with the back of your legs.

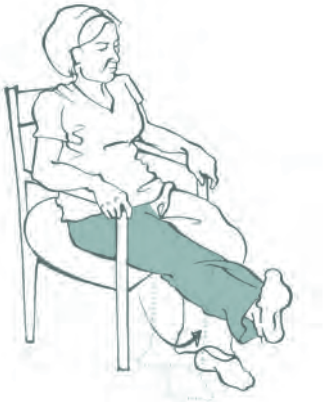
Figure 13c

Lower yourself down, keeping your operated leg about 15cm (six inches) in front.

Figure 13d

Keep your walking aid within easy reach

Figure 14



Keeping your thigh in contact with the chair, lift your foot to straighten your knee. Lower slowly.

Walking

Your physiotherapist will show you how to walk with walking aids. You will probably start with a frame and then progress to crutches or sticks. The walking sequence should be:

- walking aid (frame or two sticks/crutches)
- operated leg
- unoperated leg

You can turn around either way but take care not to pivot or twist on your operated hip. Pick up your feet with each step.

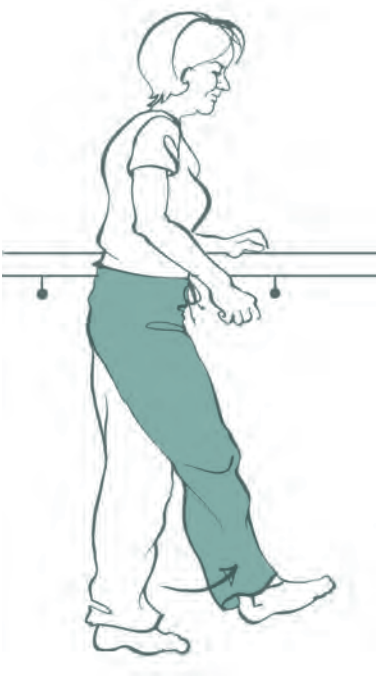
When you are walking confidently, your physiotherapist will show you exercises to do while standing. These may include those shown in figures 15 to 18 (page 23 to 24). When you do these, stand with your legs straight and your tummy tightened to keep your spine straight, and hold on to a firm surface for support.

Keep your toes pointing forward for all these exercises.

Figure 15

Standing on your good leg, raise and lower your knee on the operated side

Figure 16

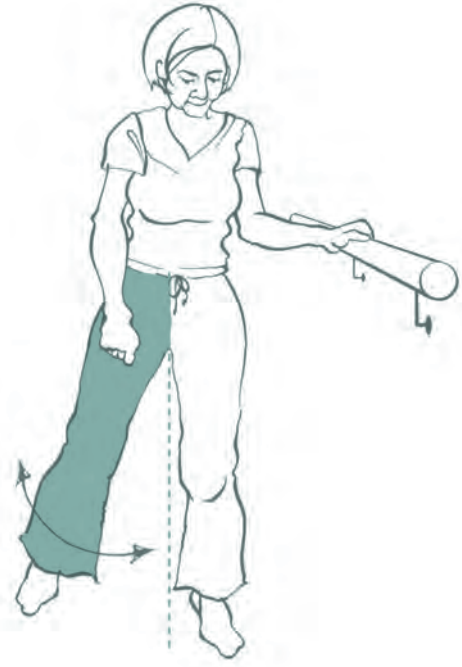


Standing on your good leg, lift the operated leg slowly forwards with your leg straight (hip **flexion**).

Figure 17

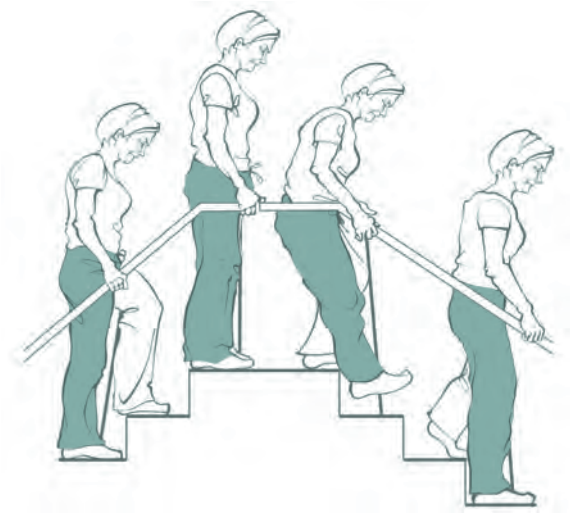
Standing on your good leg, lift the operated leg slowly backwards with your leg straight (hip **extension**).

Figure 18



Standing on your good leg, lift the operated leg out to the side (hip **abduction**), hold, and bring back to the midline.

Figure 19



Going up and down stairs

Using stairs

Your physiotherapist will show you how to go up and down stairs (see figure 19). Use your free hand on the banisters if there are any. Take one step at a time. You'll be shown how to carry your other crutch or stick.

Remember:

- going upstairs, your unoperated leg leads, followed by operated leg and walking aid together
- going downstairs, your operated leg leads, together with walking aid, followed by unoperated leg

Hold your stick or crutch in the opposite hand to your operated leg. Use it when you step forwards with the 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. Whatever activity you are doing, follow the precautions on page 15, or as your surgeon has advised.

Using the toilet

Follow the same procedure as for sitting down. Keep your clothes around your knees so you don't need to bend down to pick them up.

Some people need to use a raised toilet seat at home for six to twelve weeks after the operation. This should be firmly attached to the ceramic toilet bowl.

Showering and bathing

Many people are worried about washing themselves after the operation, but your nurse, physiotherapist or occupational therapist will show you how to do this, and advise you about any equipment you'll need.

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

A walk-in shower is easiest. If you only have a shower over your bath at home, your physiotherapist or occupational therapist will check whether you can safely step into a bath to use the shower.

If not, your occupational therapist or physiotherapist will discuss other ways to wash, such as strip-washing.

After around six to twelve weeks, you can usually have a bath.

Getting dressed

If you want to wear nightwear for walking around in the hospital, make sure your dressing gown is not too long and your slippers have backs to them to reduce the risk of tripping over.

You'll be encouraged to dress in day clothes after a few days. Loose-fitting clothing will be most comfortable.

Get dressed while sitting on a chair or bed. Dress the operated leg first.

You may require a **stocking/sock aid** or long-handled shoehorn to avoid bending forwards. Your physiotherapist or occupational therapist will show you how to use these.

You may need to wear compression stockings for several weeks after the operation. These are difficult to put on, so make sure someone helps you with them when you are dressing. Don't try to put them on yourself.

Using a "helping hand"

A helping hand device will help you to dress your lower half and to pick up objects, without bending down. You should use one of these for about six weeks.

Going home

Most people can go home three to five days after their operation. If you are on a rapid recovery programme you are more likely to go home within 3 days of your operation. You will need to arrange for someone to collect you in a car and drive you home.

Getting into a car

There are some steps you can take beforehand to make it easier to get into the car.

- The car should be parked at least 45cm (18 inches) away from the kerb, so that you can get in from road level rather than the kerb.
- The car seat should be as far back as possible and reclined past vertical.
- You may need a cushion to raise the height of the seat.
- Putting a plastic bag on the seat can help you slide on to it.
- Wind down the window so you can hold the doorframe.
- Make sure that someone holds the door wide open.

To get in:

- make sure that your operated leg is slightly forward and lower yourself slowly backwards, on to the side of the seat
- hold on to the doorframe or the seat back for support
- sit down as shown in figure 13, page 21
- slide yourself back into the seat
- lift one leg inside the car, followed by the other
- make sure you don't bend the hip more than 90°, and don't let the operated leg cross over the midline
- if you use a plastic bag, take this out before you set off so you don't slip forwards when the car slows down and stops

Getting out of a car

Reverse the above procedure, making sure your operated leg is out in front before you stand up.

At home

Getting active again

Once home, it is vital to continue with your exercises every day, as they will help speed up your recovery. Try to increase your activity gently, walking a little further each day.

You may go home with crutches or one or two sticks. If you are using two sticks, you may want to progress to one as your confidence improves. Your surgeon or physiotherapist can advise you on this.

When using one stick, remember to hold the stick on the opposite side to your operated hip.

When you feel you are no longer really using your stick and you are not limping, you may start to walk unaided. It's still a good idea to take the stick with you if you are walking longer distances or in crowded places.

Picking up objects

It's best to use a "helping hand" to pick up small objects for the first six weeks. Once you have good balance and strength in your legs, pick up objects as follows:

- place your operated leg behind you
- balance on your good leg with your hand on a firm surface or your stick
- bend forwards from the waist and bend your good leg as necessary

Driving

You can normally drive again after about six weeks, depending on your surgeon's advice. You should not drive until you feel you have the speed and mobility 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 six to eight weeks after your operation, provided that you are not in pain and that your surgeon has not given you different advice.

Sports and hobbies

Your surgeon will give you specific advice about when you can return to active hobbies or sports, such as gardening or golf. This varies for each person.

Travel

If you plan to travel in the first 12 weeks or so, talk to your surgeon first because of the risk of DVT. You should also ask the travel company to make arrangements for assistance and adequate legroom. If you plan to fly, bear in mind that your prosthesis may be picked up by metal detectors, so it's a good idea to carry a letter from your GP or surgeon as written evidence of your hip replacement or resurfacing. Your GP or surgeon can give you more advice about this.

Work

The time it takes for you to 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 around six weeks after you go home. In the meantime, if you have any questions, please call the hospital. The contact numbers are on page 33.

Continuing physiotherapy

You may be invited to visit the physiotherapy department as an out-patient until your hip has regained as much movement as possible, and the muscles are strong enough to support your hip 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 hip replacement is very low. However, you should contact your surgeon if you get any signs of infection, including a high temperature or increased swelling or pain around the operation site. You may need antibiotics to treat the infection.

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

Long-term care

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 hip.

Glossary

Abduction
Moving your leg outwards to the side.

Bath board
A short plank supported by the two sides of a bath. You can sit on it and turn around to get into the bath or use the shower.

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 veins.

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 or when immobile for long periods of time. For hip surgery, preventive measures are used. These include medicines to reduce blood clotting (anticoagulants), compression stockings or an intermittent compression pump.

Extension
Moving the leg backwards at the hip joint.

Flexion
Bending the hip by moving the leg forwards.

Helping hand
A long-handled grasping device used to pick up objects.

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

Midline
An imaginary vertical line down the centre of the body (figure 5, page 13).

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

Occupational therapist
A healthcare professional trained to show you ways to manage daily activities more easily.

Patient-controlled analgesia pump (PCA)
A device that you control, which delivers a precise dose of painkilling medicine into a vein when you need it.

Physiotherapist
A healthcare professional trained to show you how to move around and exercise as part of your treatment.

Pre-operative assessment
A hospital appointment, usually a week or so before your operation. Here you talk to the nurses and physiotherapists about your health, medicines you may be on and any equipment you need at home after the operation.

Prosthesis
An artificial substitute for a body part, such as the hip joint.

Stocking/sock aid
A plastic device with strings attached that allows you to put on socks and stockings without bending down.

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

Toilet frame
A frame that fits around the toilet, giving it arms to hold on to, like an armchair.

More information

Please ask your nurse for the Spire Healthcare hospitals leaflets, *Having a hip 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

British Red Cross
Telephone 0870 170 7000
www.redcross.org.uk

Contact details

Your surgeon

Contact number

Your nurse

Contact number

Your physiotherapist

Contact number

Your occupational therapist

Contact number

Questions and notes

Please use this space to write down any questions you would like to ask.

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