Total Knee Replacement

Introduction

If you are reading this leaflet then you have probably been sent by your GP to see an orthopaedic surgeon who considers that you would benefit from a knee replacement operation. Many General Practitioners use the Oxford Knee Score to measure your disability using it as and Activity of Daily Living Score (ADL).

You might be looking to help advise a friend or relative. Either way keep a copy of this on your phone for later reference.

This leaflet will briefly outline what this knee arthroplasty will involve for you as a patient and mention some risks and complications of this type of surgery.

What is a total knee replacement?

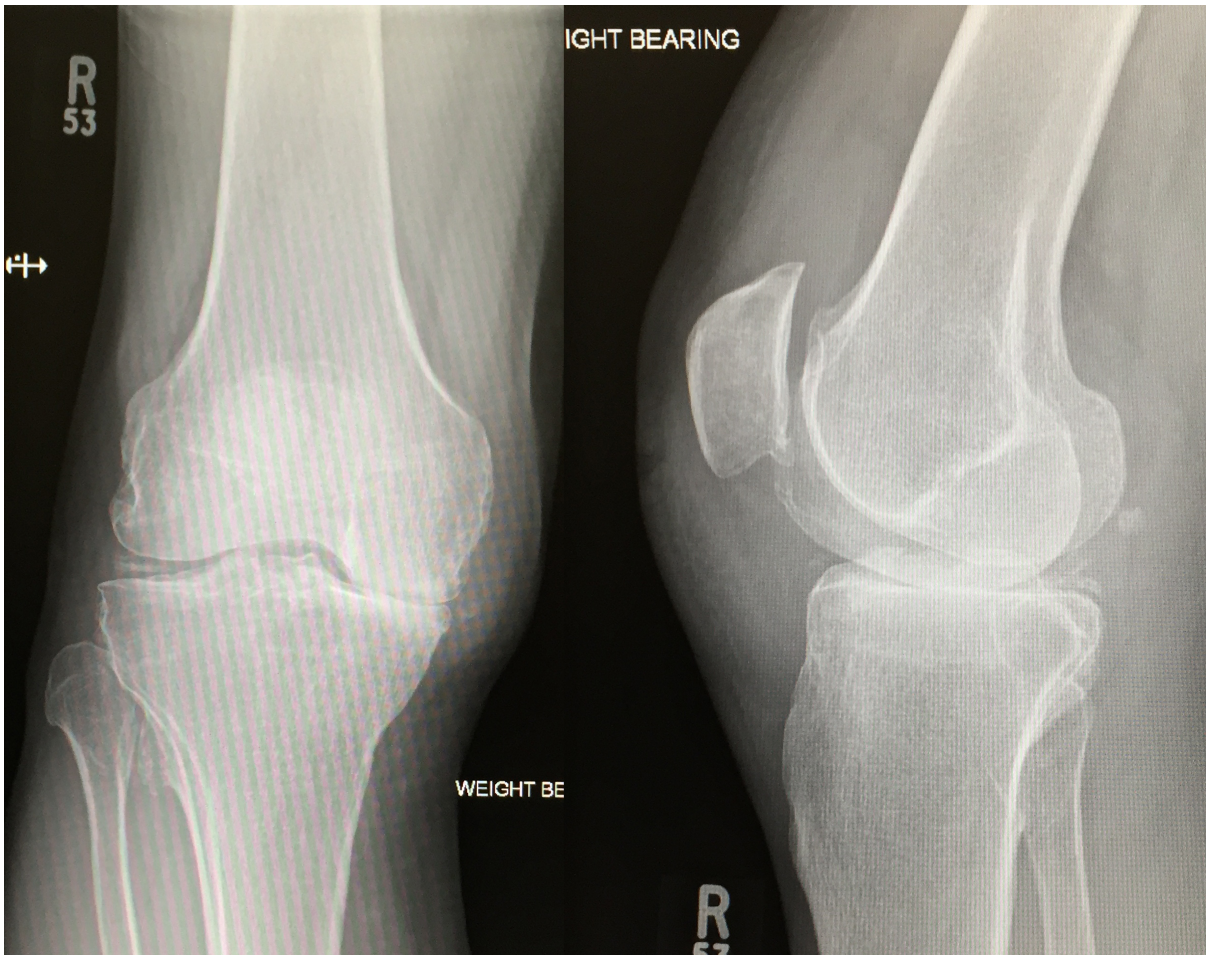
Knee replacement is a cure for the symptoms of degenerative disease of the knee. The most common cause in the UK is from the trauma of suffering an unstable meniscal tear without treatment. There are many other causes of osteoarthritis. Modern knee replacements were developed in the 1970s and involve removal of the diseased ends of the femur, tibia and patella bones that form the knee joint. These are replaced with metal and plastic parts (called a prosthesis) which are usually grouted in place with bone cement.

The aim of the operation is to replace a knee joint that is painful, stiff and often deformed with one that is not painful, moves more easily and is correctly aligned.

I have knee pain. What should I do?

If you have had your pain for months only get along to a knee surgeon. You might have a meniscal tear and it is better to treat this before you get osteoarthritis. If you think you have knee osteoarthritis from injury, rheumatoid arthritis or another cause like avascular necrosis you will have pain, loss of function, a limp and difficulty sleeping. If you now want to see one of our knee consultants who will take a history from you and examine you to confirm your suspicion then telephone Jane our practice manager to make an appointment **0044 (0)117 3171796** She will direct you to the PA of one of our excellent hip surgeons. The PA will assist you by offering you an appointment and advising on preparation for the appointment.

Figure 1 Severe knee arthritis from gout causing a medial meniscal tear.



What if I do have knee osteoarthritis?

Not to worry most patients do not need surgery. Your surgeon can give you many tips and options to improve your ADL without a knee replacement. Some patients choose to have surgery when the options and risks and benefits are discussed with them.

What can I do to help get the best result before surgery?

Prior to surgery there are certain things you can do to help:

- Visit your dentist for a check-up
- Try and lose weight
- Stop smoking
- Take good care of your skin
- Take as much exercise as your knee allows to prepare the muscles for a quick recovery

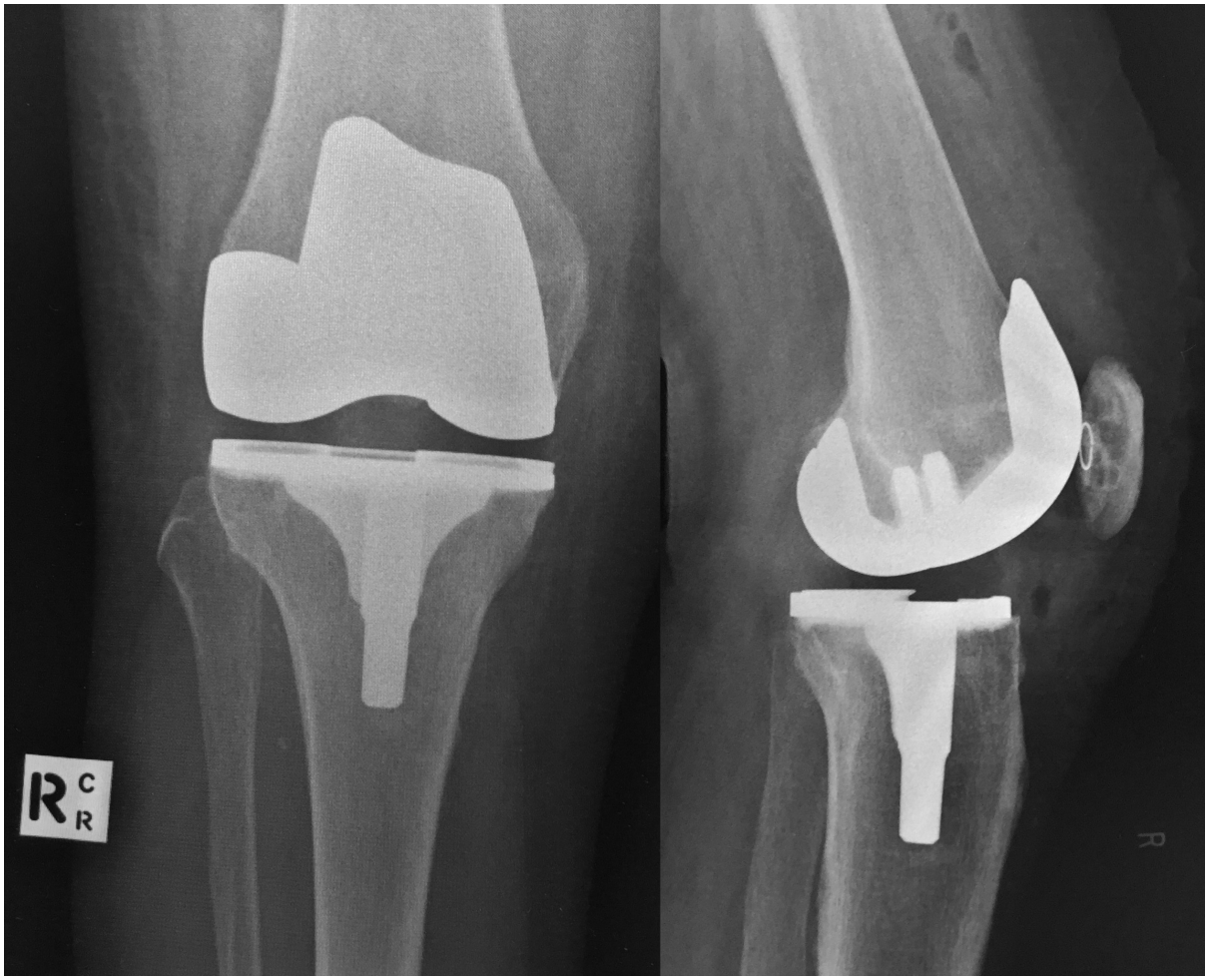
You may be seen in a pre-assessment clinic shortly before your surgery where your fitness for surgery will be assessed. You may have blood tests, an ECG and swabs at this stage.

You should have no solid food or drink for six hours before your operation. When you arrive in theatre you will be given an anaesthetic (a spinal or general anaesthetic). The surgery takes approximately 1 ½ hours and you will return from theatre with your leg bandaged and a plastic tube draining any blood that collects in the new joint.

How long do you stay in hospital?

Postoperative regimes vary between surgeons but the physiotherapist will get you bending your knee and walking a couple of days after surgery. Once you are walking safely and bending your knee, and there are no wound complications, you may be discharged (usually 5 to 10 days) with arrangements to have your stitches removed and an outpatient appointment.

Figure 2 Total Knee Replacement in one of Knee Surgeon Mr John Hardy's patients



What can go wrong?

Generally a total knee replacement is a safe procedure that can dramatically improve your quality of life. All operations however carry some risk and the most frequent and important are outlined below.

Surgical mortality – A knee replacement is a major operation and a very small number of patients may not survive their surgery.

Anaesthetic – Modern anaesthetics are generally very safe. The anaesthetist (a doctor) will explain any particular risks for you.

Thromboembolism – Blood clots may develop in the veins of your leg during or after surgery. Part of a clot may break off and travel to your heart, which can be fatal, but this is extremely uncommon and occurs in 2 in 1000 cases. This risk may be increased if you are female, overweight, have varicose veins, high blood pressure, smoke, diabetes or heart disease. Recognised ways to reduce blood clots are exercise and using stockings and foot pumps which are used here at the Hospital.

Infection – This can be a difficult problem that may not respond to antibiotics. You may require further surgery which could involve the removal of the knee replacement altogether leaving you in plaster for 6 to 8 weeks. If the infection clears up the surgeon may repeat the knee replacement. Very rarely, if the infection cannot be controlled an arthrodesis (fusion) of the knee or, more rarely, an amputation may be advised. Infection of this kind occurs in fewer than 2 patients out of 100. In order to reduce this risk antibiotics are given during the operation which is performed in a laminar flow theatre used especially for orthopaedic operations.

Loosening, wear and fractures – Current research shows that, using modern knee replacements, 9 patients out of 10 will still be walking on their knee replacement after 15 years. Heavy or violent physical activity over time may loosen the prosthesis or cause wearing of the plastic parts. The British Orthopaedic Association recommend follow up and radiographs to check for this. Additionally, patients with osteoporosis rheumatoid arthritis and neurological disorders may suffer fractures in the bones around the prosthesis or loosening. Any of these three complications may require further surgery.

Injury to nerves and blood vessels – This is a rare complication and more likely if you have a markedly deformed knee. These structures run close behind the knee and may be injured during surgery resulting in paralysis, weakness, numbness or pain in the leg and foot which is usually temporary, but may be permanent.

Patellofemoral problems – In some cases there are problems with the kneecap after surgery, including wear, dislocation, fracture, loosening and tendon rupture, any of which may require further surgery.

We hope this information sheet has answered any questions you might have. If you have any further queries please feel free to discuss them with your Consultant or nursing staff either in the Clinic or on your arrival at Hospital.

How long will it take to…

- be pain free? Be sure you take a painkiller in the first few hours after operation when offered, as your spinal anaesthetic will not last long. Pain can take 6 weeks to settle and six months to plateau.

- get the dressing off? Leave the dressing and sticking plaster until you have your sutures removed. Be sure you have made arrangements with your surgeon to have your sutures removed between 7 and 14 days after operation. Do not worry about any dried blood on the sticking plaster. Do not get the dressing wet until the sutures are removed.

- find the scar is comfortable? After your scar has healed and the scabs are off please massage it regularly with hand cream or bio oil so that the scar is desensitised and softened.

- begin driving again? You should be able to return to driving after about 6 weeks. The DVLA advice is that you the patient has to decide when it is safe for you to return to driving.

- return to work? This might take longer than a few months depending on the type of work you do.