Hip Replacement

Anterior Approach

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Total Hip Replacement Patient Guide

This handbook was written in an effort to provide you with as much information as possible in consideration of a possible hip replacement. Through the process of gaining knowledge about the procedure, it is our hope that you will become better informed to make the best decision for your own health and comfort. You will be provided with information regarding a healthy vs. diseased hip, how a hip is replaced, and a step-by-step guide of what to expect before, during and after surgery.

If you and your doctor have decided that hip replacement is right for you, a team of healthcare providers will participate in your surgical and recovery process, helping you return to your normal level of activity. All of our staff has one goal: getting you back on your feet so that you can return home safely and back to your usual activities as quickly as possible. Your active participation during your recovery period will aid in your rehabilitation. By knowing what to expect during and after your hospital stay, you can be a more active participant.

The handbook is just a guide. Your physician, physician assistant, or therapist may add to or change some of the recommendations. Always use their recommendations and ask questions if you are unsure of any information. Communication is essential to this process. Should you have any questions after reading this pamphlet, we would be happy to discuss them with you: (310) 829-2663.

Healthy vs. Diseased Hip

Your hip is a ball and socket joint. The "ball," is the higher end of thigh or femur bone, and the socket is the acetabulum of your pelvis. The head of the femur is held in position by muscles and ligaments located around the socket; the entire surface is covered with a 1/8" thick, smooth white substance called articular cartilage. The articular cartilage does not have nerves and as such, cannot transmit pain.

In a healthy hip, the surfaces are smooth and allow for painless and even distribution of body weight with movement. In a diseased hip, the articular cartilage has worn away; labral tears may be present as well. As the bone wears on the other bones of the hip they become pitted and rough; the roughness causes pain and stiffness as the hip moves. You may occasionally hear a grinding, creaking or even clicking. A decrease in flexibility may make it hard to walk up and down stairs, participate in activities such as yoga, tie your shoes, or even get in and out of sitting in low or soft chairs or cars.

The causes for such hip diseases are many and varied, however the most common is Osteoarthritis. **Osteoarthritis** is degeneration of the articular cartilage. It can be caused a congenital (birth) defect such as hip dysplasia or impingement, a trauma or injury to the

joint, previous surgery to the joint, or just plain wearing out without reason. Additionally Avascular Necrosis (**AVN**) of the hip is a condition where part of the bone dies. Secondarily, the bone collapses creating degenerative disease. The most common causes for AVN is the oral intake of steroids (e.g. prednisone/Medrol), excessive drinking of alcohol. Rheumatoid Arthritis can also affect the hip joint.

No matter the cause, if one or more of these afflictions affect and restrict the normal use of the hip, a hip replacement may be necessary.

Initial Consultation

The initial visit involves a discussion with the doctor. **X-rays are always needed** and will be taken in our office in the absence of any films brought with you. Any other diagnostic studies such as MRI's or X-rays taken by previous physicians' can also be helpful with diagnosis and signs of progression of osteoarthritic conditions. Please bring any previous studies with you to the visit. Bring a **list of medication** that you are currently taking, along with all dosages. We welcome any spouses and other family members who wish to participate in the discussion of your treatment to also attend the examination with you.

Non-Operative Treatment for Hip Disease

Since hip pain can be increased by walking, a simple **decrease in activities** can result in less hip pain. You can avoid or limit your walking by taking elevators or driving whenever possible. You should **avoid strenuous activities** such as running, jogging and other high impact sports that can be replaced by non jarring exercise. You may also, upon a doctor's recommendation, take an **Analgesic** such as **Tylenol** or Tramadol or Non Steroidal Anti-Inflammatory Drugs (**NSAIDs**) (Advil, Aleve, Aspirin, Motrin, Naprosyn and Celebrex). These medications can decrease the inflammation of the arthritic join. As everyone differs with pain and tolerance, different medications may work with different patients. NSAIDs are not habit-forming; but they can cause stomach upset and should be taken with food, milk, or an antacid. NSAIDs also have the potential to cause an increase in blood pressure, edema, swelling and affect the liver. It should be noted that **more than 3,000 mg of Tylenol daily can have a serious effect on the liver.**

Injections of steroids combined with Xylocaine are occasionally given to the affected hip by a doctor and can relieve pain and inflammation on a temporary basis. Additionally, hyaluronic **lubricant injections** (e.g. Orthovisc, Synvisc, Euflexxa) are also available; these may aid in assisting the body to reproduce better lubricants that over time have been lost in the joints of the body. It should be noted that hyaluronic injections are effective at best in only 50% of the patients and are not FDA approved; as such, they are not covered by most insurances. As extra body weight usually aggravates hip pain, patients who

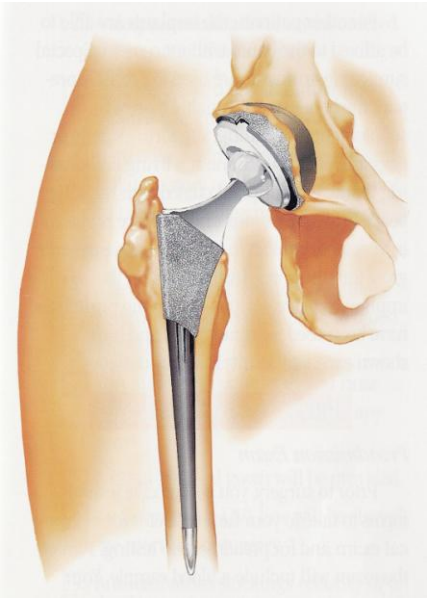
struggle with hip pain may consider a **weight-loss program** to help make them more comfortable.

A cane may aid in providing some pain relief and comfort. It is important, however, that the cane be sized for your height and should be held in the hand of the *opposite* side of the affected joint.

Exercise can be a good tool for overall conditioning of people with hip disease provided it is a ***low impact*** exercise. Swimming provides the buoyancy of the water and relieves stress on the affected joint and riding a stationary bike is usually tolerated well by the hip patient.

Operative Treatment for Hip Disease

The procedure of hip joint replacement is called a **Total Hip Replacement** (THR). Sometimes it is also referred to as "**Total Hip Arthroplasty**". The surgery involves replacing the damaged portions of the hip joint with a man-made prosthetic device. The goals of this procedure are to end pain and stiffness, thereby improving function and quality of life. Total hip replacement is usually an elective surgery and like all surgeries, comes with certain risks. Total hip replacement should only be considered when the pain and disability from the hip comes to a point where you are changing your lifestyle. If you feel your pain is a minor inconvenience and you are able to walk without a limp or the use of a cane, you are probably not ready for a total hip replacement. If you feel that your **pain is significant and your lifestyle has changed** considerably, you are probably **a candidate for the replacement surgery**. We encourage you to gather as much information as possible from your family, orthopedic doctor, family physician, and/or seek second opinions prior to your making the decision to proceed. **Our goal is to improve your quality of life.**



The total hip replacement prosthesis has similar parts to your normal hip. The worn upper part of your femur (thigh bone) is replaced with a new ball with a stem that is inserted down into the femur for added stability. A cup is placed into the acetabulum (socket) of the hip to replace the old worn socket of the hip. Like a healthy hip, your prosthesis has a **smooth surface which allows for pain free, easy movements**.

The hip has is a porous prosthesis that has a rough surface on the acetabular side of the socket as well on the side of the stem. The rough surface allows bone to grow into the prosthesis and permanently bond bone to the prosthesis. **The acetabular ball moves in the plastic socket with body weight transmitted across the hip, thereby providing significant pain relief.**

Weight bearing stimulates in-growth, or healing between the bone and the prosthesis, and **will be allowed from Day One**. The Anterior vs. Posterior approach as well as the prosthetic type will be discussed with you at that time. You and Dr. Gerhardt will both decide what is best for you and your health.

Risks and Potential Complications

Hip replacement surgery has a **95% success rate** and although complications are rare, it is important that you know what risks and complications are possible.

Infection: Although the chance of infection is **less than 1%**, it is possible. Bacteria can be introduced into the open hip at the time of surgery through the normal air source that we breathe. In the hospital and operating rooms precautions are taken against this by using specially cleaned air. Additionally, **antibiotics** are administered to the patient **at the time of surgery** to prevent infection. Infection can be introduced at any time after your total hip surgery including several years later. Infection can be spread from another part of the body to your hip.

Directly following your surgery, you will be asked to use **prophylactic antibiotics prior to any trip to the dentist for one year after your replacement**. This will help prevent infection from getting into your blood which could result in an infection of the hip prosthesis. If your hip replacement becomes infected it is very difficult to fight, even with antibiotics, and as such, the prosthesis may need to be removed. Usually viral infections such as colds and fungal infections are not a problem with your hip; however it is best to seek treatment from your family physician to put your mind at ease.

Dislocation: Dislocation of new hips occurs approximately **1% of the time**. The risk of dislocation is reduced with the anterior approach, as compared to the posterior approach. Dislocation is when the ball comes out of the socket. The ball is held in place by muscles, so if you have **poor muscle tone**, you will be **more likely to suffer a dislocation**. During the first few weeks after surgery, as the scar tissue forms and before your muscle strength returns, the hip is more prone to dislocate.
Should your hip dislocate, you will need to go to the nearest emergency room where it is usually a simple matter, after administration of sedation, your hip will be relocated. Occasionally, if you have repetitive dislocations further surgery may be required.

Thromboembolism (Blood Clot): Inflammation, swelling and immobility of the hip increase the risks of forming a blood clot in a vein in **1/500 people**. The danger of a blood clot is that it can travel to the lungs and cause problems with the pulmonary system. To decrease your chances of this occurring to you, we administer a **blood thinner** called **Lovenox for 3 weeks post-operatively**. You will also be wearing **anti-embolism (TED)**

hose for one week after your surgery. Additionally, you will have **pneumatic device** while you are hospitalized and at home to further prevent any blood clots from forming.

Tissue Injury: Numbness, tingling, and/or paralysis of the muscles in the leg can occur as a result of compression of the peroneal nerve. There are measures we can take to relieve this pressure.

Loose Prosthesis: Loosening of the prosthesis from the bone is a major long-term problem. You can decrease the chances of loosening by decreasing stress to your hip. Examples of such stresses to avoid include running jogging or impact sports. **Golf, swimming and cycling can safely be accomplished with a total hip replacement**.

Leg length: Leg lengths can be slightly changed by surgery though it is usually insignificant. X-rays are taken at the time of surgery and help to eliminate any differences.

Nerve Damage: Nerve damage occurs in **less than 0.5% of the time**. The most commonly damaged nerve is the nerve that brings the foot up towards the face. Over the period of several months this nerve slowly recovers in the vast majority of cases.

Stiffness: Rarely some extra bone, called heterotopic bone, forms around the hip joint and may cause hip stiffness.

Fracture: This is extremely rare, but the femur can fracture with the insertion of the stem of the hip prosthesis.

* The chances are very small that any of these complications will occur. Having major surgery does carry some risks, however, and you should weigh the risks versus benefits of the surgery. We will do everything possible to minimize your risks, reduce any significant pain you are experiencing and make a dramatic improvement in your lifestyle.

Surgery Scheduling

If you decide to proceed with surgery, we will schedule you at the first available date that works with your schedule. The surgery will be performed at **St. John's Health Center**.

Pre-Op Clearance: Once a date and time have been determined for your surgery, we will ask you to schedule a visit with your internist for "preoperative clearance." Edith, our surgical coordinator will contact your physician's office to request specific tests, labs and other clearance prior to your appointment.

Please note it takes a great deal of coordination to schedule your surgery so once a date and time have been set, we ask that you do not reschedule unless absolutely necessary.

Hospital Pre-Operative Course for Total Joint Replacement: St. John's Health Center offers a course for patients undergoing total joint replacement. The course is held on **Wednesdays, 10-11:30 am, twice a month**. An orthopedic nurse, a physical therapist and occupational therapist provide preoperative education for all total joint surgery patients. This includes a variety of postoperative information, including what to expect once your surgery is completed. Issues discussed include general information about your surgery and techniques on how to ensure you and your joint remain stable and healthy.
For more information please call **Debra Nimick, director,** at **310.829.8685**.

Before Surgery

Pre-Op Visit with Dr. Gerhardt

You will be given a scheduled appointment with Dr. Gerhardt prior to surgery to check to make sure all things are in order. We will give you your final instructions for surgery at that time. We will also arrange for you to have all necessary equipment ready for post-operative use in the hospital and at home. All pre-certification with insurance companies will be performed by our office in advance of this appointment to avoid any undue stress on you or your family. Please **bring any questions** to your pre-operative appointment.

Stopping NSAIDs and ASA prior to Surgery

Depending on the patient we will ask you to stop taking any kind of anti-inflammatory medication such as ibuprofen, naprosyn and aspirin and other blood thinners **5-10 days prior to your surgery.**

Reducing Infection prior to Surgery

Peri-prosthetic joint infections are one of the most serious complications in joint replacement surgery. We work diligently to lower the incidents of infections around prosthetic joints but despite these efforts, they still occur. While the percentage of prosthetic infections is low, we would like to continue to reduce that number as best as possible.

To help prevent infection, three days prior to surgery and extending three days after surgery, you will be asked to apply an antibacterial ointment called **Mupirocin or Bactroban** into the nose with a Q-tip. In addition, we would like you to use **Hibiclens** (an antibacterial soap), in the area of the surgery three days prior to surgery. A prescription and specific instructions on the use of these items will be given to you at your pre-operative visit.
Our infectious disease specialist also suggests that prior to surgery, you **do not share towels or soaps** with other people. It is hoped that these additional steps will continue to decrease infectious rates and decrease the risk of developing a peri-prosthetic infection.

Getting your Home Ready

There are several things you can do before your surgery to make your return home easier:

- Prepare food ahead of time.
- Move frequently used pots, pans and dishes for easier access.
- Remove loose throw rugs so that you will not trip.
- Make necessary arrangements for pet and child care.
- Place grip strips in the shower stall or tub so you will not slip.
- Remove electrical and phone cords out of walking areas.

Your Hospital Stay

Pack a small bag for your hospital stay. This should include: **non-slip shoes** (e.g. tennis shoes or loafers) and one pair of loose fitting, comfortable clothing (e.g. **shorts/sweats**).

The hospital can provide you with the **basic toiletries** but you may bring your own (i.e. razor, make-up, shampoo, toothbrush etc). All rooms are private and equipped with a television and telephone. Cell phones are allowed in the hospital.
* Do not bring medications, jewelry, credit cards, or large amounts of money with you.

The Night prior to Surgery

Bathe or shower (including Hibiclens) in your normal routine. You should be **NPO (no food or drink) after midnight the night prior** as food in your stomach may cause anesthetic complications. Occasionally your doctor will advise you to take your normal medications the morning of surgery with just a sip of water.

Hospital Admission

Please verify your scheduled time of surgery on your pre-op visit and plan on being at St. John's Health Center **two hours prior to the scheduled surgery time**.

Your Healthcare Team

Clinical Assistant (Edith) ext. 1293
Coordinate scheduling of your surgery.
Arrange for you to have paperwork and all necessary forms filled prior to your surgery.
Arrange your prescription for post-operative medications.
Help with obtaining necessary equipment and handicap placard.
Answer questions relating to office visits and general post-operative issues.

Administrative Assistant (Desiree) ext. 1207
Scheduling of pre- and post-operative appts.
Answer questions relating to office visits and occasionally general post-operative issues.

A Physician Assistant (PA) (Heather Adle, PA-C) or Orthopedic Fellow will…
Assist with your surgical procedure.
See you on daily rounds.
Change your dressing and check your incision.
Help manage your hospital care.
See you in the clinic for the follow-up visits, as directed by your physician.

At the Hospital

An Orthopedic Nurse Coordinator will…
Perform your pre-operative nursing assessment.
Be actively involved in your care and treatment during your hospital stay.

An Orthopedic Nurse and Certified Nursing Assistant will…
Help keep your pain under control and help make you as comfortable as possible. Help you get in and out of the bed, transfer to a chair, assist with daily bathing activities, and walk to the bathroom. Watch for any changes in your condition and coordinate your care during your hospital stay. Act as a liaison between you and your physician.

A Physical Therapist (PT) will…
Teach you how to get in/out of bed, walk with the appropriate ambulatory device, get into/out of a chair, and negotiate stairs.
Teach you the movement precautions and weight bearing restrictions if any.
Teach you exercises to increase hip motion and strength.
Recommend and order the appropriate equipment for ambulation.
Educate and instruct family or caregivers that may be assisting you after discharge.

An Occupational Therapist (OT) will…
Teach you safe techniques for dressing and bathing activities. Teach you how to transfer in/out of the shower stall or bath tub. Teach you how to transfer on/off of the toilet or commode.
Recommend and order the appropriate equipment to perform your self-care activities.
Educate and instruct family or caregivers that may be assisting you after discharge.

A Case Manager will…
Arrange home health services as ordered by the physician. Work with your insurance company or workers compensation insurance to obtain authorization for services and/or equipment ordered by the physician.

The Procedure

A total hip replacement procedure done with the takes about 1 ½ hours of actual surgical time; however, the time in the operating room could be much longer considering preparation, anesthesia, etc. A hip revision may extend this period an additional hour. Anesthesia is either **spinal or general**. Spinal anesthesia with low dose Duramorph-Morphine placed within the spinal fluid may decrease post-operative pain for 24 hours. This will be discussed with you by your anesthiologist. Antibiotics will be given intravenously to help prevent infection prior to the surgery. An oblique incision is made across the antero-lateral surface of the hip, exposing the joint. The bone and cartilage on the upper end of the femur and lower part of the pelvis are removed. The prosthetic joint is then implanted. The incision is then closed with absorbable sutures and Dermabond, a surgical glue. **Dr. Gerhardt does perform minimally invasive surgery.**

Post-Operative Hospital Stay

Hospital stay is generally **2-3 days**.

Pain Control
You will be given pain medication as needed to control post-operative pain.

Anti-coagulant therapy (Lovenox)
You will be given Lovenox injections once a day during your hospital stay. This medication is used to thin your blood and reduce the risk of blood clots. The injections are administered subcutaneously (into the skin). The nurse will teach you (or your partner) how to administer these to yourself upon discharge. You will do this **once a day for three weeks post-operatively**. Ideally you will have this medication filled and ready for your arrival back home.

TED hose and Pneumatic Compression Device

While in the hospital and/or at a Skilled Nursing Facility (SNF), you will be wearing "TED hose" or **white compression stockings**. When you are discharged to home, you no longer need to wear these stockings, provided you will be using the **pneumatic compression device** ordered with your cooling device. This device will be brought to your home with instructions on how to use it.

Sponge Baths

Since you will be spending a lot of your time in the hospital on bed rest, showers and baths will not be possible. You will be given the opportunity to have **sponge bath with the assistance of your nurse**. This may not be as great as taking a long shower; however it can be very refreshing. Most patients will be ready and able to take a shower before they leave. Upon discharge from the hospital **showering is allowed so long as a water-proof Mepilex dressing is being utilized**. You will also go home with 2-3 Mepilex dressings.

Use of Pillows

Pillows can be utilized to improve your comfort and to protect the new hip prosthesis.

Elevated Bedside Commode

Due to the fact that extremes of flexion are difficult, an elevated bedside commode will be furnished for your use at your bedside or over the toilet. After you have learned to use your walker or other assistive devises the commode can be taken into the bathroom.

Getting out of Bed

Generally speaking, most patients sit and stand by the edge of the bed on the day of surgery. As the days continue, you will progress to walking around the room to walking down the hall allowing full weight bearing.

Physical Therapy

Without complications, a therapist will meet with you the day of your surgery and begin exercises and ambulation. The physical therapist is very important to your recovery. He/She will **teach you exercises** and will show you how to walk correctly and safely with crutches, walker or cane. They will instruct you in **climbing stairs** and many other different aspects of using your body most effectively at this time.

Assistive Devices

Most patients will be **discharged with a walker** but may progress to a cane or crutches. The walker offers support and protections especially when in public. The walker also aids the patient with balance and distribution of weight. Some patients use crutches especially if the use of a walker becomes too cumbersome. The use of a cane for support and protection from falling or losing balance in public is also a common practice. The physical therapist will advise you on which assistive devices will be best for your use.

Post-Operative Care

Incision Care

Most patients will take a shower prior to discharge from the hospital. The incision will be covered during your entire hospitalization. However, once you are discharged from the hospital, you must comply with the following instructions. These guidelines are for your safety to prevent an infection.

The nurse or the physician assistant will provide you with additional bandages to cover your incision for the **first two weeks upon discharge** from the hospital.
Your skin incision will be closed with DERMABOND, a surgical "glue". The Dermabond is waterproof and sticks to the skin for about 2 weeks. It has a purplish cast to it, and sometimes wrinkles up like saran wrap. **You can shower** but do not scrub the surgical site. Just let the water run over it gently, then pat it dry after you shower. No tub bath for 4 weeks. **Do not put any ointment, alcohol, peroxide, or Betadine on the Dermabond** as it will break the Dermabond before intended. After 2 weeks the Dermabond will start to peel or flake off on its own.

If you notice any of these symptoms, please call our office! Do NOT shower or get the incision wet.

- Drainage from the incision.
- Areas of the incision that are not sealed over.
- Red pimply areas on or near the incision.
- Redness along the incision.

NO hot tubs or jacuzzi for 4 weeks. Swimming pools are allowed if you can enter safely (handrails, ramp, steps etc). It is recommended that you **wait until the incision is well healed before entering the pool**. Limit the time in the pool to 10 - 15 minutes in order to monitor your response and incision healing

Modified Hip Precautions

****We ask that you avoid all high impact, high velocity activity for 3 months following the procedure****

Diet

There are **no restrictions** to your diet. Eat a normal diet as you did before surgery. Make sure you eat plenty of fruits and vegetables and drink 6 - 8 glasses of water a day. This will help prevent constipation. If you have questions, call the office.

Driving

You may drive when you are no longer taking any pain medicine. This guideline is for your personal safety. If you had surgery on your right hip, you must have good control of your leg to work the gas and brake pedals.

Handicap Parking
You can obtain an application for a handicap-parking placard from the clinical assistant at our office. Your doctor will sign the form. You must fill out your portion of the form, and then take it to either the DMV or AAA. Temporary handicap-parking placards are issued for either 3 or 6 months.

Travel
You may get out of the house **as soon as you feel up to it**. Use the handicap bathroom stall. If you are in a hotel, request a handicap accessible room. If you must fly, request bulkhead seating or first-class seating if possible.

There is a small theoretically increased risk of blood clot in the first few weeks after surgery when flying, but you will already be on a blood thinner which will help protect against the development of a blood clot. However, please be sure to stretch frequently on your flight.

Sexual Activities
You may resume sexual activities as soon as you feel able. Your therapist or doctor can answer other questions you may have.

Exercise and Walking Guidelines
During your hospital stay, the physical therapist will instruct and provide you with a home exercise program. This will include guidelines on how to safely progress your activity level. Begin walking outdoors the day after you get home from the hospital. **Gradually increase your walking daily** with the goal of walking one mile anywhere within the first 2 - 4 weeks. However, it is important **not to over exert yourself**. If you have increased soreness or swelling, decrease your activity and ice and elevate your leg above your heart. If pain persists or increases, stop exercising and contact the office immediately.

* A good goal is to be off of the cane at around 3 or 4 weeks from your surgery date.

Follow-Up Visits

Your post-operative visits, in general, will be scheduled as follows:

1) **10 days** from the date of surgery (DOS).
2) **6 weeks** from DOS.
3) **6 months** from DOS.
4) **1 year** from DOS.

Your progression, ambulation, range of motion and any complications will be discussed at that time.

X-rays of your hip will be taken at your second post-operative visit and then again at 1 year out from your surgery to track the healing progress.

* The timing of these visits is a guideline; we may ask to see you sooner or more frequently depending on your individual recovery and circumstances.

Physical Therapy

If you are going to be discharged to a **Skilled Nursing Facility** (SNF), you will have therapy while you are an inpatient there. Once discharged to home, we would like you to have **Home Therapy for one week**, then graduate to outpatient therapy for one month after your surgery.

If you are **discharged to home** after your surgery, we would like you to have **Home Therapy for ten days**. Outpatient therapy may begin at two weeks from your DOS.

If your insurance is something **other than Medicare**, you will have **outpatient physical therapy** when discharged to home.

Your **insurance carrier determines who you will be able to see**. Please discuss this with your primary care physician and your insurance carrier at your pre-op examination and obtain their recommendations.

It is **important to continue to perform exercises** taught to you while hospitalized and by your home therapist. Leg muscles are often very weak due to under use both prior to and after the surgery. Therefore, it is important to strengthen the quadriceps and surrounding muscles. Exercises such as the stationary bicycle are excellent for rehabilitation. Any activity that causes twisting motions or excessive strain on the hip should be avoided.

*Total recovery time may take up to 1 year however most patients are better at one month post op than they were prior to surgery.

Prophylactic Antibiotics: Your total hip replacement is a combination of plastic and metal which acts like a foreign body within your body. The foreign material can lead to secondary infection that can occur any time after your surgical procedure. Any insult to the body that causes a bacteremia, or the spread of bacteria through the bloodstream, could allow the bacteria to go to the artificial hip joint. Because of this we recommend **prophylactic use of antibiotics, particularly when dental or urologic work is performed**. Though the risk of late infection spreading to the hip joint is less than 1%, it should be protected at all times.

Blood Transfusions:
With a normal blood count, the possibility of needing a post-operative transfusion is no less than 5%. On the face of this, we no longer encourage autologous blood donations which may actually weaken the patient prior to surgery.

Autologous Blood Transfusion:
Though not presently required for surgery, should the patient elect to donate their own blood, services for such are available through the Saint John's Hospital Blood bank. This is the safest blood available and therefore carries the least degree of risk of any form of blood transfusion. Given that the blood comes from the patient, there is virtually no risk of infectious disease or allo-sensitization. The only risks arise from the donation process and the remote possibility that some form of contamination or mishandling of the unit can lead to a problem.

Important Numbers for Santa Monica Orthopaedic and Sports Medicine Group

Main Line (answering service after hours) (310) 829-2663

Appointments

New patients (310) 829-2663

Follow-up Visits (310) 315-2007

SMOG Medical Staff

Heather Adle, PA-C (Physician Assistant) (310) 829-2663 x1243

Desiree Walstrom (Administrative Assistant) (310) 315-2007

Edith Rodriguez (Clinical Assistant) (310) 315-2093

Medication Refills

Edith Rodriguez (Clinical Assistant) (310) 315-2093

Billing and Insurance

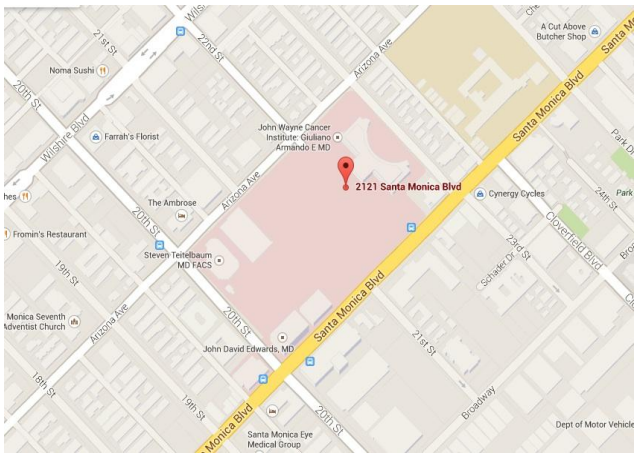
Main Line (ask for Billing Dept). (310) 829-2663

Disability Forms

These forms may be obtained online or from your employer. Please fill out the forms completely and then turn them in at the concierge's desk for **Desiree**. Online filing is also an option and can be completed at **edd.ca.gov**. If filing online, be sure to provide Desiree with the receipt number so that she can complete your claim. It typically takes 24-48 hours for claim completion once our office receives the necessary paperwork/receipt number.

Information for Friends and Family

- The hospital address is 2121 Santa Monica Blvd. Santa Monica, CA 90404. The Orthopedic unit is located on the 3rd floor. The telephone number is 310-829-5511.
- The hospital does not validate parking. The maximum daily rate is $13.00. The main entrance is located on Santa Monica Boulevard, between 20th and 23rd Streets. All parking is by valet only, no self-park lots are available. There is also metered street parking on adjacent neighboring streets.



POST-OPERATIVE HIP REPLACEMENT INFORMATION

1) **Wound Care: Once the Dermabond peels off Vitamin E oil or Mederma cream may be applied to incision. Some bruising of the lower leg is normal.**
2) **What to watch for: Infection: Signs include fever, red streaking from incision, large increases in amount of pain and/or drainage from incision. Blood Clots: Signs include increased pain, swelling or redness of your lower leg. Call the office or your primary doctor if you develop any of these symptoms.**
3) **Hygiene: You may shower with Mepilex water-proof dressing after the surgery. No baths or swimming for 4 weeks! After two weeks you can shower without a dressing on the wound.**
4) **Ice: You may apply for 20 minutes 2-3 times per day, particularly after exercising. You may use a heating pad on thigh and hip for 20 minutes before exercising to relax muscles.**
5) **Medications: Narcotic medications such as Vicodin are only to be taken as needed. Narcotics may cause constipation. An over the counter stool softener may prevent this. Ecotrin Aspirin (ECASA) or Coumadin may prescribed as an anti-coagulant by the doctor and if Coumadin is prescribed you should avoid aspirin and NSAID medications.**
6) **Follow Up: First visit is 10 days after surgery. Second visit in 6 weeks from first visit.**
7) **Physical Therapy: This will vary depending on your insurance but typically Home Physical Therapy will be arranged for 2-3 times per week up to your 4 week post-op appointment. At 4-12 weeks we will arrange for outpatient physical therapy. Mild discomfort is acceptable and expected.**
8) **Activity: Use walker, crutches or cane until hip feels secure when walking. Do exercises twice a day. You may drive as quickly as two weeks when you are comfortable, not in pain and NOT requiring day time narcotic analgesics.**
9) **Recovery: Your hip may remain swollen, warm and stiff up to 6 months. This is a normal surgical phenomenon. You may have numbness over the hip for up to one year until skin nerves regenerate.**

TOTAL HIP REPLACEMENT HOME PROGRAM

This section will cover step-by-step instructions on how to perform your activities of daily living once at home. The physical and occupational therapist will teach you these activities during your hospital stay.

BED MOBILITY

Getting out of bed:

Scoot to the edge of your bed by using your non-operative leg. (Figure 1)
Angle your body so that your legs are nearing the edge of the bed and touch down with your non-operative leg. (Figure 2)
Push up onto your hands, so that your hands are positioned behind your hips, and rotate your operative leg off the bed. (Figure 3)
Use your hands to help scoot your hips forward to the edge of the bed. (Figure 4)

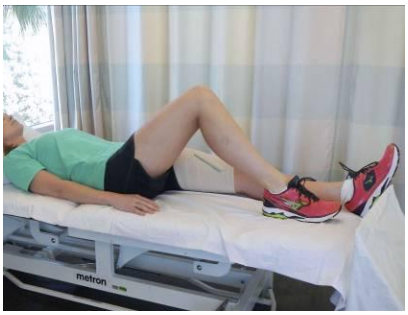
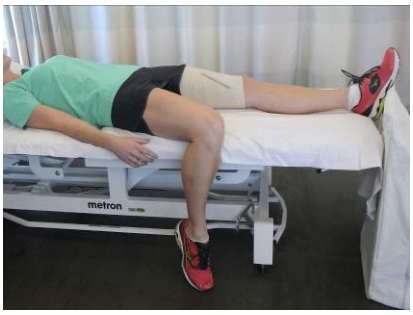


Figure 1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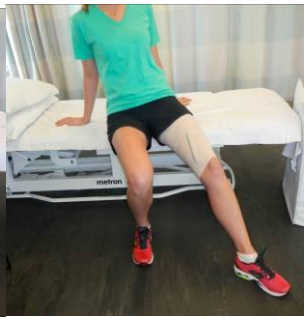
Figure 4

Getting into bed (the reverse process):

Sit on the edge of the bed and position your hands behind your hips.
Slide your buttock backwards while supporting yourself with your arms.
Begin to rotate your body towards the head of the bed.
Continue to scoot back using your non-operative leg to help until both legs are on the bed.

Sleeping:

You can sleep on your back or side. Some patient's prefer to sleep a pillow placed between their legs for comfort.(Figure 5)


Figure 5

SITTING

Find a firm, sturdy chair with an armrest when sitting (e.g. dining room chair).

Sitting Down:

Back up to the chair until you can feel it with the back of your legs.
Place your cane/crutches aside.
Reach back for the armrest.
While holding firmly to the armrest, lower yourself Slowly (Figure 6)
You may sit up straight with your hips scooted back into the chair and knees bent underneath you. (Figure 7).

Figure 6


Figure 7

Standing Up:

Scoot forward in the chair while extending and un-weighting your operative leg.

With most of your weight on the non-operative leg and your hands on the armrests, push up against the armrests.

TOILETING

You may use a raised toilet seat for comfort.

DRESSING

You may bend over to put on your shoes and socks, as long as you work in between your legs. Make sure to point both knees and toes outward and **un-weight** your operative hip when reaching down. (Figure 8)

You may bring the foot of your operative leg and rest it on the non-operative knee to put your shoes and socks on. (Figure 9)

If you experience difficulty or were unable to put your shoes and socks on prior to surgery, you may temporarily need to use adaptive equipment to assist you. Adaptive equipment includes a long handle reacher, long handle sponge or brush, long handled shoehorn, and/or a dressing stick.

Figure 8

Figure 9

BATHING

Most patients will shower in the hospital prior to discharge. The occupational therapist will help to determine if any at home bathroom equipment is needed for safety.

STAIR CLIMBING

Going Up:

Remember to step up with the non-operative leg (or the "good" leg) first.

Use a handrail if available. (Figure 10)

Going Down:

Remember to step down with the device and operative leg (or the "bad" leg) first.

Use a handrail if available. (Figure 11)

"Up with the good, down with the bad"

Figure 10

Figure 11

GETTING IN/OUT OF THE CAR

If possible, park the car away from the curb allowing entry/exit from a level surface.
Maximize leg room by reclining the seat and positioning it as far back as possible.
With help from your cane/crutches, back up to the front passenger car seat.
Slide your operative leg forward and reach back for the seat. (Figure 12)
Lower yourself slowly onto the seat, keeping the operative leg extended.
Scoot back onto the seat. (Figure 13) and
Back into the seat in a semi-reclining position.
Pivot into the seat, bringing your legs into the car, and face forward. (Figure 14)


Figure 12


Figure 13


Figure 14

TIPS FOR WALKING WITH THE CANE OR CRUTCHES

Do not be afraid to put weight on your operative leg (unless you have been instructed otherwise).
Take even stride lengths to emphasize a normal heel-toe walking pattern.
Do not lean over on the cane or crutches. Remember to stand straight.
If you are ready to progress to one crutch or to a cane, use the device on the opposite non-operative side (e.g. Place the device in the left hand if the right hip was replaced). (Figure 15-16)


Figure 15


Figure 16