

enjoy a good result 10 years after surgery and 80% 20 years after surgery, sometimes serious complications occur. These complications may include bleeding, infection, blood clots in your legs, pulmonary embolism, wear or loosening, death and persistent pain.

If you have any of the following after returning home call your surgeon or the hospital who will contact your surgeon:

- Fever over 101° F (38°C).
- sudden shortness of breath or chest pain.
- increase in knee pain.
- excessive warmth, redness, or discharge from the incision site.
- swelling or pain of the calf or leg.

Your surgeon will be happy to discuss these complications and which might be the higher risks in your circumstances or the other rarer complications that he or she should be able to manage should they be unfortunate enough to occur.

WHAT ELSE SHOULD I KNOW?

After you go home you should continue exercising to strengthen and improve the range of motion of your new knee. Although you should be able to get back to light work (such as a desk job) in about a month, it may take longer (3 or 4 months) to start doing more active work.

Don't engage in strenuous activities like jogging, running, or active sports until your surgeon says so. Avoid twisting your knee - if you have to turn while standing, do so by stepping with your feet and not simply by turning at the waist. Take care of your prosthesis and it should last you for many years.

Total Knee Replacement

Further copies of this brochure can be found at:

www.JohnHardy.co.uk

Phone 0044 (0)117 3171793

Fax 0044 (0)117 973 8676

KNEE REPLACEMENT SURGERY

INTRODUCTION

The knee joint is formed by the lower end of the thigh bone (femur) and the upper end of the shin bone (tibia). The knee cap (patella) sits in the tendon of the quadriceps muscle which is connected to the tibia by the patella tendon. It forms a third joint with the femur.



Arthritis is a degenerative condition of the cartilage on the surface of a joint. The cartilage normally provides a low friction, impact resistant, bearing that contributes to efficient pain free stability in posture and locomotion. Cartilage like any other tissue or material can be damaged by high pressure or repetitive loading. Please see the brochure in this series on arthritis. There are many causes of arthritis.

WHO SHOULD I SEE?

Your referral by your General Practitioner with pain from knee arthritis has resulted in a consultation with a Consultant in Orthopaedics and Trauma. The Consultant should have taken a history, examined you, performed investigations and helped you come to a decision on the best treatment for you under the circumstances of your current medical condition. The purpose of this leaflet is to explain the surgical option of knee replacement (arthroplasty) to relieve your symptoms.

DIAGNOSIS

During your assessment the surgeon will ask you the site of your pain, when it started and for how long you have had it. You will be asked whether it is constant or intermittent, how long it lasts, its character (sharp or aching), severity (1-10) and if it radiates anywhere. The surgeon will want to know what makes it better, what makes it worse, associated symptoms (swelling etc.). The surgeon will ask about the level of disability and may ask you to fill in a quality of life questionnaire like the Oxford Knee Score. The surgeon will ask if you have ever injured your knee recently or in the past, and whether you have had surgery to the knee in the past. The surgeon will also assess the impact of other diseases like asthma, allergies, angina, tuberculosis, jaundice, epilepsy, diabetes, rheumatic fever, heart attack, stroke, high blood pressure, previously diagnosed arthritis, renal problems and bleeding disorders. You should also give details of any medications you are currently taking.

The surgeon will examine your spine, hip and knee. He will check how good the blood supply in your legs is. You and your knee will be examined for its range of motion, strength and stability.

X-rays help determine the size, shape and condition of the bones of your knee. You will require other types of tests such as an ECG (electrocardiogram), blood tests and tests to exclude MRSA.

Although other measures like medications, [osteoarthritis braces](#), walking sticks and knee arthroscopy for mechanical impingement may have been helpful with symptoms, the best cure may be replacement of the affected knee with an artificial joint (prosthesis). An artificial knee joint can help you return to many of your routine activities.

“My advice to patients is that they should not accept an operation from a surgeon who has not been through this extensive process of assessment and consent”.

PREASSESSMENT

Please refer to the brochure on preassessment in the same series.

THE OPERATION

At surgery, an incision measuring about 8 to 10 inches long will be made either on the front of your knee. The surgeon will remove small amounts of worn bone from the lower end of your femur and the upper end of your tibia to make flat surfaces to fasten your new prosthesis to. Some patients require computer navigation to ensure optimal fit. Once your surgeon is satisfied that the prosthesis fits properly it will be secured in place. When you surgeon is ready to close the incision, a tube may be inserted to drain excess fluid. This is usually removed the first day after the operation.

Patients rarely need transfusion after knee surgery and these days your surgeon and anaesthetist should recommend transfusion with your own blood rather than donor blood.

RISKS AND BENEFITS

Although knee replacement is generally a safe procedure and approximately 90% of patients