

PATIENT INFORMATION: HIP ARTHRITIS

Hip arthritis is a condition where the cartilage, or the articular surface of the hip, has worn away. Patients can present with stiffness, pain or occasionally a leg length discrepancy.

Why does the hip hurt if it has arthritis?

This is still a matter of ongoing research. Some patients have complete cartilage loss and significant x-ray changes and have relatively little pain. Some patients have minor changes on x-ray and severe, debilitating pain. Stress hormones, body fat percentage, employment status and smoking all play a role in the degree of pain and inflammation experienced by a patient.

What can cause hip arthritis?

In many patients the exact cause of arthritis is uncertain. There is a strong family history and patients with a first degree relative with hip arthritis are likely to develop it themselves. Patients who had a childhood history of hip dysplasia, or developmental problems with their hips, are also at risk of arthritis of the hip later in life. Trauma, some hormonal conditions and some metabolic diseases are also associated with the development of hip arthritis. Rheumatoid arthritis and other inflammatory arthritides can be associated with hip pathology as well.

What are the non-operative options?

It is important to trial non-surgical treatment options first. This would include, importantly, weight loss. It has been shown that fatty tissue actually mediates inflammatory chemicals that collect in arthritic joints, making the joint more inflamed and painful. Losing some fatty (or adipose) tissue reduces the inflammatory mediators and may eliminate the need for a patient to undergo major surgery.

Other non-operative options include physiotherapy to strengthen the gluteal muscles and address any contractures. Analgesia such as paracetamol and ibuprofen can help control pain. An injection into the joint may help relieve some pain temporarily.

What are the surgical options?

For many patients with hip arthritis, a joint replacement can be a good solution for the pain.

How long does a hip replacement take?

A total hip replacement can take up to two hours.

Do I need a general anaesthetic?

This will be discussed with you prior to surgery. Hip replacements can be done under a spinal anaesthetic or general anaesthetic, and this can be supplemented by nerve blocks. Each patient is different so the type of anaesthetic most suitable for the patient is a very individual decision made between the patient and anaesthetist.

What happens afterwards?

Patients are in hospital for as long as they need to be to recover. Some patients recovery very quickly and are home within two days. Some patients require a longer stay in hospital for pain relief, nursing support or to manage any complications. Occasionally a period as an inpatient in a rehabilitation unit is required.

Physiotherapy commences immediately after the operation. It is important that patients mobilise to avoid stiffness and reduce the risk of complications such as pneumonia or blood clots.

After two weeks, the wound is checked and any stitches removed. If the wound is clean and dry, it is reasonable to commence hydrotherapy or swimming.

A check-up with the treating surgeon six weeks post-operatively is normally done to check the range of motion, gluteal strength and ensure the patient is able to mobilise relatively comfortably.

Over the next three to twelve months, the pain and swelling subsides and patients generally resume driving, playing low-impact sport like golf and return to work.

What are the risks?

In the majority of cases, a hip replacement is an effective procedure that can significantly improve quality of life. However, it is a major operation which comes with inherent risks. Some of these risks include:

Heart attack, stroke and death – these are very

rare events but are serious risks of a joint replacement. This can occur either during or in the first few days following a procedure. The risk of heart attack, stroke or death is higher in someone with pre-existing heart disease, vascular disease or diabetes.

Leg length discrepancy – some patients can feel that their operated leg is longer or shorter than the other following their hip replacement. This is normally tolerated well and treated with a shoe raise. Rarely, the hip replacement may need to be revised to address any significant leg length discrepancy.

Infection – the risk of infection is around 1 in 100 patients for an osteoarthritic hip. Deep joint infections can be devastating, requiring multiple procedures, prolonged antibiotic treatment and sometimes removal of the implant altogether while the infection heals.

Deep vein thrombosis (DVT) – these can develop in the deep veins in the legs during or after surgery. Part of a clot can break off and travel to the lungs (called a pulmonary embolus). Very rarely this can be fatal. To lower the risk of DVT patients are encouraged to mobilise, foot pumps are applied and some blood thinning agents may be used for some patients.

Failure of the implant – the prosthetic replacement can wear over time resulting in loosening, polyethylene wear and fractures. On average, around 4-8 people per 100 knee replacements will need a revision after 10 years.

Dislocation and fracture – rarely a patient can have a dislocation of the prosthetic hip joint that can also include a fracture of the bones around the hip joint. This may require a reduction under sedation in the local emergency department and occasionally a complete revision of the hip joint.

If you have any questions or concerns about your joint replacement please don't hesitate to contact the surgery:

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