BIRMINGHAM HIP RESURFACING

INTRODUCTION

Hip Resurfacing is a type of hip replacement which replaces the two surfaces of the hip joint. The procedure is very bone conserving as the head of the femur is retained. Instead of removing the head completely, it is shaped to accept an anatomically sized metal sphere i.e. the same size as the normal head of the femur. There is no large stem to go down the central part of the femur and the surface of the acetabulum (the socket) is also replaced with a metal implant, which is wedged directly into the bone.

The resurfacing components are made of ‘as-cast’ cobalt chrome which is finely machined to produce a very high quality surface with a low friction finish, hence low wear.

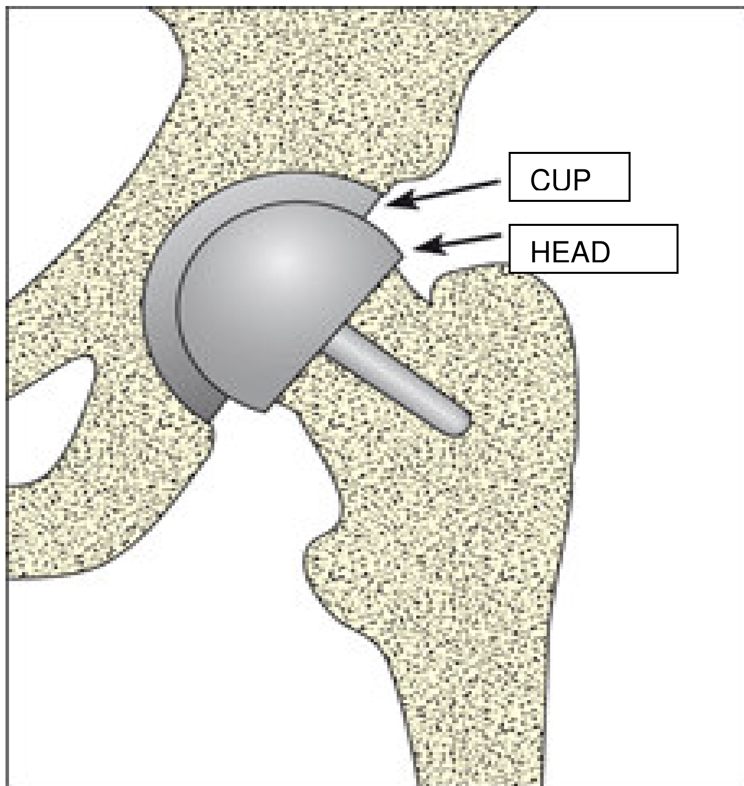

Diagram of resurfaced hip.
The ‘cap’ fits over the top of the femur (thigh bone) and the cup goes into the socket of the hip (acetabulum).
The 2 components are machined to within 1 micron sphericity, i.e. a highly exacting standard for perfect fit.

PRE – OPERATIVE PROCEDURE

You and your orthopaedic surgeon will participate in an initial surgical consultation. This appointment may include pre-operative X-rays, a complete medical and surgical history, physical examination and a review of your medications or allergies. During this visit, your orthopaedic surgeon will likely explain the procedure and answer any questions. You may be visited by your physiotherapist, who will explain your course of postoperative rehabilitation.

INPATIENT TREATMENT PLAN

- Your recovery program usually begins the day after surgery.
- In these first few days after surgery, the nursing staff or physiotherapists may elevate your leg to assist in keeping swelling under control.
- The physiotherapist will teach you exercises to improve circulation and strengthen the muscles around the joint.
- You will be allowed to walk a few steps the day following surgery with an appropriate assistive device (usually a walking frame, crutches, or walking sticks) within the limits of your comfort.
- Regular walking, sitting, standing and exercising is highly essential and needs to be progressed steadily with the physiotherapist.
- You will be allowed to fully weightbear on the operated leg unless otherwise stated by your surgeon and have completed a flight of stairs safely and confidently before you will be discharged from hospital.
- Your stay in hospital will usually be around five days, assuming normal recovery and all post operative hip checks have been completed.
- In the weeks after your surgery, it is important to continue walking and exercising on a regular basis to further strengthen your hip muscles. An exercise and walking program helps to enhance your recovery from surgery and makes activities of daily living easier to manage.

OUTPATIENT PHYSIOTHERAPY

The role of the physiotherapist is to teach you exercises to restore normal range of active and passive movements. This includes helping you regain normal functional activity and to restore dynamic stability of the muscles in the pelvic and hip regions. It is recommended that you see your physiotherapist at least once, two weeks after your surgery. Further physiotherapy requirements will be based on your progress and confidence.

GUIDELINES TO RECOVERY

- **Regular active exercise:** This includes regular walking and continuing with your exercise regime given by the physiotherapist.
- **Sleeping:** You will be able to sleep on your side, unless your surgeon advises otherwise.
- **Aspirin:** You are required to take 75mgs daily for 6 weeks. High-risk patients are to continue for 3 months. Very high-risk patients may be placed on heparin or warfarin.
- **TED Stockings:** To be worn for approximately 3 weeks.
- **Clips:** To be removed 10 – 12 days after surgery.
- **Bath:** When the wound is sealed and dry, usually at 14 days. Patients are to shower prior to this time, as long as the wound is protected by a waterproof dressing.
- **Toilet:** No raise to toilets or chairs are needed unless your physiotherapist advises otherwise.
- **Driving:** The left hip (able to drive automatic when comfortable, manual car at 4 weeks). The right hip (able to drive when can do emergency stop at somewhere between 4 and 6 weeks)
- **Work:** Sedentary occupation may be commenced around 6 weeks, heavy physical occupation to be commenced at 10/12 weeks.
- **Flying:** You are able to fly at 6 weeks as a general rule. Any flying prior to this period needs your surgeon's approval.
- **Sport:** Swimming is allowed once the wound is healed and if confidence allows i.e. 14 days. Non – impact sports may be commenced at 4 weeks. Impact sports at 3 to 6 months depending on progress and confidence.
- **Sexual activity:** This can be commenced from day 10 onwards. Patients are recommended to maintain the supine (on your back) position initially for both sexes.
- **General advice:** Always wear non - slip shoes, which provide back support.

PREVENTING POST-OPERATIVE DISLOCATION

Please note that dislocation is highly unlikely with hip resurfacing. However, to follow is a list of precautions, which should be taken to prevent this from occurring:

- NO heavy lifting
- Do not twist on the spot or squat to the floor
- Avoid extreme movements of the new hip
- Do not cross your legs
- Do not bend over your hips to pick up objects from the floor

Your surgeon or physiotherapist will advise when these rules no longer need to be followed.

COMPLICATIONS

As with any major surgical procedure, post – operative complications can occur following hip resurfacing surgery. Be aware that all surgery carries some risk. The risks usually mentioned in the context of hip surgery include:

- **Infection:** This may present some time after the operation and can occur by bacterial spread through the bloodstream from another infected site (haematogenous). The risk of haematogenous spread of infection is greatest in the first 6 months to 1 year.
- **Dislocation:** Theoretically possible but less likely with hip resurfacing than with total hip replacements.
- **Major nerve or bloodvessel damage:** Nerve injuries usually recover but with a delay which may take several weeks or months to heal.
- **Deep Vein Thrombosis:** Clots in the legs or pulmonary embolism, which are clots that break off and travel to the lungs and heart.
- **Minor Leg Length Discrepancy:** Hip resurfacing does not usually change the pre – operative leg length but minor alterations may be unavoidable. These may need a small shoe raise on one or other side to compensate.
- **Bruising, swelling or blistering** is common and usually not serious, nor do they usually delay discharge from hospital.
- **Peri-prosthetic fracture.** Hip resurfacing carries the specific risk of fracture of the bone in the femoral neck, below the 'cap'. This occurs in less than 1% of patients. If it should happen, the situation is relatively easily retrieved by conversion to a metal-on-metal total hip replacement.

None of the above except swelling, bruising and blistering are common. All others are relatively rare. If any potential complication worries you, speak to your surgeon directly.

A patient support group using email is available at:

hipsrus-subscribe@yahoogroups.co.uk
Send an email explaining where you live and why you want to join. Further instructions will follow by return email.

This patient guide was compiled by:
Ms Shireen Dalvie (MCSP SRP) Senior Physiotherapist
Mr. Mark Bloomfield FCS (SA) Ortho – Consultant Orthopaedic Surgeon
With the assistance and involvement of physiotherapists at the Runnymede Hospital .