NHS
West Suffolk
NHS Foundation Trust

Patient information

Revision hip replacement

Procedure

A revision hip replacement is the removal of one or both parts (cup in the acetublum and/or the stem in the femur) of a previously inserted total hip replacement and inserting a new replacement. Your surgeon will explain why this is required, but it is normally done for loosening or infection of the old hip.

The only real alternative would be to accept the situation but this will not lead to any improvement and any pain or mobility you already have will almost certainly deteriorate. It is possible that damage done by the loose hip components to the surrounding bone may make surgery more difficult and complex if there is a prolonged delay. Your surgeon would be able to advise you about this.

If your surgeon does need to reconstruct your hip then you may need to be on crutches for a period of up to 3 months after your operation. While this can sometimes be anticipated, there are occasions where it is unexpected.

Revision of an infected hip replacement

If your hip replacement is infected then surgery may be carried out in 2 stages. The first stage (operation) is to remove the infected hip and any other infected tissue. Potential due to the nature of infection you will require a course of antibiotics prior to the second stage operation, this will be discussed further with the Mircobilogist. The second stage operation takes place between 6 weeks and about 6 months later to put in another hip replacement. Patient mobility between the 2 stages is limited the use of walking aids will be necessary.

Your surgeon will normally warn you that this is what he is planning to do, but very occasionally an unexpected infection is found at surgery, and only the first stage is carried out, where a full replacement has been originally planned.

Putting you first

Surgery

Removing an old hip replacement and replacing it is a larger and more complex procedure than having a hip replacement for the first time. The bone around the old hip replacement may have become quite damaged and require reconstruction either using bone graft taken from the bone bank together with metal mesh and screws, or specialised hip components or a combination of the two,to replace any missing bone. It can be very difficult to assess the degree of damage before surgery and though your surgeon may be able to give you an indication of what he intends to do before the operation, this plan may well change during surgery.

Complications

The complications of revision hip replacement are similar to those in a first time replacement, but because the surgery is more difficult, the risk of any single complication occurring is significantly higher.

In general terms revision hip replacements seldom work as well as the original one when it was first put in, there is likely to be some loss of range of movement and up to half of patients have some (usually slight) discomfort in their revised hip from time to time.

More than a third of patients are likely to experience a complication of one type or another, though the majority of these are minor and can be treated satisfactorily and so do not affect the long-term outcome.

Specific complications may include:

Blood clots in the veins of the legs: As long as the clots remain in the legs they are a relatively minor problem. Occasionally, they dislodge and travel through the heart to the lungs (pulmonary embolism). This is a potentially serious problem, since (very rarely) death can result from embolism.

To reduce the risk of blood clots forming you will be given daily injections of heparin, to thin the blood slightly while in hospital, and tablets to continue the blood thinning for several weeks after your surgery when you go home. You may be given compressive stockings to wear and will be encouraged to move your feet and get up as soon as possible after the operation. Blood clots can still occur despite all these precautions, though the incidence of this is much reduced.

Infection: This is a serious complication that can lead to the need for the implant to be removed. Great care is taken to try and reduce this risk, with the

sugical team operating in a special ‘laminar flow’ operating theatre, wearing a protective hood, and antibiotics are given to the patient routinely. The infection rate is in the region of 2% but is higher in patients who have had multiple previous operations and in some medical conditions including diabetes and for people taking steroid medication.

Dislocation: This means that the metal ball slips out of the plastic socket. In the first six weeks after the surgery, the ball is only held in the socket by muscle tension. During this time, before scar tissue forms around the ball, and before muscle strength returns, the hip is more likely to dislocate. The risk of this happening after a revision hip replacement is higher than after a first hip replacement and is in the region of 5% (one patient in 20).

The physiotherapist will teach you what positions to avoid, and how to safely use your hip replacement during this early phase of your recovery. If the hip does dislocate, it is usually a simple matter for the surgeon to pull on the extremity and ‘pop’ the hip back into place under an anaesthetic. Occasionally patients develop repetitive dislocations and this can lead to the need for further surgery.

Leg lengths unequal: This is common particularly where there is already some inequality of leg length caused by the hip becoming loose. **Occasionally the leg will be deliberately lengthened or shortened, in order to stabilise the hip or to improve muscle function.** Most patients learn to live with small leg length differences with no problems but a few feel unbalanced and need to use a shoe raise to make their legs feel equal.

Bone forming in muscles around the hip (ectopic bone): Small amounts of ectopic bone appear frequently around hip replacements but do not cause a problem. Significant new bone formation is rare but can cause the hip to be stiff.

Inability to replace the hip: This occurs when the bone damage is too great to attempt reconstruction and will leave the patient with a short leg and the need to use walking aids. There is always a very small chance of this happening, but it is very uncommon unless there has been extensive damage to the bone around the original hip. Your surgeon will tell you if there is a high chance that this might be the case.

Fracture of the femur: May occur during revision hip surgery, usually while removing the implants. Your surgeon may deliberately split a segment of the femur (thighbone) to make removal of the implant easier. If your femur is accidentally cracked during surgery, you may have to remain on crutches to allow healing to occur.

Nerve or artery damage: Injury to the arteries of the legs is a very rare but possible complication. In some cases the sciatic nerve which runs very close to the hip joint can stop functioning after surgery, occasionally because it has been damaged but much more commonly for no obvious reason. This will cause alteration in sensation of the lower leg or foot and a foot drop, this is where the muscles that pull the foot up stop working so the foot tends to hang down. This happens in about 1-2% of cases (one patient in 50-100). Half of these will recover spontaneously over 6-24 months, but this can be a permanent condition. Foot drop can lead to the need to wear a splint inside your shoe.

Bleeding complications: Blood loss during revision hip replacement can be substantial. We give drugs to limit blood loss and collect and reinfuse some of your blood during the operation if we are able to do so, nontheless about half of patients end up needing a blood transfusion. On very rare occasions the blood loss can be sufficently large to pose a risk to the patients life.

Blood and bone disease transmission: Disease transmission by blood transfusion or donor bone graft can occur but is very rare. The incidence in the UK is estimated at one and half million for each unit of blood. All blood and bone is screened for diseases that are known to be a risk. There are no recorded cases of disease transmission by bone from a bone bank in the UK.

Further loosening: It is possible for a revised hip to become loose over many years in exactly the same way as the initial one did.

Wearing out of, or breakage of, the new hip: Both these events are rare but not unheard of, and usually only occur many years after the implant has been put in.

Anaesthetic and general complications: These can occur during or after any big operation. They include problems with chest, heart, bowel, bladder and a stroke. They are usually caused by the stress of surgery making a pre-existing condition, which may or may not be known about, worse. The anaesthetist will see you before your operation and can explain these risks in more detail.

Death: There is an increase in risk of dying after surgery this complex. This risk is less than 1% (one in a hundred) in the first six months after the operation for all patients, though your individual risk may be higher if you already have other significant medical conditions.

In hospital stay

Your stay is likely to be longer than a primary total hip replacement, due to the weight bearing status after the operation, which may be limited due to the

nature of the operation. The use of walking aids will be required (crutches or walking frame) and recovery may be longer, following a longer anaesthetic time.

Pain control: You will be asked if you require regular painkillers during your stay. It is important that you take these to aid your rehabilitation. It is reasonable to expect pain as you have had major surgery but your pain will be kept under control.

Wound care: Your wound will be closed with either stitches, clips (staples) or glue. The District or Practice Nurse removes these at 10-14 days after the operation. There will be a dressing over the wound until it is healed to prevent infection. This will only be changed as necessary. If your surgeon has used wound glue, you may not have a dressing over your wound. Some surgeons us revision tape (glue) over the wound, don't not remove this until 2 weeks after the operation to be undertaken by the practice nurse or district nurse.

Follow up: You will be given a follow-up clinic appointment 6-8 weeks later, sooner if specified by the operating consultant. This will be sent to you in the post. It is at this point that you need to check with your consultant about returning to normal activities and resuming driving. Before this appointment you **cannot** drive.

Physio and Occupational therapy input will be intense to help you recover from the operation and to also ensure a safe discharge back to your home environment. Hip precautions will be discussed in depth with you please ensure you read the leaflets provided as well as engaging in the exercises needed to help the recovery process.

Most patients do not require social services input after their operation. However, if you do have any concerns, please discuss this with the staff when you attend the pre-operative assessment.

Rehabilitation after the operation

The rehabilitation team consists of physiotherapists, occupational therapists and rehabilitation assistants. They will assist you in getting up and mobile after your operation and provide you with advice and exercises to help you get home safely. They will also teach you how to look after your new hip joint.

You will begin to get moving within 24 hours of your surgery. You may even be able to move around within a few hours of your surgery.

You will be taught how to use a walking aid (frame, crutches or sticks), you will need help initially when you first get mobile. You will soon be independently

walking around the ward with your aid. Restriction on the amount of weight you can put through the operative limb may be restricted (individual patient specific).

The physiotherapists will show you how to manage stairs and/or steps when you are mobile.

You should expect to get up and dressed each morning so you can get back to a normal daily routine as soon as possible.

Hip precautions: When the surgeon puts in the hip replacement, the muscles and soft tissue around the joint are cut. Whilst they heal, the new hip is at risk of coming out of its socket (dislocating). This is why you will need to follow 'hip precautions'.

You need to follow your hip precautions for a minimum of 6-8 weeks as this is the length of time it takes for the muscles and soft tissue to heal providing the necessary support for your new hip.

Hip precautions are movements that you must avoid, as doing so will strain the hip causing it to dislocate. They are:

1. Do not cross your legs, even at the ankles, whether standing, sitting or lying down.

2. Do not bend your hip past an angle of 90° angle, in other words, not bending down to your feet or bringing your leg up towards you.

3. Do not twist your hip or over-reach, always ensure you face what you are doing.

These precautions will have an effect on how you carry out your everyday activities. Your OT will teach you the safest ways of completing these tasks, for example how to dress using equipment to avoid bending down to your feet and how to get on and off a bed safely.

We would like to remind you that this is only a general guide. Every patient is an individual and their care is tailored towards their needs and so may differ slightly from the information provided in this leaflet.

If you have any questions please do not hesitate in contacting us on the numbers below. We will try to answer your questions to the best of our ability.

Useful telephone numbers

Pre-operative assessment	01284 712810
Physiotherapy department	01284 713570
Occupational therapy department	01284 713570
Post-discharge advice helpline	01284 713924
Ward F4	01284 713290

If you would like any information regarding access to the West Suffolk Hospital and its facilities please visit the hospital website www.wsh.nhs.uk and click on the link, or visit the disabledgo website:

http://www.disabledgo.com/organisations/west-suffolk-nhs-foundation-trust/main