

If you are facing the prospect of surgery on your hip, you are certainly not alone. Hip replacements are one of the most commonly performed and most successful operations in the UK.

Do I need hip surgery?

Arthritis can damage your hip joint, preventing it from working smoothly. As the connecting joint between the thigh bone and the pelvis, the hip is vital to most everyday activities — from sitting to standing and walking. There are many avenues to explore before considering the option of surgery, including exercise, medication and alternative therapies. But if the quality of your life is becoming seriously affected, your doctor may suggest surgery. The operation should aim to reduce the pain you are experiencing and improve your mobility.

Surgery will mean a hospital stay and a recuperation period. New techniques have brought about quicker recovery times, but it is important to consider carefully all the benefits and risks, including the possibility of needing further surgery.

REAL LIFE STORY

‘ Before my hip replacement I was in an extreme amount of pain and a lot of discomfort — the hip had gone completely. I was almost immobile and depended on others to get about.

I had done a lot of research on my surgeon and found that he had a special interest in patients with rheumatoid arthritis. I had great faith in him. And the anaesthetist said an epidural was the best type of anaesthetic for me, so I went with that.

I was up and moving the day after the operation. I was given exercises to do, which I built up as time went by. In time I could get about by myself again and could resume the quality of life I’d enjoyed before the hip had got so bad.

The operation really does make a difference. I would recommend shopping around a bit — be sure you know who is doing the surgery and what options are available to you. ’

What types of surgery are there?

Options regarding hip surgery include the method by which the surgeon gets to the joint, the type of prosthesis (artificial hip) that is attached to create the new hip joint, and how this is anchored.

Once you have been referred to a surgeon, he or she should talk you through the possibilities open to you - and the risks and benefits involved in each. Bear in mind that not all the following types of artificial hips and methods of surgery might be suitable for your needs.

Hip replacements

In a standard hip replacement operation, the artificial hip comes in two parts. One part is usually shaped like a ball on a stem and replaces the head of the thigh bone, the stem pointing down into the thigh bone. The other part is shaped like a cup, which replaces the socket in the pelvis.

The two parts will move together every time the hip joint is used; it is estimated that we take an average of one million steps a year. This inevitably creates a very small amount of debris — miniscule in most cases. The debris created by this wear can sometimes cause joint inflammation and bone loss, although this is rare. Artificial hips also come in different shapes and sizes and would be selected depending on the shape of your natural hip. The materials used to make artificial hips are shown below, with the toughest material listed first:

ceramic ball and ceramic cup

metal ball and plastic (polyethylene) cup - used most commonly

ceramic ball and plastic (polyethylene) cup

metal ball and metal cup - now only used in rare cases

The size of the cup is determined by the needs of the patient. A larger ceramic or metal with newer highly cross linked polyethylene, ball allows for a greater range of movement and reduces the risk of dislocation. This means that you can take part in more vigorous exercise. The more durable materials are more likely to be offered to younger, active people.

If manufactured prostheses are not right for you, the surgeon may need to use a custom-made prosthesis but these are very rare.

How the prosthesis is fixed onto the bone can also vary. There are three choices —cemented, cementless and hybrid.

The cement (polymethyl methacrylate) simply holds the prosthesis fast to the bone.

Cementless methods include the use of screws, nails or pegs, and/or the use of a coating which encourages the bone to grow and bind onto the surface of the prosthesis. This should prove more successful if the bone is strong and healthy, although you may need to be more careful with weight-bearing immediately after the operation.

A hybrid prosthesis means that the ball is cemented on while the socket is cementless. This allows for immediate weight-bearing, so might be suitable for people unable to use crutches.

The surgeon has three options for getting to the joint, which are described below.

The traditional/standard method — by making an incision as large as is needed to make sure the implant is in the right place. Previously incisions have been made over the hip (usually 10-25cm long). This allows for plenty of room to access the thigh bone and the pelvis. The punctuation needs sorting out here.

While the smaller incisions may make the initial recovery slightly quicker, clinical studies have shown no significant difference in long-term outcomes regarding hip function. Therefore, the type of surgical approach used will depend on your surgeon's personal experience and what is determined best for you.

Hip resurfacing

This newer technique has only been in use since around 1997. In hip resurfacing, the damaged surfaces in the hip joint are replaced with a metal surface.

Instead of removing the whole head of the thigh bone as in the total hip replacement, the top of the bone is shaped down and covered with a metal cap. This fits into the metal socket attached to the pelvis. This technique is often referred to as MoM (or metal on metal) resurfacing.

However, since 2010 concerns have been raised with regard to using metal on metal resurfacing techniques. Some patients have been found to have progressive soft tissue reactions to the wear debris associated with the metal on metal articulations, which has led to revision surgery in some patients. The Medicines and Healthcare Products Regulatory Agency have removed some prostheses from the market due to this issue.

Although this procedure is still available to patients, careful consideration regarding any possible side effects should be discussed with the consultant surgeon and a regimen of annual reviews following surgery should be implemented prior to surgery.

How can I prepare before surgery and what can I expect after?

While exercise may be difficult if you need hip surgery, your recovery should be smoother the fitter you are, as less stress will be placed on your hip. Strong leg muscles will also help your recovery. A well-balanced diet will help put you in a fit state to fight infection and can also help you lose weight. Some hospitals in the UK are now reluctant to offer surgery to people who are overweight. If you smoke, either give it up or cut down the amount that you smoke in the weeks leading up to the operation. This will reduce the risk of developing a chest infection or circulatory complications afterwards. You must tell the anaesthetist if you smoke.

It is also important to consider beforehand how you will manage back at home after the surgery. Think about whether to ask a friend or family member to help out for the first few weeks. Could you sleep downstairs whilst you recover? Ask for an assessment by an occupational therapist at home.

Being aware of what you cannot do after surgery will help you plan your practical arrangements. These are all in order to minimise the risk of your new hip dislocating and are particularly important for the first six weeks. Some caution will still be necessary in future as well.

Do not lie on your side.

Do not cross your legs.

Do not bend the hip excessively (i.e. more than 90 degrees) by sitting upright, or bending your knee towards your chest (whilst cutting your toenails, for example).

Do not twist the operated leg in or out.

Do not rotate your body excessively on the operated leg when standing (for example, avoid stiles if you are out walking).

When walking or turning, keep your foot and knee pointing straight ahead.

Before you are discharged, a physiotherapist should visit you to give you some exercises to do, including how to exercise your leg safely, how to put weight on your joint, and how to go up and down the stairs. They will give you walking aids if necessary. These exercises are extremely important in aiding your recovery, which will be delayed if you do not keep them up.

An occupational therapist will give you some advice on dressing techniques and on useful equipment, before you go home. Ensure your healthcare team have given you all you need to know about your recovery before you leave hospital. Also, see Arthritis Care's booklet *Independent Living and Arthritis* at: www.arthritiscare.org.uk/what-is-arthritis/resources

How can I avoid complications?

It is important to remember that hip operations are routine and among the most successful types of surgery carried out today. Together with your medical team, you can work to avoid the following, which can happen in a minority of cases:

dislocation (one to two per cent risk) — this is more likely to happen in a replacement hip, but following the rules above will reduce this risk.

deep vein thrombosis (two to three per cent risk) — caused by blood clots forming in the leg veins. The risk of this is reduced by wearing anti-embolism stockings, using calf/foot pumps, stopping smoking, taking medication to thin the blood and getting moving as soon as possible after the operation.

infection (one - two per cent risk) — this is a rare but serious complication. It is usual to be given antibiotics before and after the operation to reduce the risk.

Loosening of the joint may occur over time. How long a replacement will last can vary enormously depending on the artificial hip fitted and how active you are. A small percentage of people will eventually need a further operation.

What happens in revision surgery?

While standards are higher than ever and materials more durable, it is possible that one day your new hip will fail. Long-term studies indicate that for most hip replacements, fewer than 10 per cent will require revision surgery within the first 10 years. An X-ray or scan should confirm whether the joint has loosened. The operation you will have to correct this (usually by replacing the prosthesis) is known as revision surgery.

One of the reasons a replacement may fail is because of a deep infection, which can be very hard to detect. If an infection is detected, the surgeon may recommend a two-stage revision. This involves the removal of the original replacement, leaving you without a hip joint. It may still be possible to get about without help if your other hip and leg are OK. Once the infection has fully cleared, a revision hip replacement is inserted in the second stage operation.

A one-stage revision will be performed if there is no infection. You may want to discuss with your surgeon whether a cemented, cementless, or hybrid prosthesis would be suitable for you, depending on your previous experience.

Frequently, if it is some years since your original surgery, your own bone will have begun to weaken. The bone can be rebuilt either using your own bone (normally removed from the pelvis), or another person's bone from a bone bank. Once the bone has been reconstructed the revision hip prosthesis is inserted. This may need to be a specific design, sometimes specially reinforced.

Post-operative care will be similar to your original operation, although you may need to use crutches for longer.



Hip surgery

Revision surgery is still more difficult and complex than primary surgery. Some orthopaedic surgeons have become experts in this field — and in most hospitals one or two orthopaedic surgeons will have this expertise.

This factsheet is intended to give you a brief outline of some of the options that may be available to you regarding your hip surgery — but do discuss everything thoroughly with your consultant. For more information read Arthritis Care's booklet *Surgery and Arthritis*.

Where can I get more information and support?

Arthritis Care is the UK's largest charity working with and for all people who have arthritis.

Talk to someone in confidence about your arthritis by contacting our free helplines:

0808 800 4050 (09:30-17:00 weekdays)
or **Helplines@arthritiscare.org.uk**

Our website has information and discussion forums where you can find support from others with arthritis:

www.arthritiscare.org.uk



Arthritis Care and Arthritis Research UK have joined together to help more people live well with arthritis. Read how at arthritiscare.org.uk/merger. All donations will now go to Arthritis Research UK and be used to help people with arthritis live full and active lives in communities across England and Wales, Scotland, and Northern Ireland.

Registered Charity Number 207711, SC041156.

Our factsheets are reviewed every three years. Please check our website for up-to-date information and reference sources or call 020 7380 6577.

Last reviewed: 2015. Next review: 2018.

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