Total Knee Arthroplasty FAQs
Pre-Op Patient Handout
Dr. Kathryn Schabel

The Basics

What is a knee replacement (Arthroplasty)?
Knee replacement involves the removal of the damaged and worn cartilage and bone and replacement of the joint with metal and plastic. Joint realignment and ligament balancing are also performed.

What can I do pre-op to get ready and make recovery easier?
✔ Stay active and strong
✔ Minimize pain medicine
✔ Eat healthy food
✔ Maintain a healthy weight or lose excess weight
✔ Manage any existing medical issues
  • Blood sugar
  • Blood pressure
  • Take medications regularly and as prescribed

What should I avoid?
Stress and anxiety

What do I need to prepare for my recovery?
✔ Walker (front wheel adjustable walker)
✔ Cane (adjustable or correct height for you)
✔ Solid railing on stairs
✔ Ice pack (frozen peas, ice, gel pack, ice machines available)
✔ Consider bathroom shower chair, pull bar installation

How much help will I need?
You will need to be home with a family member, friend or caregiver who is going to be available and helpful most of the days and nights. For the first few nights home, having someone around 24 hours a day is best.

When will I be able to drive?
Most patients resume driving about one month after surgery.
✔ Walking well with cane
✔ Weaned off pain medication
✔ Have good control of the leg

Will I be able to climb stairs?
Yes, you will be taught how in the hospital. “Up with good, down with bad.” Lead with your good, non-operative leg going up the stairs, and lead with your sore operative leg going down. Work toward using both legs symmetrically.
The Basics

How do I know if I need to go to a skilled nursing rehab facility after surgery?
If you live alone and have no one available to come and care for you, then a rehab stay is recommended. Details of this all depend on your early recovery and insurance benefits. Case workers at the hospital will be available to arrange this after surgery. Having several facilities in mind and visiting them before surgery is very helpful for this process, though availability and insurance plays in to the final planning.

Who will be taking care of me?
Before surgery, the care team is comprised of me (Dr. Schabel); my physician-assistant (P.A.) Mollie Page; nurse-practitioner (N.P.) Timi Iddings, and a resident physician. Elyse, or one of our other schedulers, will assist you with scheduling surgery and all pre- and post-operative visits.

After surgery, the resident physicians and I will coordinate your care. We are fortunate to have a dedicated and experienced orthopaedic nurse practitioner on the inpatient ward to assist with your care and discharge planning. A nurse will be assigned to you every shift, along with a nurses’ aid. A team of dedicated orthopaedic physical therapists will evaluate and work with you daily, typically twice a day. An occupational therapist may evaluate you as well. A nurse case manager will be available to assist with any discharge planning needs, such as arranging a rehab stay. Our team is a consistent and dedicated team on our orthopaedic specialty ward. This ward was specifically designed to optimize your comfort and recovery and is equipped with a physical therapy gym complete with a car simulator to facilitate your transition to home.

Who are resident physicians? Why should I let them be involved in my care?
Resident physicians who work with me are college and medical school graduates are part of our orthopaedic surgery training program. Orthopaedics is frequently one of the most competitive medical subspecialties to get into, and thus orthopaedic surgery residents were at the top of their medical school classes. They are all physicians with several years of experience. They assist with your care to your benefit and theirs, and I am in control of all protocols, decisions and the entire surgical procedure. As faculty at a teaching institution, I highly value my role as professor and educator. This commitment is the foundation of the future of medicine. Being an instructor makes me a better physician and surgeon. If you have specific questions or concerns about this, please let me know.

Pain

How painful is knee replacement?
There is significant pain involved in knee replacement. I tell patients that I make you worse before I make you better. The best candidates for knee replacements are patients who have severe arthritis but who have coped well and maintained their activity levels in spite of discomfort.

Much of the early pre- and post-operative care is directed toward controlling post-operative pain. Regional anesthesia procedures such as femoral and sciatic nerve blocks, nerve catheters, and spinal anesthesia are encouraged to minimize early pain. Oral narcotic (opioid) and non-narcotic pain medications are used. Intravenous (IV) pain medication is also available. In addition to pain medications, ice and elevation are used for comfort.

What if I hate taking pain medications?
Typically some degree of pain medication is necessary to get people mobilized after knee replacement. Without adequate pain control and mobility, you cannot participate fully in physical therapy exercises that are crucial for successful results. Pain medications have several common adverse reactions, such as nausea, itching, confusion, and even delirium. Also, constipation and sleep disruption can occur. Some side effects can be treated; others are more difficult to control. Several different oral and IV pain medications exist, and patients respond differently to pain medications. Please inform us if you have had a previous reaction to a pain medication. While adverse reactions to pain medications are problematic, they rarely represent true allergies.
How long will I need pain medications?

Every patient is unique. A typical patient who did not take pain medications before surgery is able to wean off of all narcotic medication in the first month after surgery.

Patients who were taking oral narcotic pain medications prior to surgery may take longer to wean off of pain medications. Patients who take narcotics for some other reason may not wean off at all. The goal is to get you back to at-or-below pain medication doses by six weeks post-operatively. At that point you will be transitioned back to the prescriber who was providing your chronic pain medication prior to surgery.

How do I wean off pain medications?

Weaning off of medications is a natural process. Pain medications are “as needed” or “prn” medications. They are to be taken when needed, not on a rigid schedule. If you are sleeping, you should not set an alarm to awaken you to take more pain medications. They should only be taken when you are awake and feeling discomfort. Sleeping is a sign of appropriate pain control. You will notice in the early days after surgery that if you rest, and ice and elevate your knee, you will take less pain medication. If you are up standing or walking for long periods, you will need more. As time passes, pain from surgery naturally abates. As this happens, you decrease the dose and frequency with which you take medications. For example, if you are taking three pain pills about every four hours when you are discharged from the hospital, you will likely be able to decrease to pain pills every five to six hours within the first week after surgery. Keep track of how many pain pills you take every day, and slowly decrease the number of pills per day over time.

We may be able to switch you to a more mild pain medication than the one you left the hospital with. We will discuss this with you at your follow-up appointments.

How do I get refills on pain medications?

Please plan ahead. We provide you a reasonable estimate of the quantity of pills you will need until your first follow-up appointment. If you are running low and do not have an appointment, please call our office and request a refill when you still have at least two or three days of medications left. Narcotics are controlled substances and all but the mildest narcotics require a physical paper prescription to have them filled. We cannot phone in most pain medication prescriptions or refills. You will need to arrange to have the prescription picked up or it will be mailed to you. Every pain medication refill request will be answered with weaning encouragement and instruction.

Extremely large quantities of pain medications are not safe to prescribe, and each prescriber must use his or her judgment as to an appropriate quantity of pain medication that can be prescribed at one time.

Physical Therapy

When will I start physical therapy?

Some people start physical therapy before surgery. All patients start physical therapy the day of, or morning after surgery. A continuous passive motion machine, or CPM, is used to control swelling and initiate motion. Therapists will teach in-bed stretching and strengthening exercises. Therapists will also assist you with standing and walking. You will be taught to walk with a walker and how to maneuver stairs.

Why is therapy so important?

The success of knee replacement is dependent on correct surgical implantation (my job) and early achievement of motion and strengthening (your job). Both are absolutely necessary for a successful outcome. Pain control, swelling control and dedication to achieving early motion with daily exercises are the keys to success.

What are therapy goals?

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<tr>
<th>By two weeks:</th>
<th>By four weeks:</th>
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<tr>
<td>✔ Full active knee extension, straightening, against gravity</td>
<td>✔ Minimal swelling</td>
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<tr>
<td>✔ Knee flexion, bending, to at least 90 degrees</td>
<td>✔ Heel-toe gait with cane only or no device</td>
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<td>✔ Wean pain medication to low dose, occasional use</td>
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What are the best exercises to achieve these goals?

✔ Ice and elevation to control swelling and pain
✔ Successful pain medication regimen that enables you to move and perform therapy, but does not make you goofy, sleepy or feel over-sedated
✔ Keeping knee straight while in bed or in a chair by resting your heel on a rolled towel, armrest, footstool or coffee table
✔ Actively straightening knee in this position by tightening quadriceps muscle and pushing the back of the knee to the floor
✔ Sitting in a hard chair and bending knee, using non-operative leg to assist with bending
✔ Meeting with your therapist for active and passive stretching, strengthening and gait training exercises

How do I elevate my knee?
Helpful post-operative elevation requires that the knee is above the level of the heart. This requires that you are lying down completely and elevating your leg on multiple pillows or cushions.

Wound Care

When can I remove my bandages?
Surgical dressings are changed in the hospital on the second day after surgery. If you are home before then, you may remove the dressings 48 hours after surgery. The wound should remain clean and dry for that 48 hours with the sterile surgical bandage intact. While counter-intuitive, most particularly harmful bacteria reside in the hospital, so we will keep your wound covered while you are hospitalized. Once you are home you may remove your dressings. If your wound has any bleeding or draining after surgery, it should quickly improve and resolve in one or two days. In this case, you will be provided one or two dressing changes for this reason. If drainage persists after this, please call.

When can I shower?
You can shower without a bandage 48 hours after surgery. No submerging the wound in a bath. No hot tubs or swimming until cleared by me. Routine shower with water and soap is allowed. Gently pat the incision dry. Wrapping your knee gently with an Ace wrap to protect the wound is allowed. Exposing your incision to air is encouraged. Keep any dirt, mud, or pets away from your wound. General cleanliness habits such as daily showering are absolutely necessary.

Anticoagulation

Why am I on a blood thinner?
Thinning blood, or anticoagulation, after hip or knee surgeries is routine and recommended by several national guidelines. It is done to prevent blood clots from forming. Blood clots, or deep venous thromboses, form in the legs and can cause pain and swelling. If the clot mobilizes, it travels through the heart and into the lungs. This is called a pulmonary embolism, or PE, and can be life-threatening.

Blood clots are common after hip and knee replacement surgeries if we do nothing to prevent them. I follow national guidelines and do several things to prevent blood clots:

✔ Early mobilization after surgery
✔ Anticoagulation
✔ Sequential compression devices (SCDs) on legs in the hospital

Xarelto, or rivaroxaban, is one of several choices of anticoagulating medicine. It has the advantage that it is a pill that does not require blood monitoring. Other anticoagulants are low molecular weight heparins (Lovenox, Fragmin), Coumadin (Warfarin), or aspirin.

In addition to the three preventive measures above, I ask if you have a personal or familial history of blood clots or clotting disorders. I may ask that you temporarily stop taking hormone replacement therapy. Blood clot prevention is one of many reasons I require patients to quit smoking before surgery, as nicotine increases the risk of blood clots.

Like many aspects of medicine and surgery, anticoagulation has benefits and risks. We carefully monitor for signs of hematoma or other bleeding while patients are on an anticoagulant.