**A Total Hip Replacement**

**Introduction**

A total hip replacement can be defined as a surgery that involves the removal of the ball and socket that is diseased in the hip joint. This surgery involves the total removal of the diseased part. The diseased part is removed and replaced with an artificial fitting. Osteoarthritis is a condition that is characterized by the wear and tear of the cartilages in the joints. This condition results in stiffness, also the patient may also experience joint pain. The condition affects the whole joint area from the synovium, capsule, pericapsular muscles, subchondral bone and the articular cartilage (Seth, 2015).

**Pre-operative Management**

Any patient scheduled to undergo a total hip replacement for severe debilitating osteoarthritis pre-operative management is put into consideration as a vital factor. The patient should, first of all, inform the patient any medication that he or she may be using (Edwin 2010). This helps to ensure that any side effects that may result after the operation are dealt with effectively. The surgeon then can look into any information provided by the patient and evaluate the findings. During registration, the patient is requested to provide the needed contacts and also the information on his or her insurance providers (Hamel, Toth, Legedza, & Rosen, 2008). The patient is then provided with bills from different healthcare providers. The healthcare providers include pathologists, radiologists, and anesthesiologists amongst others.

When preparing for the surgery, the patient is put under tests. These tests include but not limited x-rays, EKG and imaging procedures. Additionally, the patient also receives a nursing assessment, during these tests the patient is recommended to be in comfortable clothes because he or she may be required to change in order to facilitate the tests (Spaková, Rosocha, Lacko, Harvanová, & Gharaibeh, 2012). The fact that patients suffering from osteoarthritis endure a lot of pain makes them inactive. The state of being inactive can make the healing process to become difficult. In order to deal with this, the patients are required to undertake an exercise program, (Lee, Nardo, Kumar, Wyatt, Souza, Lynch & Link, 2015). The patient should also be provided with advanced directives as this is a requirement by the federal law. The pre-operative exercise that the patient can undertake include thigh squeezes, ankle pumps and heel slides. When the patient is about two to four weeks before the surgery, he or she should visit an anesthesiologist. This professional helps the patient to understand the anesthesia that will be used during the surgery. The anesthesiologist does this by examining the medical records of the patient.

The patient is also requested to attend pre-operative classes. These classes are attended to weeks before the surgery. In this class, the patient learns a number of important aspects such as pain management (Paolo, Serafino, Mattia, et al 2011). Moreover, the patient is also taught on the various activities that he or she should indulge in after being discharged from the hospital. The patient is advised to take a family member or a friend to these classes (Glyn-Jones, Palmer, Price, Vincent, Weinans, & Carr, 2015). The relative or the friend becomes the coach of the patient. The patient is also required to attend an appointment with the surgeon that is two weeks prior to the surgery. During this meeting, the patient can raise any issues that he or she feels should be addressed by the surgeon.

Approximately ten days before the operation, the patient is advised to stop using any form of medication that may influence massive bleeding (Hamel, Toth, Legedza, Rosen, 2008). Examples of medications to be avoided by a patient include; naproxen, Motrin and any medication that have aspirin content. Moreover, the patient is also requested to prepare his or her home for return. The preparation for returning may include doing away with any obstructions that may be in the walkways and also preparing meals in advance and freezing them for reheating (Hamel, Toth, Legedza, & Rosen, 2008).

According to Paolo, Serafino, Mattia, et al (2011), finding out about the arrival time at the hospital is also important. This ensures that the patients arrive two hours before the surgery is initiated. Arriving early provides the nurses with ample time to carry out intravenous therapy and also respond to any questions that the patient may feel they were not addressed in the previous sessions. Moreover, being early also helps to handle any problems that may arise in case one arrives late. It is also advisable that the patient stays off any foodstuffs the night before the operation commences, this is according to (Christian, 2017). The patient is also advised to bring a number of items that include, personal emoluments, a list of medication that the patient has been using, durable power of attorney if the patient has one. In addition, the patient can bring flip-flops or flat shoes.

A patient should also be aware of the anesthesia that is tailored to him or her. Mostly the anesthesia to be used depends on the needs of that patient (Glyn-Jones, Palmer, Price, Vincent, Weinans & Carr, 2015). Therefore, the patient may be provided with, the general anesthesia, the regional anesthesia or the combined therapy approach. The general anesthesia is for the loss of consciousness, while the regional anesthesia is for loss of pain and numbness. Combined therapy is administered mainly for postoperative pain (Glyn-Jones, Palmer, Price, Vincent, Weinans, & Carr, 2015). The anesthesiologist should be in a position to discuss with the patient the benefits and also the risks associated with these different types of anesthesia.

**Postoperative Management**

After the surgery, the patient is taken into the recovery area. Here the patient stays for approximately two hours. When it the recovery area pain control is initiated and vital signs of the patient are closely monitored. After the two hours, the patient is taken back to his or her room and is put under the care of a nurse. During the first twenty-four hours of recovery, the patient is only allowed to be visited by one to two family members. During the first hours of recovery, the patient experiences many discomforts (Glyn-Jones, Palmer, Price, Vincent, Weinans & Carr, 2015). At times, the patient may be in need of numbing medication. The patient is required to remain in bed for the first night. In order to prevent blood clots, the patient is advised to engage in uncle pumps. The patient also experiences numbness immediately after the surgery, especially in the lower abdomen. In addition, due to the epidural, the patient may find it hard to move the legs. However, a patient is advised not to panic when he or she experiences such problems.

The first day after the procedure, the surgeon visits the patient and assess the progress. Additionally, the nurses assist the patient to bathe and get dressed. On the first day of recovery, the catheter is done away with and the epidural medication decreased gradually. However, the patient still continues taking the oral pain drugs regularly (Edwin Su, 2010). The nurses also assess the patient regularly with the aim of ensuring that the pain is managed effectively. The most important aspect of the first day is to manage and control pain. The physical therapist then visits the patient to undertake an assessment (Rheumatology, Volume 51, Issue 3, 2012). This assessment helps to determine the most appropriate time for the patient to start therapy. In order to control pain, the therapists work in collaboration with the nurses. Rest is vital for the patient, therefore the sleep should sleep adequately even during the day. In case, the patient is needed for medication or therapy then he can be awakened.

The second day after the surgery involves more motion exercises. During the second day, the patients experience less pain and generally, they feel better. Physical therapists also conduct two visits in order to reinforce the hip and also educate the patient on how to take care of the healing joint (Thomas, Simon,  Evans, Turner,  Vela,  & Gribble, 2018). Day three after the surgery it is expected that the patient experience less pain, there is more movement and also improved strength. During this day, the patient can now start preparing to go home. The preparation is done by the physical therapy team. This team trains the patients how to use stairs via the help of assistive devices. In case, the patient is not ready to be discharged, the physical therapy team communicates this to the surgeon. This leads to the drafting of specific instructions by the surgeons to have a rehabilitation set up for the patient.

Before, the patient leaves he should be able to show that he can safely use the stairs, get in and out of bed. Also, be in a position to show that he can effectively use the assistive devices. The patient should also make prior management and ensure that there is someone to pick him or her from the hospital facility (Ahsan, Natasha, Bhupinder, & John, 2018). The person selected should be responsible. The patients who live alone can opt to hire a personal attendant or stay with family for a while. Additionally, he or she can request a friend or a family member to stay at his or her place and provide the needed assistance (Ray, 2008). In situations where the patient feels that he is not safe to go home. The patient should at this point is recommended to stay at a skilled nursing facility. The rehabilitation care offered at these facilities corresponds with the care offered at the hospitals. Once the patient is discharged, the nurse reviews the instructions provided to the patient together. This helps to ensure that the patient is well informed about what he or she is supposed to do after being discharged from the hospital (Thomas, Simon, Evans, Turner, Vela, & Gribble, 2018). Moreover, the patient should also be guided by how he or she should be taken care of himself or herself while at home. The aspects that the patient should be informed on when going home include on aspects such recovery and the comfort of the patient. Furthermore, the patient should also be educated on the various myths and misconceptions associated with the recovery process. This will help to ensure that the patient stays on the right track of recovery.

**References**

Dimitriou, D., Antoniadis, A., Flury, A., Liebhauser, M., & Helmy, N. (2018). Total Hip Arthroplasty Improves the Quality-Adjusted-Life-Years in Patients Who Exceeded the Estimated Life-Expectancy. *The Journal of arthroplasty*.

Edwin P. Su, M.D. (2010). *Arthritis of the Hip - Total Hip Replacement (Arthroplasty) and Other Treatments at HSS.* Retrieved from: <https://www.hss.edu/conditions_hip-replacement-for-arthritis-of-hip.asp>

Glyn-Jones, S., Palmer, A. J. R., Price, A. J., Vincent, T. L., Weinans, H., & Carr, A. J. (2015). Osteoarthritis. *The Lancet*, *386*(9991), 376-387.

Glyn-Jones, S., Palmer, A. J. R., Price, A. J., Vincent, T. L., Weinans, H., & Carr, A. J. (2015). Osteoarthritis. *The Lancet*, *386*(9991), 376-387.

Hamel, M. B., Toth, M., Legedza, A., Rosen, M. P. (2008). *Joint replacement surgery in elderly patients with severe osteoarthritis of the hip or knee: decision making, postoperative recovery, and clinical outcomes.* Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/18625924>

Hamel, M. B., Toth, M., Legedza, A., & Rosen, M. P. (2008). Joint replacement surgery in elderly patients with severe osteoarthritis of the hip or knee: decision making, postoperative recovery, and clinical outcomes. *Archives of internal medicine*, *168*(13), 1430-1440.

<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/414360>

Lee, S., Nardo, L., Kumar, D., Wyatt, C. R., Souza, R. B., Lynch, J., & Link, T. M. (2015). Scoring hip osteoarthritis with MRI (SHOMRI): a whole joint osteoarthritis evaluation system. *Journal of Magnetic Resonance Imaging*, *41*(6), 1549-1557.

Hamel, M. B., Toth, M., & Legedza, A. (2008)*. Joint Replacement Surgery in Elderly Patients with Severe Osteoarthritis of the Hip or Knee Decision Making, Postoperative Recovery, and Clinical Outcomes*

Ferrata, P., Carta, S., Fortina, M. et al (2011). *Painful hip arthroplasty: definition*. Retrieved from: [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3279074/#](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3279074/)

Marks, R. (2008). *Hip Surgery Candidates: A Comparative Study of Hip Osteoarthritis and Prior Hip Fracture Patient Characteristics. Retrieved from:* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2687111/>

Rheumatology, Volume 51, Issue 3(, 2012). *Predicting OA progression to total hip replacement: can we do better than risk factors alone using active shape modelling as an imaging biomarker****?*** Retrieved from: <https://academic.oup.com/rheumatology/article/51/3/562/1797690>

Spaková, T., Rosocha, J., Lacko, M., Harvanová, D., & Gharaibeh, A. (2012). Treatment of knee joint osteoarthritis with autologous platelet-rich plasma in comparison with hyaluronic acid. *American Journal of Physical Medicine & Rehabilitation*, *91*(5), 411-417.

Thomas, A. C., Simon, J. E., Evans, R., Turner, M. J., Vela, L. I., & Gribble, P. A. (2018). Knee Surgery is Associated with Greater Odds of Knee Osteoarthritis Diagnosis. *Journal of sport rehabilitation*, 1-21.

Nordqvist, C. (2017). *Everything you need to know about osteoarthritis.* Retrieved

from: <https://www.medicalnewstoday.com/kc/osteoarthritis-causes-symptoms-treatments-27871>

Sheerz, A., Picardo, N., Mann B., & Skinner, J. (2018). *Melorheostosis*

*of the Hip Joint Treated With Total Hip Replacement.* Retrieved from: <https://online.boneandjoint.org.uk/doi/abs/10.1302/1358-992X.94BSUPP_XXV.ISTA2010-211>

Hurlstone, J. (2013). *Total Hip Replacement: Surgery, Recovery, and Outcomes.*

Retrieved from: <https://www.healthcitycaymanislands.com/hip-replacement-surgery-recovery-and-outcomes/>

Leopold, S. (2015). *Osteoarthritis of the Hip (Hip Arthritis).*Retrieved from:

<http://www.orthop.washington.edu/?q=patient-care/articles/hip/osteoarthritis-of-the-hip-hip-arthritis.htm>

Lam, S., & Amies, V. (2015). *Hip arthritis presenting as knee pain.*  Retrieved

from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4336883/>

Ayers, D. C., LI, W., Oatis, C., Rosal M. C., Franklin P. D. (2013). *Patient-reported outcomes*

*after total knee replacement vary on the basis of preoperative coexisting disease in the lumbar spine and other nonoperatively treated joints: the need for a musculoskeletal comorbidity index.* Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/24132356>

Poppert, E., & Kuling, K. (2011). *Hip degenerative joint disease in a patient with medial*

*knee pain.* Retrieved from: <https://www.ncbi.nlm.nih.gov/pubmed/21322846>