KNEE REPLACEMENT

A Guide for Patients and Families

Written by Dr. Richard Lawton
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Surgery Date: _____

Admit Time: _____am/pm

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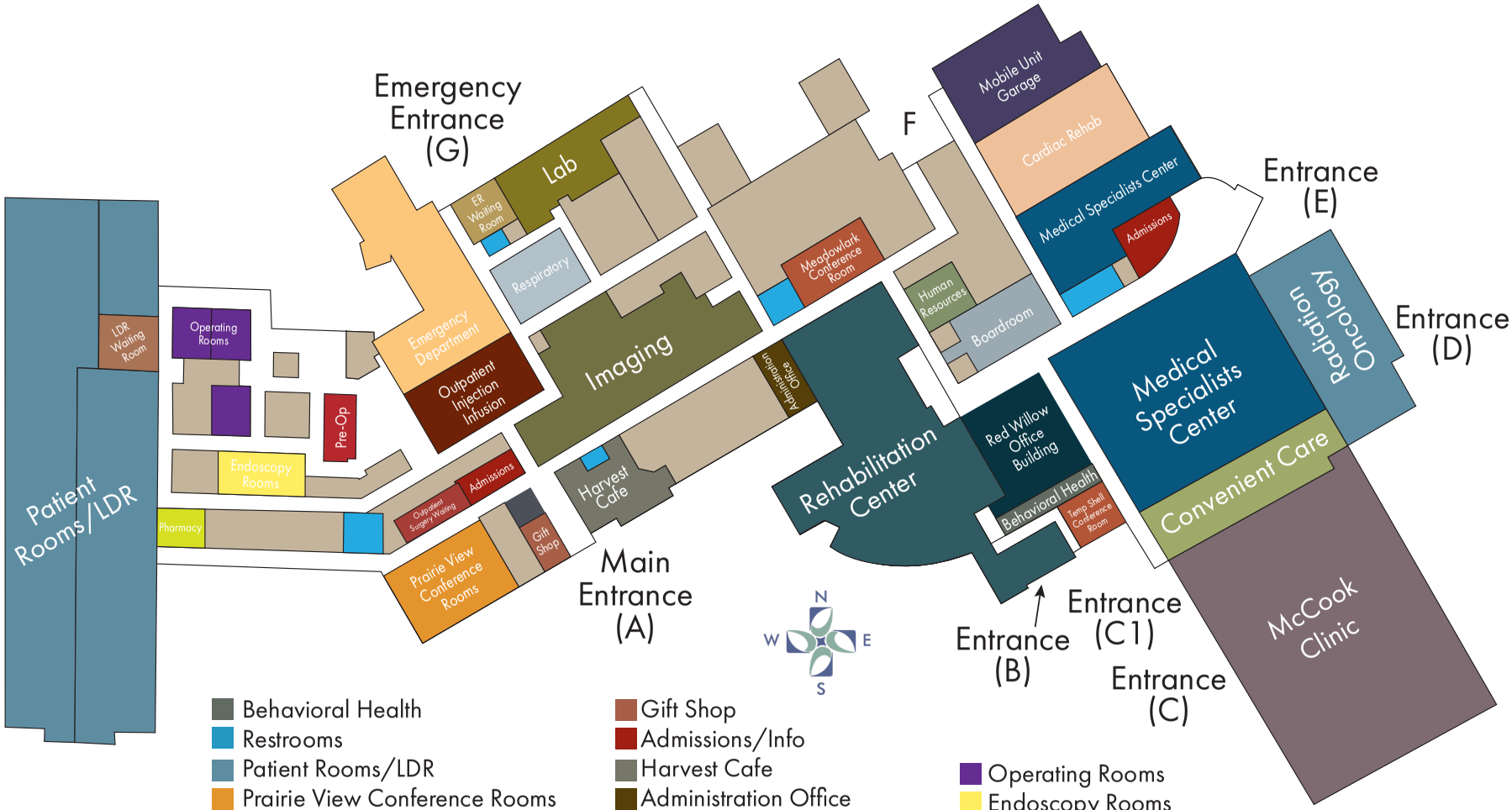

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Advanced care. Always there.

LETTER FROM DR. RICHARD LAWTON

Dear Patients,

I am sorry that your knee arthritis is so bad that you must consider knee replacement surgery. I am a patient myself of joint replacement and understand the pain that comes from arthritis. As your knee arthritis has worsened, you are robbed of your ability and interest in doing daily activities that you want and need to do.

When your arthritis was milder, things such as medication and braces were effective, but now as your arthritis is getting worse, those same treatments are less helpful.

My hope is this handbook will provide you and your family with information about knee replacement surgery and help everyone understand what to expect. I have learned from past patients that his sort of information can help reduce anxiety and uncertainty that they may experience at this phase.

There is a lot of information out there on the internet regarding knee replacement surgery or you may have heard some from friends and family that have undergone similar procedures. A lot of this information is accurate, but some of it may not be and it is difficult to know the difference. With this handbook my intent is to help you cut through the information out there and provide facts to help navigate you though your knee replacement.

Sincerely,

Lawton

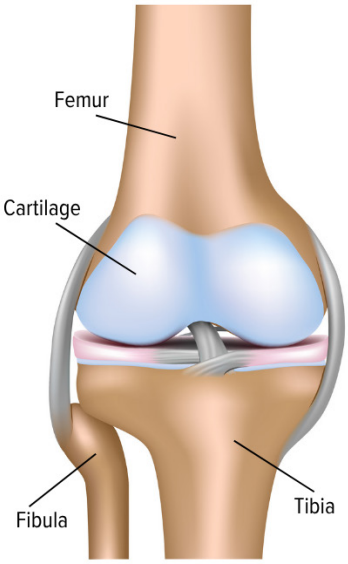
Richard Lawton, M.D.

Left to Right: Evan Dekok, AT-C, Denise McConville, RN, Kaitlyn Huxoll, PA-C, Richard Lawton, MD, Michelle Braget, PA-C, Twila Tyan, Medical Assistant, Becki Lampe, Clinic Manager

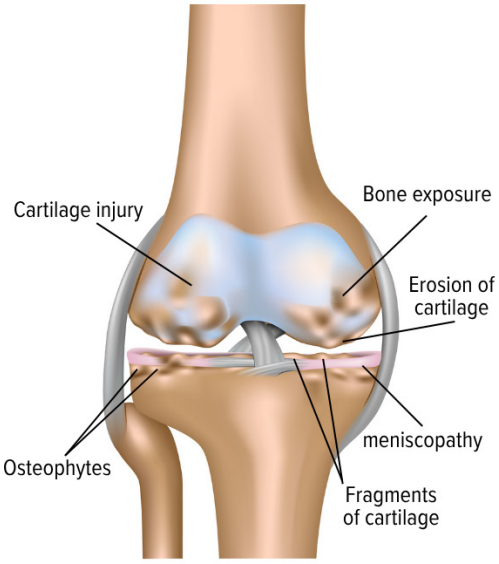
INTRODUCTION

What is a Knee Replacement?

Knee replacement surgery consists of resurfacing the arthritic bones in your knee and replacing them with metal (cobalt chrome) & plastic (polyethylene) implants. This process involves removing the arthritic surfaces, about a half inch of bone and cartilage from the end of the femur, top of the tibia and usually the underside of your kneecap. The size and thickness of the new implants are roughly the same as the removed bone and cartilage.



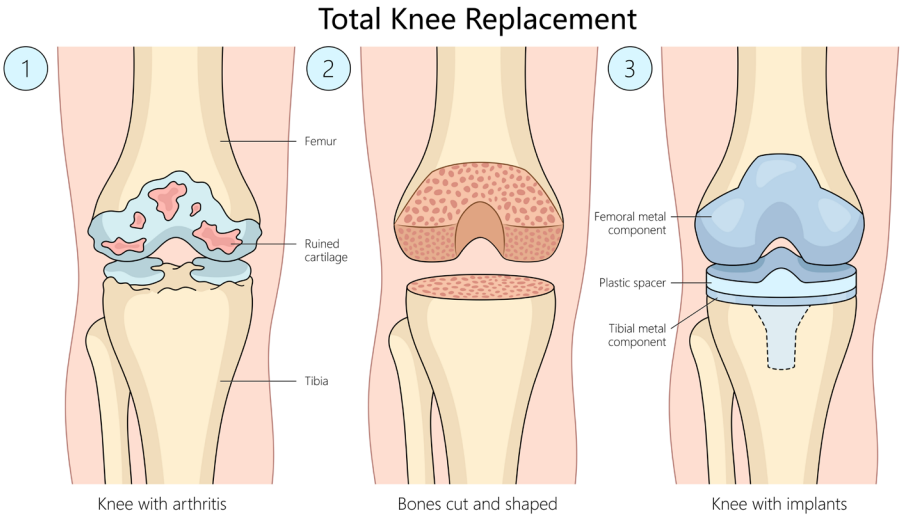
Healthy knee joint



Osteoarthritis

These new implants rub against each other and since they have no nerve endings and are lubricated with your own joint fluid, this allows your knee to glide smoothly and painlessly when walking.

The arthritic bone is gone, and so is the pain. That's the theory at least and works that way for the vast majority of patients choosing to have their knees replaced.



As you can see in the picture, a knee replacement does not require removal of huge chunks of bone or require use of long rods into the bone. Moreover, the bones of the femur and tibia that have been resurfaced are not linked together like a hinge, but rather held together by your own ligaments and other tissues that normally stabilize your knee.

Who Decides Whether I Get a Knee Replacement?

The only person who should be deciding if you undergo knee replacement surgery in YOU! It is up to you the patient, not your spouse, surgeon or other family members to decide whether the surgery is appropriate. Our job as the orthopedic team is to work with you to accurately diagnose our knee problem and lay out your treatment options. Most patients choose to put off knee replacement surgery as long as possible, using other treatments such as over the counter medications, supplements, corticosteroid injections, hyaluronic acid injections (chicken comb shots), bracing and physical therapy. Eventually, as your arthritis worsens, these treatments become less effective and

knee replacement surgery enters the conversation. In the end, the decision to undergo surgery is up to you, the patient. Your friends and family will be an excellent support system to have with you through this process.

Chances of a Good Outcome
About **85-92% of knee replacement patients are satisfied with the outcome of their knee replacement surgery** according to many research studies. Most patients can get back to light and moderate activities, including walking, working, skiing, hunting and bicycling with no pain and good strength. Patients who want to run, especially in cutting and pivoting sports, can be disappointed, noting the biomechanics of cutting and pivoting are so complex that most knee replacement part simply cannot reproduce that level of function compared to normal, un-arthritic knees.

30-50% of patients with knee replacements after recovering from surgery consider their knee to be normal, without any pain and function like a native knee.

30-40% consider their replaced knee to be nearly normal and good. The patients in this category are still glad they underwent surgery, but noted there was “something that is not quite normal” about their new knee. Among the most common abnormalities affecting replaced knees include stiffness in bending and difficulty going downstairs or steep hills. Patients in this group disliked how their replaced knee felt with kneeling. However, even with these limitations, patients in this group were still glad they had the surgery because the intense pre-operative pain is gone, and their function is better.

8-15% of knee replacement patients are not satisfied with their new knee. This number is higher than we would like and are working to lower it. Factors that can increase the risk of patient dissatisfaction include complications such as infection, pre-existing medical conditions, chronic narcotic use prior to surgery, patients with less severe arthritis before surgery, lower quality of life, and having unrealistic expectations of the results.

Knee replacement surgery is a very complex subject and the topic of extensive ongoing research in the Orthopedic community. Dr. Lawton and his team keep up to date with the latest information to provide the best options for you, the patient on treatments for your knee arthritis.

The bottom line is that, for the right patient, knee replacement surgery is the best chance of producing durable pain relief and improved function when compared to other options for patients with severe knee arthritis. Does it work for most patients with severe knee arthritis? Yes. Does it work satisfactorily for all? No. Please discuss with your surgeon about your chances of a good outcome.

How Long Does a Knee Replacement Last?
Most patients and their families want to know how long a knee replacement will last. There is good research on this topic, the best coming from the American Academy of Orthopedic Surgeons Joint Replacement Registry. Over 1300 facilities are enrolled in this registry and collect data on joint replacements. Large institutions including the Mayo Clinic and international organizations in Australia and the Scandinavian countries have been collecting data for decades on joint replacements. All this data collection yields high quality research material about issues such as how long a new joint replacement will last. Often data is then divided out even further into subcategories like manufacturer, model, patient characteristics, age and gender.

92% of knee replacements will last 20 years.

Patients that are younger and more active at the time of their knee replacement surgery will be more likely to require a revision at some point in their lifetime. Other factors that could increase the risk for revision surgery include significant pre-existing medical conditions such as heart disease, diabetes & obesity. Socioeconomic factors such as poverty and ethnicity can also contribute to having revision surgery.

How Will I Know if I Need to Have Revision Surgery?
Patients with knee replacements may need revision surgery due to the following:

- The plastic parts of your knee replacement wear out
- Infection of the knee
- Loosening of the implants from the bone

Less likely events that could contribute to revision surgery are excessive stiffness, fracture of the bone, or instability of the joint.

With the average age of knee replacements being 65 years or older, most patients will NOT have to have a revision surgery in their lifetime.

Information about the Prevelance of Knee Replacement Surgery
Knee replacement surgery is becoming more common. Every year in the U.S. about 700,000 knee replacements are done. This trend continues to increase from 10 years ago.

It expected that this number will continue to grow to approximately 2,000,000 per year by 2030. Reasons for this growth are mostly tied to the aging demographic population of the U.S. The number of people entering their 60's and 70's is growing which is the time in life arthritis is most likely to occur.

YOUR SURGERY TEAM

The Community Hospital Surgery Team

Dr. Richard Lawton, MD

Providing medical care is a team sport, requiring communication and dividing the work for one patient among different people. This is especially true for surgery such as knee replacement. The nature of surgical work requires many people with different types of training, each of whom contributes necessary parts of the workload. Every team, whether in athletics or in an organization, has individuals with special skills or training, all of whom are necessary for that team, noting that no single individual can do the job of the entire team. It takes a village to provide all the care around knee replacement surgery.

Surgeon

Your orthopedic surgeon will discuss options to treat your knee arthritis. If you choose to proceed with surgery, you will see the surgeon again on the day of surgery before you head back to the operating room. In the operating room the surgeon will be the one removing the arthritic bone and resurfacing to allow for new implants to be placed. The surgeon oversees the entire process and directs other members of the surgical team on use of instrumentation. At your 3-week follow-up appointment your surgeon will also make a short visit with you along with our orthopedic physician assistants.

Kaitlyn Huxoll, PA-C and Michelle Braget, PA-C

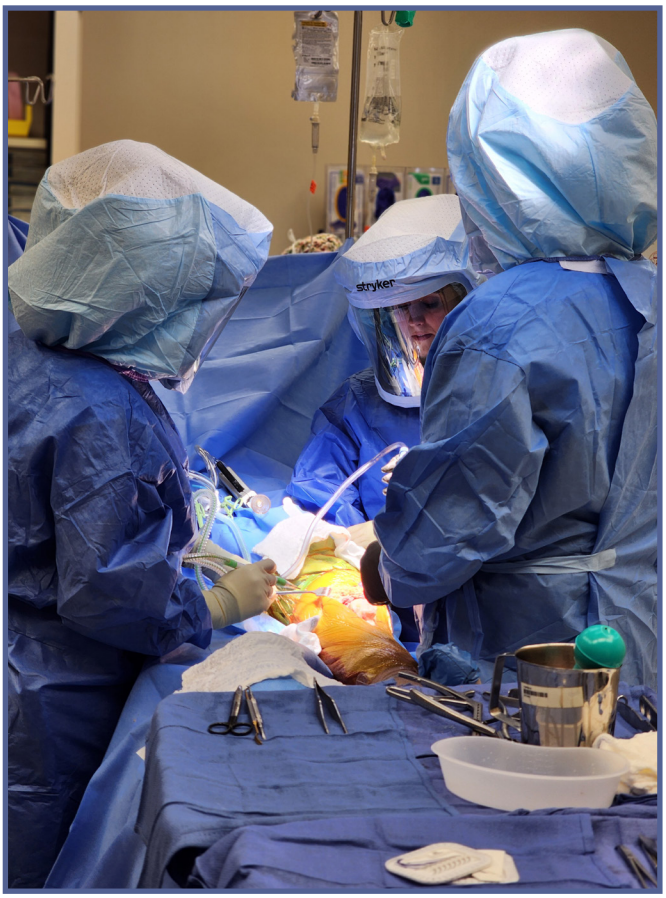
Physician's Assistant
Community Hospital has two orthopedic physician assistants or "PA's" that assist Dr. Lawton in surgery and the clinic. They play an active role in your care and function as an extension of the surgeon. While in the operating room they retract tissue, help with instrumentation, and sew up your incision. If you spend the night in the hospital after surgery, you will see the PA's the morning after to discuss discharge instructions. You will then make all your follow-up appointments with them in the weeks and months to come after surgery. Our orthopedic PAs are very knowledgeable regarding your orthopedic care and will take excellent care of you!

Surgery Education Nurse
This nurse will meet with you and a family member several weeks prior to your surgery. During this meeting she will discuss admission time on the day of surgery, when to stop certain medications, review wound care and answer any other questions you may have.

Pre-operative Nurse
Upon admission on the day of your surgery you will be assigned a pre-op nurse. This nurse will help get you ready for surgery including changing into appropriate attire, taking your vital signs, reviewing medical history, starting an I.V., giving you antibiotics, and scrubbing your leg with antibacterial soap. The pre-op nurse will help your family members to the waiting room once you are taken back to the operating room.

Evan Geilenkirchen, CRNA and Tina Daughtry, CRNA

Certified Registered Nurse Anesthetist (CRNA)
The CRNAs are the advanced practice providers that will be administering the medication to you in surgery to put you to sleep. They will also be the ones performing your spinal block after you arrive in the operating room. Dr. Lawton's preference for anesthesia for total knee replacements is a spinal block rather than general anesthesia. The advantages include better pain control and avoiding general anesthesia side effects such as nausea. Your CRNA will discuss the risks and benefits of both in the pre-op area upon admission. About 96% of our knee replacement patients choose a spinal block for surgery. During the surgery, the CRNA is responsible for monitoring your vital signs and breathing. They communicate with the other members of the surgical team throughout the entirety of your surgery. They will also accompany you to the recovery room.



Operating room view with the surgery team at work.

Circulating Nurse
This nurse will be responsible for the care of you, the patient, and the entire surgical team in the operating room. The circulating nurse will retrieve you from your pre-op room and roll you back to the operating room on a gurney. During the surgery, your circulating nurse will be responsible for charting, retrieving supplies for the surgical team and assisting with anesthesia if needed. The circulating nurse will also communicate with staff outside the operating room updating on how the procedure is going to relay on to your family. Once the surgery is over the circulating nurse will accompany you to the recovery room and hand off your care to the recovery room nurse.

Certified Surgical Scrub Technician
The "scrub tech" is the team member in the operating room that sets up all the instrumentation, prepares all the sterile supplies and ensures the surgeon has everything they need to complete your knee replacement. The scrub tech often communicates with the implant representative's weeks in advance to ensure the surgical plan is accurate and that all implants needed are available.

Second Assistant (nurse or scrub tech)
Total knee replacement requires additional assistance for the surgeon to be able to visualize the patient's anatomy and perform the surgery safely. A second assistant will be present and stand next to the surgeon during your surgery to help retract tissues and position your leg appropriately.

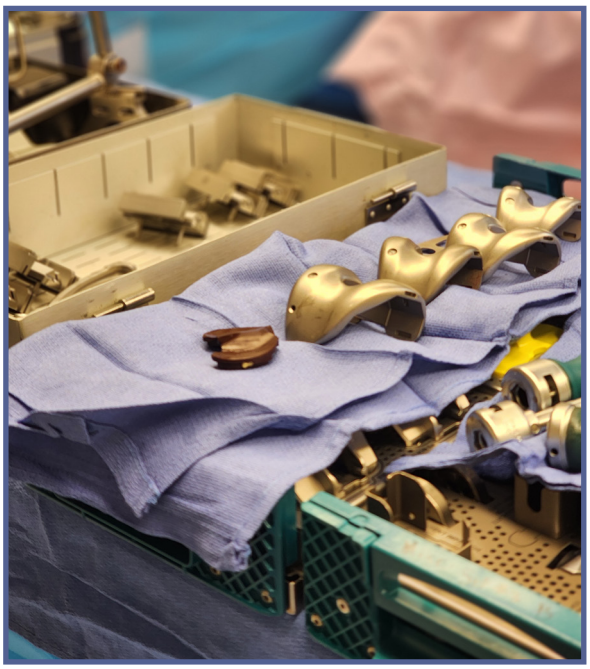
Recovery Room Nurse (Post Anesthesia Care Unit "PACU")
The recovery room nurse will be taking care of you after the surgery is complete. You will be taken to the recovery room via gurney and spend one hour or more there slowly waking up. The recovery room nurse will monitor your vital signs, administer pain medication through your I.V. line and report any complications to your surgeon and CRNA. The recovery room nurse will transport you to your room in the hospital or prepare you to go home if you are stable.

Radiology Technician
These team members will perform an x-ray of your new knee in the recovery room to ensure the implants are in the proper position. You will also encounter our radiology tech's in the clinic area at your follow-up appointments.

SURGERY SPECIFICS

Knee replacement surgery typically takes 1 to 2 hours to complete. During the procedure, the surgeon makes an incision that usually ranges from 4 to 6 inches, although the exact length may vary depending on the individual patient's anatomy and surgical needs.

Most modern knee implants are cemented into place, providing immediate fixation. However, emerging research supports the use of cementless implants, which rely on the patient's bone to grow into the implant for long-term stability. This technique may offer benefits in certain cases, although it is not yet the standard approach.

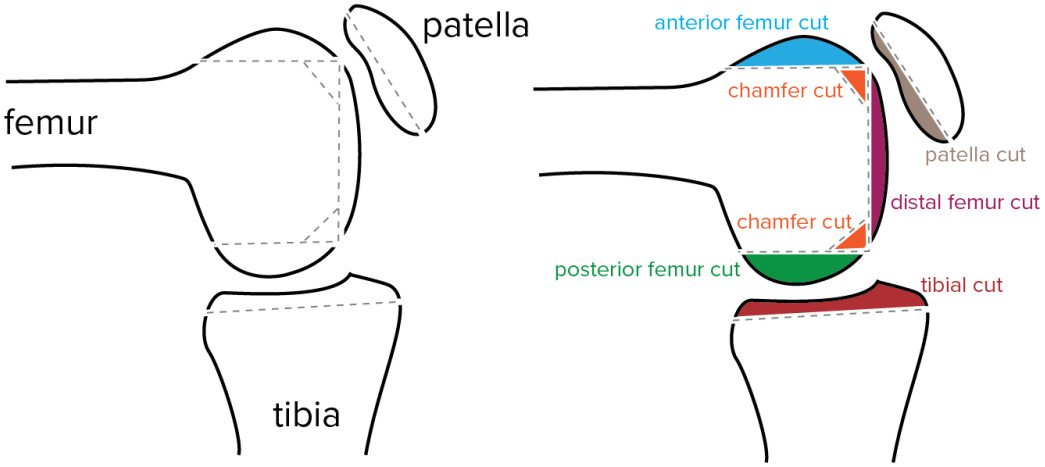


The photo above shows typical parts used in knee replacement.

In the United States, the majority of knee implants are manufactured by four leading companies: Stryker, Zimmer Biomet, DePuy Synthes, and Smith & Nephew. Surgeons typically select implants from manufacturers they are familiar with—those they have used successfully in the past and that are supported by strong clinical research. It's important to note that community hospitals and surgeons do not have financial relationships with these manufacturers, ensuring that implant selection is based solely on clinical considerations and not influenced by commercial interests.

Knee implants come in a variety of sizes to accommodate different body types. The appropriate size for each patient is determined in the operating room using specialized measurement guides. While custom-sized implants are available, current evidence suggests that they do not lead to significantly better outcomes compared to standard, off-the-shelf implants. Additionally, custom implants tend to be more expensive, which may not be justified by the clinical results.

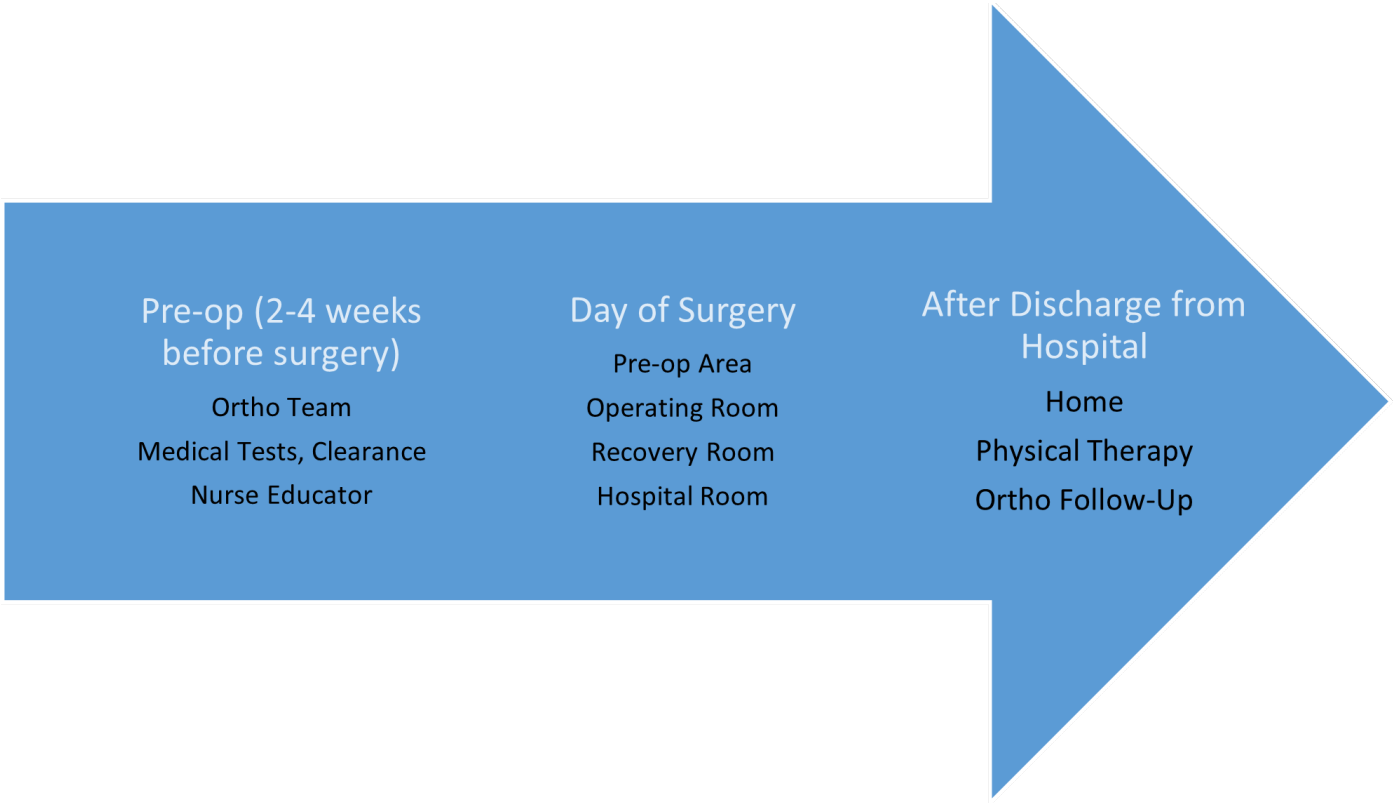
Overview of Cuts for a Total Knee Replacement



Left photo: Typical bone removal in knee replacement surgery. These are views from the side illustrating removal of bone and arthritic cartilage from the end of the femur, top of the tibia, and underside of the kneecap.
Right photo: The parts of a knee replacement, including the new surfaces capping the femur, top of the tibia, and underside of the kneecap.

SURGERY: BEFORE, DURING, AFTER

In this section, we will walk you through the typical timeline of the surgery process, so you have a better idea of what to expect. We will divide the process up into different parts, from start to finish, noting the steps we describe are typical or average, and things may vary a bit from one person to another. Please feel free to ask questions along the way.



Before Surgery

Before the surgery, your process begins with getting the right diagnosis, which often starts with the primary provider, such as a family doctor, nurse practitioner, or PA. Patients may first bring up their knee pain to their family medicine team, while other patients may mention it first to an orthopedic provider. Either way, these providers usually obtain x-rays and begin some sort of non-surgical treatment, such as medicine, physical therapy, injections, or stretching. However, as discussed above, when knee arthritis gets bad, nonsurgical treatments tend to be less effective and therefore surgery enters the discussion. The fact that you are reading this document indicates you have met with the orthopedic surgery team and are considering knee replacement surgery.

Once you decide to undergo knee replacement surgery, several steps transpire, and among the first of these is discussing surgery with the orthopedic surgeon, who usually reviews with you the specifics of your case and treatment options, including the chances of a good outcome from surgery, nature of the surgery, possibility of complications, and nature and duration of recovery. It is their goal to inform you and answer your questions. They know surgery is scary and want to reassure you. Once you make it clear that you would like to go ahead with surgery, you select the date you would like, sign some forms, and set off with a few other pre-op steps.

Medical Clearance

One of the next steps prior to surgery is obtaining medical “clearance” for surgery. The team wants to make sure they can perform the surgery as safely as possible, and thus want to thoroughly understand any known or potential medical conditions that could put you at risk for surgical

complications. Some conditions need to be “tuned-up” or optimized prior to surgery; for example, diabetes or heart conditions may require special changes to treatment prior to surgery. This process requires an appointment with a family medicine provider, who will review your medical history, blood tests, EKG, and chest x-ray to make sure everything is okay for surgery. For patients with serious medical problems, such as those under the care of a cardiologist for heart problems, or a pulmonologist for lung problems, additional appointments with these specialists may also be required in addition to the family medicine appointment. We are aware that these appointments are a hassle, as are the tests that may accompany them, and cost you time and money. We are patients ourselves, and these details are not lost on us. However, medical teams have learned what should be done before surgery, and recommendations for pre-op medical clearance are well-established. Official medical societies have carefully designed guidelines for pre-op evaluation and testing, using research and data to arrive at the plan you are going through. While we apologize for the inconvenience and cost associated with this step, the bottom line is that it’s necessary and in your best interest.

Rarely, something turns up in the pre-op medical clearance process that leads to postponement of surgery, sometimes identifying conditions that have to be more fully evaluated or treated prior to surgery in order to minimize risk and increase the chances of a good surgical outcome. It is unlikely but possible this could happen to you. Conditions that could lead to postponement can include a heart murmur or abnormally high blood sugar. The good news is that once these issues are corrected, surgery can usually proceed.

A small subgroup of patients may be medically cleared for surgery but may have medical problems requiring a higher level of care than can be provided here. Community Hospital is an excellent medical facility, with a great team of dedicated providers, however, it does not have all the resources that are available at some bigger centers. For example, Community Hospital does not have an Intensive Care Unit which is significant because if a potential knee replacement patient has medical conditions that are likely to require ICU care after surgery, then that patient would not be able to have surgery at Community Hospital and would require referral to a larger center. There are a few other similar circumstances for which this is true, but overall, we estimate this group constitutes about two to three percent of all hip replacement candidates, so chances are, that is NOT you.

Even more rare is the decision to avoid surgery altogether. The reality is that some patients are simply too medically frail to undergo surgery, the risks of the surgery are too great for them, and they should simply not have the surgery anywhere. This is rare, perhaps applying to one percent of patients with bad knee arthritis.

Pre-Op Education

Prior to surgery, you will be scheduled to meet with our pre-operative educator. Their job is to let you know what to expect, and review with you important details of your care before and after surgery to make sure you are well prepared. They will advise you of specific parts of care that you may not have considered, such as the layout of your home, and availability of family members and friends to assist in your recovery. Your care is far from over when you leave the hospital, and the patient educator informs you of what you may need to ease your transition and optimize your chances of a good outcome.

Amanda Dixon, RN

Day of Surgery
If you are feeling anxious today that is expected and completely normal!

Community Hospital Surgical Registered Nurses and Certified Registered Nurse Anesthetists (CRNAs)

You will be asked to arrive one and a half to two hours prior to your surgery start time. After checking in at the front desk registration area you will be ushered back to the Surgical department by one of our pre-op surgical nurses and taken to your own private pre-op room. There you will be asked to change into surgical attire, an I.V. will be started in your arm, your leg will be scrubbed with antibacterial soap and your pre-op nurse will review your medical history. One to two family members or friends are allowed to sit with you until you are taken back to the operating room. They will then be asked to wait in our surgery waiting room at the front of the hospital while you are having your procedure done.

Kaitlyn Huxoll, PA-C, Richard Lawton, MD, and Michelle Braget, PA-C

An anesthesia provider will stop by and visit with you about your anesthesia preference and answer any questions you may have. Your surgeon and their P.A's will also stop by to visit with you about any last minute questions you may have regarding the procedure itself and go over wound care and pain control expectations post operatively. The surgeon will place their initials on the correct leg with a marker. This is a safety protocol intended to avoid doing the wrong site surgery, which has never happened here at Community Hospital.

After Surgery, or "Post-Op"
Once the surgery is over, you are wheeled on a gurney into the Post-Anesthesia Care Unit, or PACU. The PACU features specially trained nurses who only take care of patients immediately out of the OR. You will be received by the PACU nurse, who will review details of the surgery with the anesthetist and OR nurse, and then that PACU nurse will take over your care. The PACU nurse will monitor your vital signs, pain control, and treat any other conditions that may arise, such as nausea. The PACU nurse has experience and instructions for dealing with the issues you will encounter together in the PACU and will call the anesthetist or surgeon if there are any questions about things.

Same-Day vs. Overnight Discharge: Do I stay, or do I go?
Advances in anesthesia, pain prevention, and surgical technique have gotten to the point where now about 10 to 20 percent of knee replacement patients can be discharged six to eight hours

Picture of a standard pre-op room. It is here that you will meet your pre-op nurse, who will help you change clothing, start an I.V., and review your records. The anesthetist typically meets you here as well.

after surgery and do not have to spend a night in the hospital. Patients discharged home are called, “outpatients”, or “same-day outpatients”. The other 80 to 90 percent of patients will spend one night in the hospital. Determining whether you are a good candidate for outpatient status is something we consider carefully before the surgery, and you will be made aware of that status prior to surgery, though patients considered good candidates are relatively healthy and strong, with good help at home from family and friends, and a safe environment to ease the transition. If you do indeed choose to have your knee replacement done as an outpatient, you will recover back in the pre-op/post-op area, where a recovery nurse and physical therapist will work with you and monitor you prior to discharge, making sure you can walk safely, do steps and meet general discharge criteria. If you originally requested to be a same-day outpatient knee replacement patient, and things are not going well for you in the recovery room, we can together decide to change course and keep you overnight to make sure you receive the appropriate care.

If you are planning on spending a night in the hospital after your surgery, after about one to two hours in the recovery room, you will be wheeled to your private room on the inpatient medical-surgical wing of the hospital.

At that point, your care is transitioned to your nurse, often referred to as the “Floor Nurse”, who will look after your care from that point until you are discharged from the hospital. The floor nurse will do initial checks and make sure you are doing well with respect to pain control, vital signs, and other factors. The floor nurse will have a list of instructions about your care there, including things like pain medication, blood clot prevention, medicines you were taking at home before surgery, etc. They will call your doctor and/or PA if they have questions or concerns about something.

Shortly after your arrival in your room, you will be able to visit with friends and family members. You will likely be visited by a physical therapist, an occupational therapist, a respiratory therapist, the hospitalist (a physician working with the orthopedic team on the medical side of your care), discharge planner, and the orthopedic team as well. It can seem like an endless string of visitors, but each person visiting you plays an important role in your care.

During your stay in the hospital, you will be encouraged to communicate with your nurse and

medical team about your needs. If you are experiencing pain, it's best to let the nurse know so they can get you pain medicine. The same goes for other symptoms such as nausea, or concerns about the temperature of the room, difficulty sleeping, hunger, etc. We are here to help you be as comfortable as possible and want to hear from you if there is something you need.

Pain Control While in the Hospital after Surgery
Pain control after surgery can be a challenge because you have just undergone a significant operation in which tissues are incised and parts of bone have been removed, all of which can cause pain. The good news is that usually pain control is judged to be good or excellent by most patients in the end. Your team employs multiple tools to help decrease pain after surgery, including the nerve blocks administered by the anesthesia team, IV and oral medicines of different types, all working together to keep you as comfortable as possible. In general, we use:

- Tylenol
- Anti-inflammatory (NSAID)
- Ice
- Narcotics
- Nerve blocks

Our goal is to keep you as comfortable as possible, noting that it is impossible to get rid of all your pain entirely. Close communication between the patient, nurses, PAs and doctors is important to do as good a job as possible for each individual, noting each person experiences pain a bit differently, and responds to different medications variably as well.

Eating and Drinking after Surgery
This is pretty straightforward. Typically, the nurses will start you out on liquids, and once your stomach proves it can handle more, your diet gets ramped up to normal food and drink pretty quickly thereafter. Patients with special dietary needs, such as diabetics or gluten-free, are accommodated with special foods fitting their needs.

Sleeping
Sleeping in the hospital is tough. You are in a strange place in a strange bed, it can be noisy, and you can have symptoms such as pain that can interfere with sleep. Typically, the nurse has at their disposal medications that can help you sleep. If you'd like to try one of those, please let the nursing staff know and they will provide it. We certainly understand the importance of sleep and will do what we can to help you.

Duration of Stay
As mentioned above, some patients are able to go home from the hospital on the same day as their surgery. However, most patients stay in the hospital one night after surgery, much less than the three-night stay that was typical for knee replacement patients as recently as five years ago. Currently, after one night, patients are ready for discharge home because they are stable medically, have achieved good pain control with pills, and have been able to walk short distances with aids such as crutches or a walker. It's rare for patients to need to stay longer than one night. Some patients want to stay longer than one night, even if they have met discharge criteria, but the honest truth is that once the patient can get around a bit, they are safer at home and less likely to experience complications. Once home, they can sleep in their own bed, eat their own food, and be in more familiar, quieter surroundings.

Discharge from Hospital
The discharge process puts a premium on good preparation for discharge, which typically takes place prior to surgery. Between the orthopedic team and the pre-operative educator, the challenges

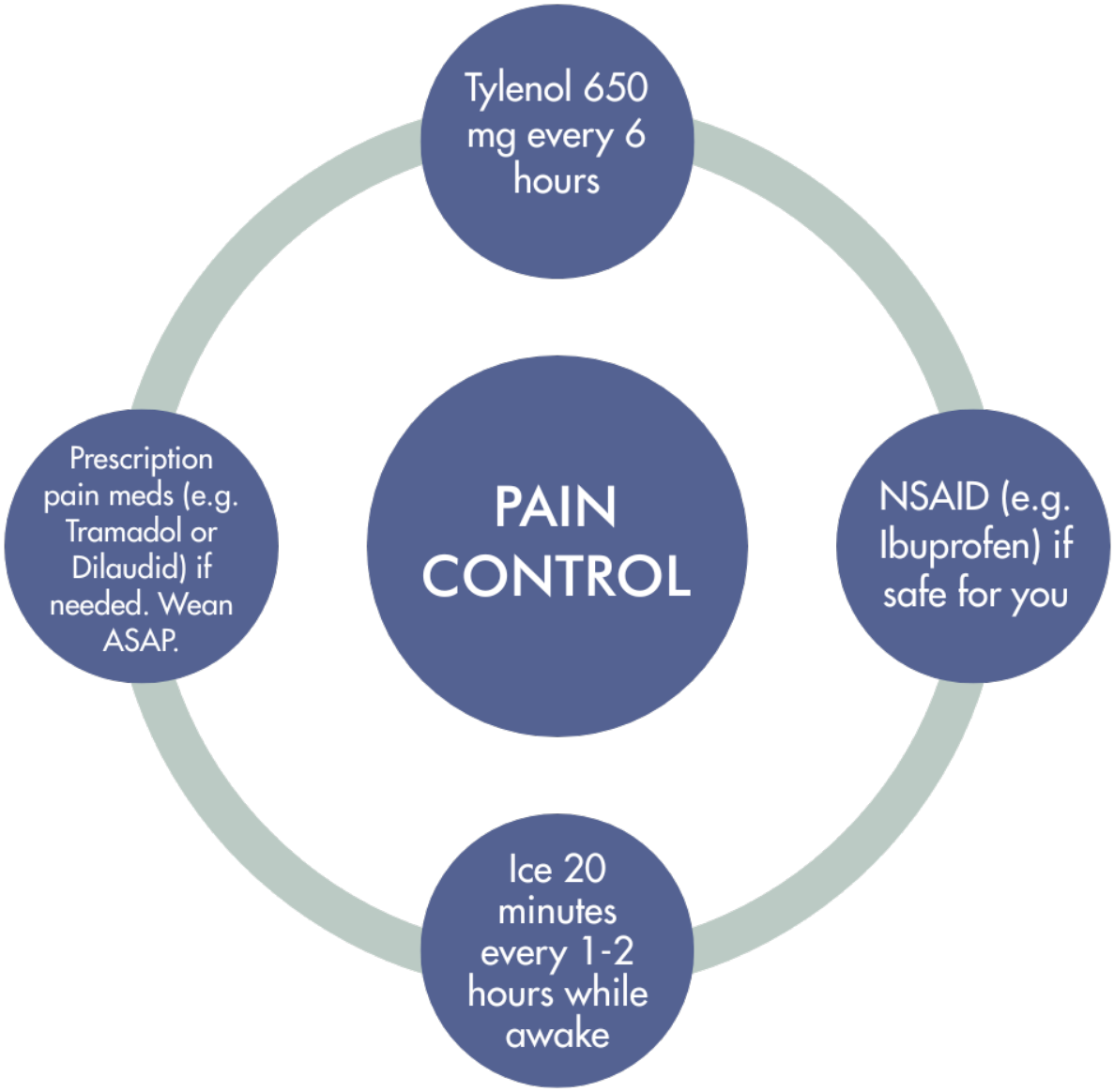
of discharge have been addressed prior to surgery, appropriate equipment has been obtained, and help summoned from family members and friends.

Discharge can be a stressful time because patients and family members worry that they will not have the necessary support they need to recover safely. Usually the preparation pays off, and the transition home goes smoothly. The medical staff provides you with all the instructions, prescriptions, and other needed material they can provide to ease your transition.

Recovery and Rehabilitation after Discharge
After leaving the hospital, you enter the rehabilitation and recovery phase of your knee replacement. This is the longest phase, and it usually goes well, and consists of several parts. Your orthopedic team and other providers (nursing, physical therapy, medical team) will review the important parts of discharge prior to you leaving the facility. Important instructions will be provided to you in written form.

MEDICATIONS

Surgery hurts. Incisions are made, tissues removed, and new parts are inserted, all of which occurs on and around tissues that have pain fibers, so it is understandable that pain results. Our goal after surgery is to decrease the amount of pain you experience, noting most patients never achieve complete relief of surgical pain, especially for the first several days.



Multimodal pain control: We use as much non-narcotics as possible, adjusting the treatment to what's best for each individual.

Sleeping Aide at Home
We recommend taking over the counter Melatonin as directed on the bottle if you are having difficulty sleeping after your surgery.

Blood Clot Prevention/Blood Thinners
With knee replacement surgery, there is a low chance of blood clot formation. Thankfully, there are ways to lower this risk, including use of blood thinning medication for several weeks after surgery. In addition, while you are in the hospital, staff will likely place on your feet and legs, sequential compression devices (SCDs). These inflatable sleeves wrap around the legs and are connected to

a pump that inflates and deflates them to mimic natural muscle contractions—an action shown to reduce the risk of blood clot formation.

Blood thinning medication most typically used after knee replacement surgery is aspirin, which can be purchased over the counter without a prescription. The typical recommendation is either regular strength (325 mg), or “baby” aspirin (81 mg) twice a day for three to six weeks after surgery, noting the recommendation for which dosage and duration varies from one doctor to the next. When discharged from the hospital, the dosage and duration of aspirin use will be clarified for you. **It is important to take this as prescribed for the entire 4 week period.**

If you have a history of blood clots prior to your knee replacement surgery, it is likely that a different blood thinning medication will be prescribed, such as Coumadin or Eliquis, for example. If you have a history of blood clots prior to your knee replacement, your orthopedic surgery and medical doctors will review the specific recommendations for these blood thinners prior to your discharge.

Constipation
You will likely experience some constipation after knee replacement surgery. There are several reasons for this occurrence:

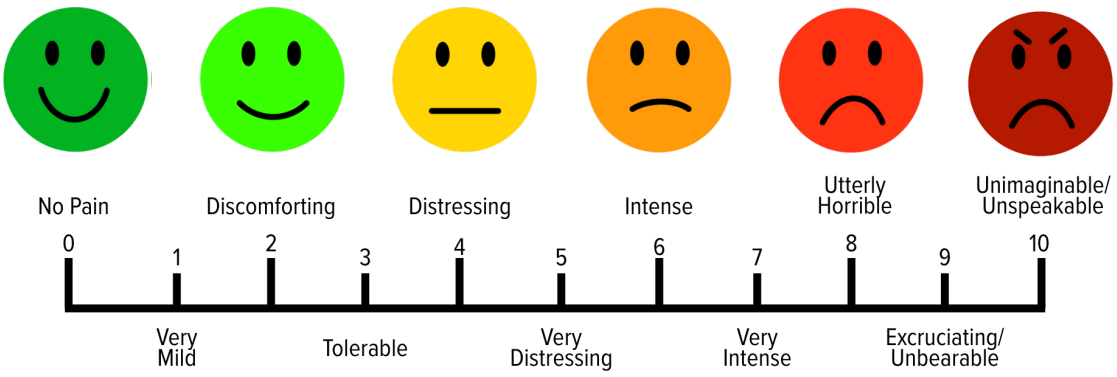
- Anesthetics
- Decreased activity
- Pain medication side effects
- Diet Alterations

The most relevant remedy is time alone. It will take three to five days before things get moving more normally, even if everything else is done perfectly. Things you can do to decrease the chance of prolonged constipation include:

- Activity
- Tapering off your narcotic pain medications as soon as possible
- Stool softners (over the counter)
- High fiber foods:
    - » Bran or whole grain cereals
    - » Vegetables such as broccoli, peas, and brussel sprouts
    - » Nuts and seeds
    - » Fruits such as bananas, apples, and berries
- Increase fluid (water) intake

It’s a good idea to get started on these methods as soon as possible and taper away from them as gut function normalizes.

How Do You Rate Your Pain?



☐ Ice:

- Apply ice bag to the area of surgery for 20 minutes every hour.
- The cold pack should be on top of your gauze/surgical dressing, and not be in direct contact with the skin.
- Some patients have access to cooling cuffs, which is a thermos of ice-cold water connected to a pad placed over the surgical site, permitting circulation of cold water. These are OK to use as well.

☐ Tylenol (acetaminophen)

- Tylenol comes in different dosages over the counter. You may take **ONE** of the following:

  Regular Strength (325 mg each): Take 3 tabs at a time every 6 to 8 hours

  Extra Strength (500 mg each): Take 2 tabs at a time every 6 to 8 hours

  Arthritis Strength (650 mg each): Take 1 tablet at a time every 6 to 8 hours

☐ Ibuprofen (Advil or Motrin) & Naproxyn (Aleve) are NSAIDs (non-steroid anti-inflammatory drugs)

- If able, take ONE of the above listed NSAIDS. Do not take ibuprofen AND Aleve, just one or the other.
- Some health conditions prevent you from taking NSAIDs, please check with your family physician if you are unsure.
- Ibuprofen can be taken 4 times per day.
- Naproxyn lasts longer and should only be taken 2 times per day.
- Patients that are already taking prescription anti-inflammatories such as Celebrex or Meloxicam should not take additional ibuprofen or Naproxyn. (These medications are all NSAIDS. Just take one of these meds.)
- If you are taking blood thinning medication, check with your primary care provider before taking any anti-inflammatories.If you experience stomach pain, excessive bleeding or have blood in your urine or stool, discontinue the anti-inflammatory immediately and contact your primary care provider.

☐ Narcotic Pain Medications

- Narcotic pain medications are an important, often necessary part of pain relief after knee replacement surgery.
- The most common narcotic pain medications we prescribe after surgery are Dilaudid (hydromorphone), Oxycodone, or Tramadol.
- We recommend taking only if you do not get relief from using the ice, Tylenol and NSAIDs first.
- Taper off the narcotic medications first while continuing to take the Tylenol and NSAIDs on a scheduled basis.
- Narcotic medications have side effects such as constipation, nausea and mental fogginess.
- It is extremely rare for knee replacement patients to become addicted to narcotic medications if they have no history of prior addiction.

AFTER DISCHARGE FROM HOSPITAL

After leaving the hospital, you have gotten over hurdles in your knee replacement course of care, namely the surgery and hospitalization. While it is nice to have these things behind you, your recovery is really just starting, and there are events and challenges ahead.

Skilled Nursing Facilities
Rarely, there will be a knee replacement patient who needs to go to a Skilled Nursing Facility (SNF) immediately after post-op hospitalization at Community Hospital. Ten to fifteen years ago, it was not unusual for knee replacement patients to spend three nights in the hospital, and then go to a skilled nurse facility or "swing bed" as part of the recovery. Often this care was paid for by insurance, including Medicare. Recent changes from Medicare and other insurance companies have occurred such that extended stays in the hospital or at a skilled nursing facility or rehabilitation center are no longer paid for by those insurances. That means the practice that existed ten or more years ago of sending patients to a rehabilitation facility has now gone away almost completely. The good news is that we have learned that most patients do extremely well if they are discharged directly home from the hospital, and that skilled nursing facilities and rehabilitation centers are not as necessary as we use to consider them. This trend has shifted the care to the patient to friends and family. In the end, patients who go directly home from the hospital seem to do at least as well if not better as those treated post-operatively at rehab centers.

For your safety, we require a family member or friend to be with you full-time for 48 hours after your discharge.

Wound Care
Surgery requires an incision, and at the end of surgery, that incision is "closed" using some combination of suture, staples, and/or glue. Regardless of which material is used for closure, it will take the knee incision two to three weeks to completely heal, and during that time, the incision should be looked after.

Different doctors recommend different methods for caring for the incision while it heals, but the goal for all is to prevent infection. You will receive instructions from your surgeon about your wound care, and you should follow them carefully. Be aware that those instructions may be different from what other doctors have recommended for you in the past. Refer to these printed instructions to make sure that you are doing things appropriately. If you did not receive printed wound care instructions at the time of your discharge, have lost them, or have questions, please contact your orthopedic surgery team.

You should be hearing the same instructions for wound care from others involved in your care, including nurses, therapists, and office staff. Everyone should be consistent in their message about your wound care. If you are not hearing a consistent message, for example a nurse or therapist is advising different wound care than the surgeon, please speak up and ask your surgeon for clarification. We want to eliminate any confusion, and provide you with a consistent message, especially for something this important.

Physical Therapy after Discharge

A physical therapist will visit you while you are in the hospital to make sure you can walk safely, coaching you through the use of gait aids such as a walker or crutches. Following discharge from the hospital, visiting a physical therapist in their office or in your home has become a bit more controversial. Most recent studies show that knee replacement patients do not necessarily benefit from supervised physical therapy following their knee replacement surgery. That is, in general, patients that undergo physical therapy following their knee replacement seem to do no better than patients who do not visit with a physical therapist as an outpatient. That is a general rule. Naturally there are exceptions, and certain patients we think are well served by visiting with the physical therapist one to two times per week for one to two months following their knee replacement to make sure they can walk safely and transition from the use of gait aids such as walkers and canes to walking without them. If you are interested in working with a physical therapist after discharge from the hospital, please discuss this with your orthopedic surgery team. From our perspective, your best therapy following knee replacement surgery is walking a bit further every day, using gait aids if you need them, and tapering away from them as your safety permits.

Community Hospital Rehabilitation Center's Physical Therapy Team

Stairs

Patients and family worry about stairs after knee replacement surgery. Will I be able to go up the stairs to get into my house? Will I be able to get to the bathroom or bedroom? The good news is that the short answer is "yes". Most people are able to go up and down stairs within one to three days after surgery. You may have to go one stair at a time for a few weeks before resuming doing stairs more normally. Right after surgery, your physical therapist will show you how to go up and down stairs, including leading with your non-operative leg first, then bringing your surgical leg up to that same stair, and repeating for the next stair.

UP with the good;

DOWN with the bad.

Descending stairs is similar, though a bit different. Descending stairs requires you to lead with your surgical leg, using your non-operative leg to lower your body weight down to the lower step. Once the foot of the surgical leg is on the lower step, the non-operative leg is brought down to it.

Most people get the hang of it pretty quickly, but it does take some coaching and coordination, and practice to do safely. Medically frail and physically weak patients may not be able to take the stairs as early and thus may need help getting in and out of their homes or live on one floor of their home for one to two weeks until they are able to do stairs safely. This may require anticipation and

planning before surgery for such patients, including potentially re-arranging furniture, or setting up sleeping arrangements on a main floor until the patient regains the ability to do stairs safely post-op.

Walkers, Crutches, and Canes

After knee replacement surgery, you will need to use a gait aid, such as a walker, crutches, cane, or walking stick. The typical duration these devices are needed is one to three weeks, noting some patients are able to wean their use more quickly than others. Typically, patients start out using a walker, because it is the most stable of the gait aids, then advance to the use of a cane or walking stick as they feel more able. Walkers can be a bit bulky and hard to maneuver inside narrow hallways and doors, so a crutch or cane can be more user-friendly. Your physical therapist or orthopedic provider can advise you about how to transition from one device to the next, and eventually discontinue their use altogether.

You can stop using gait aids when you can get around safely without them, which usually means, early in your recovery. You will likely stop using them for short distances, but still need them for longer distances and uneven ground. For example, it's not unusual for patients a week out from surgery to not use any gait aids inside the house but will often lean on furniture or walls as they walk past. At the same time, they will use a gait aid when they leave the house. Eventually, you will feel comfortable completely discontinuing the use of gait aids.

Driving

Do not drive until your surgeon or physician assistant says it is okay. From our perspective, you have to be able to operate your vehicle safely, which requires you to:

- Not be under the influence of narcotics or similar medicine while behind the wheel
- Be able to move your right foot quickly from the gas to the brake pedal, and slam on the brakes if needed.

It's that simple. Some patients meet these criteria within a few days of surgery, especially for driving short distances around town. Other patients take longer to meet these criteria. It can take a little longer for patients undergoing right compared to left knee replacement because the right leg is used more in driving than the left. Another assumption is that the patient is driving an automatic transmission, noting a clutch operated by the left leg can add complexity and time before it can be operated safely by someone undergoing left knee replacement.

We think it's best to practice driving first by simply sitting in the car without it running, and practice moving your feet from the pedals and slamming on the brakes as a trial. This may give you a sense

of how ready you are and can be done in the presence of a trusted spouse or friend to make sure you are not kidding yourself. Once you pass that test, it may be worthwhile practicing driving yourself on a nice quiet road or large empty parking lot, with a trusty assistant in the passenger seat. We always include in our recommendations the option of having your driving assessed by a DMV tester to verify your ability.

Exceptions can include driving long distances or having to climb up into the cab of large trucks or machinery, which is more demanding than driving a standard car or light truck. It will take time to safely perform these more demanding types of driving, so feel free to ask your surgery team and therapist for their advice.

Back to Work
Many patients can return to work 6-12 weeks after surgery. If your job involves heavy, physical work, please discuss this with your surgeon.

Knee and Leg Swelling
Knee replacement is a big surgery, and the tissues in the knee take a while to settle down. The amount of swelling and warmth decrease over time and usually goes away completely, but it can take 4-6 months before it stops altogether. There will be days the swelling is worse, usually when doing increased activity and will subside with rest and elevation.

Swelling with occasional warmth is normal after a knee replacement.

However, if you are having swelling along with a fever, pus drainage from your incision and or shaking chills and sweating those can be signs of infection. This happens in less than one to two percent of knee replacement patients. If you experience any of these symptoms, please contact your orthopedic team or primary care provider right away.

Popping and Clicking
Popping & Clicking commonly occur temporarily in a new knee replacement. Patients may notice it early in the recovery process, but most notice it 6-12 weeks after surgery. Most patients have no pain with the popping & clicking. Some reasons you may experience this include

- Healing tissue that is still rough around the edges
- Early scar tissue that will eventually smooth out
- Tissues rubbing over the new plastic and metal implants
- The implants themselves clicking around in each other

After a few months these noises should become less noticeable. Some patients may however always have a click or snapping noise with their knee replacement. In rare occurrences some patients may develop painful scar tissue, limiting motion without improvement beyond the 6-month post op mark. Treatment for this could include additional physical therapy, medication or surgery.

Numbness Adjacent to Incision
After knee replacement surgery, patients often notice the outer part of the knee is numb, and this can cause concern. This is common and experienced by everyone undergoing knee replacement surgery, or any other surgery with an incision over a few inches. Nerves that provide sensation to the skin on the outside part of the knee are tiny and reside in the skin in the path of the incision. They are so small that they cannot be seen, and even if they could be seen, they are still in the way of the surgery. At the time of skin incision, these tiny nerves are cut. Once the incision is closed at

the end of the surgery, the skin begins healing, but the nerves are another matter. Nerves do not heal as well or as fast as skin incisions, and since these nerve branches provide sensation, when they are cut, patients experience numbness in the area they normally sense. This new area of numbness can alarm patients, so we want to let you know to expect that area of numbness. Over time, there is capacity for those nerves to regain at least some of their function, but it can take months and even up to a year to occur. Some patients are left with a permanent area of numbness, typically much smaller than what they experience right after surgery. Believe it or not, that final area of numbness typically does not bother patients in the long run, and we are not sure why. Either the numbness goes away mostly, and/or the patient simply gets used to the patch of numbness such that it doesn't bother them anymore.

Focus on things you enjoy, listen to music, watch a movie, read a good book, or talk with a friend on the phone. These things can help take your mind off of the pain or feeling depressed.

Fatigue and Depression

Big surgeries can lead to fatigue and depression in patients during the first six weeks of recovery. We are not sure why this happens so consistently, but everyone seems to get it to some degree, some mildly so, others pretty badly. It has been observed in not just knee replacement surgeries, but other large surgeries as well, including heart surgery and hip replacement cases. When we experience a big tissue trauma such as surgery, our body responds by releasing substances and changes to the behavior of cells in an effort to repair the traumatized tissue. The fatigue and depression that can follow surgery may be related to this sort of process.

After knee replacement surgery, patients notice not having their usual energy level, being easily fatigued, and perhaps needing mid-day naps. The emotional side of this includes feeling depressed, sad, easily tearful from time to time, often without warning. You may feel like you have been hit by a truck. Understandably, these sorts of symptoms can worry patients and family members. We would like to reassure you that this is normal after knee replacement surgery and seems to go away on its own approximately six weeks after surgery. There does not seem to be much we can do to prevent it from happening, but at least if you expect it, you can understand it a bit better. It is very rare for patients to really be troubled by it, but in those circumstances, we recommend visiting with your mental health professional or primary provider for assistance.

PROCEDURES AFTER SURGERY

We ask that you postpone the following procedures listed below until at least three months after your surgery:

- Dental procedures (cleanings)
- Endoscopies (colonoscopies, EGDs)
- Pap Smear
- Pedicure
- Dermatology procedures

The reasons for postponing are based on lowering your risk for infection. Having these procedures too soon after surgery puts you at risk for a small number of bacteria getting into your blood stream that could potentially travel to your new knee replacement. This scenario is very unlikely but possible.

PLEASE NOTE: After the three month mark, we recommend taking oral antibiotics one hour prior to any of the procedures listed above. **This recommendation is for a lifetime.** When you recheck with our Orthopedic Team in the clinic, these antibiotics will be prescribed for you to use at any time over the course of that year. We then ask that you call back for any refills you may need in the future. Some dental providers have different opinions on the length of time post-surgery that you may need to take these antibiotics. For this reason, we ask that you please reach out to our staff for appropriate prescriptions.

FOLLOW-UP APPOINTMENTS

3 WEEKS

- Your first follow-up appointment will be three weeks after surgery with our orthopedic PA. Dr. Lawton will also stop in for a short visit.
- Your suture will be removed, knee motion checked, and wound care instructions reviewed.
- Pain control and blood thinning medications will be reviewed.
- X-rays are not taken at this time.

2-3 MONTHS

- At this appointment you will have x-rays taken and review them with our orthopedic PA.
- Progress with physical therapy and activity level will be discussed.
- You will be prescribed prophylactic antiobiotic to have available prior to minor procedures.

1 YEAR

- At this appointment you will have x-rays taken and review them with our orthopedic PA.
- Discuss any concerns you may have.

EVERY 5 YEARS

- Every five years, we will ask you to follow up with the orthopedic team to take x-rays, make sure your implants are still in good position, and ensure you are doing well.

RISKS AND COMPLICATIONS

Any medical treatment, even non-surgical treatments, has potential for complications your physician must inform you about.

The bottom line is that most knee replacement patients will experience no complications. A smaller percentage of patients will experience a minor complication, and an even smaller percentage major or multiple complications. The odds are in your favor that you will come out on the good end of things, but you need to be informed of the risks.

Minor Complications After Knee Replacement
Complications considered minor by the research journal editors are typically conditions that go away with medical treatment and do not cause any long-term problems. These can include:

- Hematoma formation or bruising
- Superficial wound healing problem, skin (only) infection
- Suture or staple related incision problems
- Temporary drop in kidney function
- Blood clot in the leg
- Temporary numbness
- Need for blood transfusions
- Pneumonia

Recognizing these problems is the first step to their appropriate treatment and resolution. The treatment for each of these conditions is a bit different, and in some cases is provided by the orthopedic team, and in other cases, by your primary medical providers. These conditions may require additional tests and doctor visits, which can add stress, travel, inconvenience, and cost to your treatment. It is best to recognize and treat these conditions so they will go away as quickly as possible, and not blossom into something worse.

Major Complications
Major complications are rare, occurring in approximately two percent of knee replacement patients, noting the rate is higher among patients over the age of 80, with multiple medical problems, obesity, or poor nutritional status.

Pulmonary Embolism
A PE is a condition in which a blood clot forms in the leg and breaks free, flowing upstream in the veins, then into and through the heart, usually into the lungs. The is a very serious medical condition, symptoms include shortness of breath, pain with taking deep breaths, and heart palpitations. One percent of PEs are fatal. The incidence has decreased lately because of the multiple tools used to decrease their probability, including blood thinning medications, SCD compression devices in the hospital, and early mobilization of patients after surgery. However, even with these measures, a small percentage of patients will still experience PE. The time period they are most likely to occur is the first six weeks after surgery. **If you are experiencing any of the above symptoms, please report to the nearest emergency room for an evaluation.**

Heart Attack or Stroke
These are extremely rare events after knee replacement, and occur less than one percent of the time. Symptoms of a heart attack include chest pain, pain in the jaw, neck or left arm/shoulder,

shortness of breath, lightheadedness or dizziness, rapid heartbeat, sweating or fatigue. Symptoms of stroke include sudden numbness or weakness on one side of the body affecting the face arm or leg, confusion or trouble speaking, blurred vision, loss of balance, severe headache, loss of consciousness.

Nerve Palsy

A nerve palsy is a condition in which a nerve stops working, usually temporarily. There are two main nerves that bypass the knee, the tibial and peroneal nerves. These provide sensation to the tissues below the knee and the impulses controlling muscles in the leg below the knee. Some ways these two nerves can become injured during surgery include compression from the tourniquet, retraction required to visualize the inside of your knee during the procedure, and more rarely nerve blocks. If the nerves are compressed or irritated from these mechanisms, the nerves can shut down, resulting in the lower leg being weak or partially numb. This occurs in less than 1% of knee replacement patients. Typically, the nerves will “wake up” over the course of several weeks to months following surgery. During this time patients may have to use braces and/or medication to help with weakness, pain or numbness caused by the palsy. Eventually, the palsy usually completely resolves.

Injury to the Popiteal Artery

The main artery bypassing the knee and providing blood to the lower leg is the popliteal artery. It is damaged in less than one percent of knee replacement surgeries. If it is injured, an emergency repair by a vascular surgeon would be required, noting there is no vascular surgeon here at Community Hospital, meaning an emergency transfer to another facility would have to occur to restore blood flow and save the leg.

Fracture of the Bone

In less than one percent of knee replacement surgeries, a fracture of the bone may occur. Bones are strong but can be fractured while preparing them for trialing and implantation of the prosthetics of your new knee. Typically, these fractures are treated with screws or plates at the same time as your new knee is implanted and heal normally with no long-term effects or dysfunction.

Tendon Rupture

Tendons are tissues that attach muscle to the bone. The kneecap (patella) tendon is the one we worry about the most with knee replacement surgery. In about one percent of knee replacement surgeries the patella tendon is torn away from the tibia where it normally attaches. It typically is repaired and has a good chance of healing normally.

Kneecap Dislocation

The underside of the kneecap normally glides in a groove on the front of the femur bone. In less than one percent of knee replacements, the kneecap can jump out of this groove and dislocate. In some cases, this is a partial dislocation, referred to as a subluxation. Causes of this happening could be caused from looseness of the tissues on either side of the kneecap or position of the implants. Unfortunately, nonoperative treatments such as bracing or physical therapy are ineffective leading to surgery to fix the problem.

Wear and Loosening of the Knee Replacement Implants

Knee replacement implants can wear out or work their way loose from your bone. This is rare and if it occurs at all, takes years to develop. The chances of it happening in your knee replacement are 0.5% per year, meaning there is about a ten percent chance it will occur within the first twenty years after surgery. The knee replacement implants are engineered with strict standards, but just like parts on your pickup truck or refrigerator, they can wear out over time. Patients who are younger,

under the age of 50, at the time of surgery are more likely to experience this problem. Parts that are worn out or become loose require revision surgery to solve the problem.

Stiffness/Scar Formation
These are among the more common complications occurring after knee replacement surgery, occurring in two to seven percent of patients according to recent studies. The technical term for this is arthrofibrosis. Some patients form more scar tissue around their newly replaced knee than others, limiting the amount of bending and straightening the knee can do. The average range of motion in the replaced knee is about 115 degrees. Patients with scar formation often have less than 90 degrees of motion, making it difficult to go down stairs, or get out of low chairs. Treatment includes extra physical therapy sessions to help stretch things out or some patients choose to undergo anesthesia in surgery to release or remove the scar tissue, which typically helps significantly.

Problems with Kneeling
Many knee replacement patients do not like kneeling down on their new knee. Technically, this is not reported as a complication but is still something that you should be aware of if you are considering surgery, especially if your job or hobbies require lots of time kneeling. It is not that most of these patients have pain with kneeling, most do not. Instead, they simply don't like how it feels when kneeling on their replaced knee. Some patients find it helpful to use a kneeling pad for comfort.

You will not damage your new knee replacement by kneeling on it!

Chronic Pain
According to some research studies, two to twenty percent of knee replacement patients will have pain in their knees for reasons we cannot understand. They do not have infection, instability or stiffness. The cause of chronic knee pain after replacement surgery could include unrealistically high expectations, technical problems during the procedure, pain from other sources or poor coping skills.

Infection
Infection of the knee replacement implants occurs in one percent of knee replacement patients. If it happens, infection requires surgical treatment, which can include removing all of the parts and inserting temporary parts laden with antibiotics, and then another surgery to remove the temporary parts and insert new final parts. Between these surgeries, patients are typically receiving daily IV antibiotics.

In these rare cases of infection, the treatment described above usually works, curing the infection 90 percent of the time. Risk factors increasing the chances of infection occurring in the first place, and failing treatment include immunosuppression, poor health, diabetes, obesity, prior knee fracture surgery, multiple medical problems, and wound healing problems, among others. One

in 10,000 knee replacement patients will develop an infection that is incurable, that fails to be eradicated by surgery and medicines, and requires an amputation.

Infected knee replacements are very complex issues, and our Orthopedic Team here at Community Hospital take many preventive steps pre-operatively, intra-operatively and post-operatively to avoid an infection from developing. Unfortunately, if you are one of the few patients that must go through treatment of an infected knee replacement, you would be referred to our orthopedic colleagues at a larger facility that has infectious disease physicians and orthopedic joint replacement revision specialists on staff.

Death
Dying from knee replacement surgery is almost unheard of. We understand why people may be fearful of dying with any surgery, including knee replacement, with all they hear and read about, and see on television and movies. Advanced age and having lots of medical problems at the time of knee replacement surgery increase one's risk for death. The risk of dying during surgery is one in many thousands.

SUMMARY

This booklet contains a lot of information about knee replacement surgery. We know it can be overwhelming to consider and undergo. However, the bottom line is that for severe knee arthritis, it usually works well, with most patients experiencing a good outcome including dramatic relief of pain and improvement in function. These results tend to be durable and last the remainder of the patient's life. Sadly, this is not true for all patients, as some may experience complications or persistent pain. To some degree, the risks can be managed to increase your chance of having a good outcome.

Discuss your concerns and questions with your orthopedic team to see if knee replacement is right for you and to determine what we can do together to get you the best outcome possible. If you have any questions after reading this booklet, please don't hesitate to contact us at (308)344-8285. We're here to help.

BEFORE SURGERY CHECKLIST

One Month Before Surgery:

- ☐ If you are employed and plan to use Short Term Disability (STD), please speak with your employer and have them forward the necessary paperwork forms to our office for completion. Our office fax number is 308-344-8375. Please include your input on how much time you will feel like you will benefit from for recovery time.
- ☐ Choose who speaks for you if you cannot speak for yourself. Talk with them about your wishes and create an advanced directive.
- ☐ Get a dental checkup.
- ☐ Eat healthy. Protein (chicken, fish, eggs, etc.) can help your body heal.
- ☐ If you are overweight, losing ANY weight will take stress off your joints.
- ☐ If you smoke, vape, or chew tobacco, work with your primary care provider to quit weeks before surgery. Nicotine use impedes the healing process. Studies have shown that people who use nicotine in the weeks before surgery are more likely to have problems with their heart, lungs and surgical incisions during and after surgery. You may be asked to have a nicotine level checked prior to surgery.
- ☐ If you will benefit from a temporary Handi-cap permit, please contact the Orthopedic Office and they can submit an application online.
- ☐ Coordinate a friend or family member to be with you full-time for at least the first 48 hours after surgery.

2 Weeks Before Surgery:

- ☐ You will be scheduled to meet with a provider at the McCook Clinic for pre-op physical.
- ☐ On the same day as your physical you will be scheduled for labs, EKG and time with our Surgical Education Nurse at Community Hospital.
- ☐ Your primary care provider or Surgery Education Nurse will inform you of any medication that may need stopped.
- ☐ You will be informed how many hours to stop eating and drinking before surgery.
- ☐ Purchase liquid antibacterial soap, 4x4 gauze pads, and medical grade tape to use for wound care after surgery. Also purchase over the counter Tylenol and Ibuprofen/Aleve (if you do not take a prescription NSAID).

☐ Set up your home to make life easier when you get back from surgery

- Put things where they are easy to reach.
- Move furniture and rugs out of the way to make sure you can get around with your walker.
- Buy food/meal prep.
- Put nightlights in hallways so you don't fall.

1 Day Before Surgery:

☐ You will receive a phone call from our surgery department with your admit time for surgery

☐ Write down any questions you may have forgotten to ask your surgeon.

☐ Put clean sheets on your bed.

☐ Shower with Chlorhexidine soap.Pack clean, comfortable clothes and toiletries.

☐ Pack your photo ID, list of medications, health insurance cards and this booklet.

☐ Pack a copy of your advanced directive (living will) if you have one.

☐ Only bring what you need to the hospital. Leave your valuables at home or give them to a family member.

COMPUTERS, TABLETS, AND CELLPHONES ARE ALLOWED.

THERE IS WI-FI (INTERNET ACCESS) AVAILABLE AT COMMUNITY HOSPITAL

ORTHOPEDIC CLINIC

1301 East H Street, McCook, NE 69001 | 308.344.8285 | www.chmccook.org

December 2025