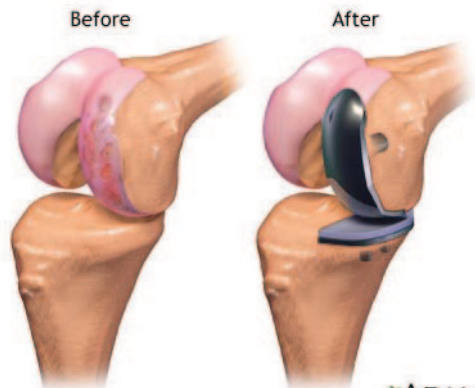




Unicompartmental Knee Replacement

Osteoarthritis of the knee is a disease of the articular cartilage or gliding surfaces of the knee. Over time the smooth, glistening cartilage surface of the knee wears out. It becomes roughened and worn which leads to pain and stiffness. Over time this can lead to complete wear of the cartilage surface and to contact of bone on bone of the femur and tibial surfaces. Knee replacement surgery involves removing the diseased, worn-out cartilage and replacing it with metal and plastic components which take over the role of the gliding surfaces of the knee.



Often both the inside and the outside compartments of the knee as well as the kneecap (patella) are involved and each needs to be replaced. Occasionally only one side of the knee is involved, usually the inner side (the Medial side). If all the ligaments of the knee are still working normally and certain other criteria are met then a Unicompartmental Knee Replacement (UKA) may be used.

Unicompartmental Knee Replacement is an excellent operation when used in the right setting, however if the wrong indications are present then it is reasonable to expect that the UKA may not last as long as one would hope.

Why use a unicompartmental knee replacement rather than a total knee replacement?

When put in the right situation a UKA results in excellent long term pain relief with very good function. When compared to a full or Total Knee Replacement a UKA tends to feel better to the patient and function better. Total Knee Replacement patients tend to report that there is a sense of having nothing there between their femur and tibia. A UKA often feels like a normal knee. UKA's tend to bend better than a Total Knee Replacement and patients report they walk better and climb stairs better with the UKA. It is also a smaller operation with potentially less complications. UKA is also an easier operation to recover from with less post-operative pain.

The main problem with UKA is putting the knee in the wrong patient. The prosthesis is designed for elderly patients with single compartment osteoarthritis with intact ligaments and minimal deformity. If these factors are not present then the knee may wear out quicker than expected and need further more difficult surgery. If these factors are not present a different approach is necessary.

The following information is a guide to your upcoming surgery. It describes what is likely to happen at your upcoming surgery. This is a guide only and there may be some individual variation depending on your individual circumstances. Dr Lawrie will discuss this with you. Please become familiar with this guide and discuss any aspects you wish to with your surgeon, anaesthetist and/or nursing staff.

You will be admitted to the ward either the morning of surgery or the night before, depending on the time of day of your surgery. A typical hospital stay is 2-5 days. You will be able to travel home in your own vehicle but cannot drive for at least six weeks.

Before surgery

You should stop anti-inflammatory drugs at least five days prior to surgery as they can increase the chance of bleeding (e.g. Voltaren, Naprosyn, Nurofen, Brufen, Feldene, Naprosyn and Indocid. Celebrex and Mobic are not a problem). It is extremely important that you have no cuts, scratches or sores on your lower limb at the time of surgery. If present, these increase the chances of infection. If present, your surgery should be postponed till all sores are well and truly healed.

Please ensure you let Dr Lawrie if you have cuts, abrasions etc. well before the date of your surgery.

If your surgery needs to be postponed that surgery time may be used for another patient and resources can be redirected (such as the joint replacement and associated equipment).

On the day of surgery a nurse will inspect your leg for lesions. The nurse will use clippers to remove long hair from the knee and dress the knee with an antiseptic solution. Dr Lawrie will also inspect the leg and mark the appropriate leg to be operated on with an indelible marking pen.

You should stop smoking prior to surgery. Smoking increases the risks associated with an anaesthetic and the risk of blood clots (DVT) following surgery.

Admission

You should not eat or drink 6 hours prior to surgery.

You should bring with you:

- ❖ Personal effects (nightgown or pyjamas, slippers, dressing gown, toiletries)
- ❖ Any medication you are taking
- ❖ All relevant x-rays, scans and reports
- ❖ Medicare and private health fund membership cards
- ❖ This paperwork

Prior to going to the operating room, the ward staff will direct you to:

- ❖ Have a shower with an antiseptic soap
- ❖ Be dressed in a theatre gown and disposable underwear
- ❖ Have the limb inspected and dressed with an antiseptic solution and sterile drape

If you wish Dr Lawrie to speak to a family member after the operation please notify the nursing staff with contact details.

The procedure

You will be taken into the operating room on a trolley by the nursing staff.

The operation will take about 90-120 minutes but you may spend up to two and a half to three hours in the theatre complex by the time you wait in the pre-operative area, are prepared from your anaesthetic and then woken up in the recovery area.

The anaesthetic

You will meet the anaesthetist prior to your admission when he will discuss with you the different anaesthetic options. The type of anaesthetic you have will be tailored to your needs, taking into account any medical conditions you may have. You may be given a general anaesthetic (where you are completely asleep) or a regional anaesthetic such as an epidural or spinal anaesthetic where the nerves to the limb are numbed from a needle placed in your back.

The surgery

You will be placed on the operating table lying on your back. A tourniquet will be placed around your thigh. You will be covered in sterile drapes so as only to leave the operation site exposed.

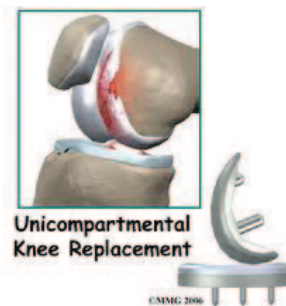
Dr Lawrie will check your x-rays and use those to ensure that your new UKA is placed in exactly the right place and at the right angle for your knee.

Dr Lawrie will use a minimally invasive approach to the knee joint. An incision will be made over the front of the knee joint slightly towards the inner side of the knee. A typical incision is about 10-15cm long. This may be greater if more access is needed due to individual circumstances. Great care is taken to ensure that the major nerves and vessels about the knee joint are protected.

A final check is made of the joint surface and ligaments to make absolutely sure that a UKA is the right procedure for your knee.

If we find that the ligaments are not intact or there is wear of the other compartments of the knee then we will change to a full Total Knee Replacement.

Very accurate jigs are used to ensure the right size components are used on the femur and tibia and/or patella (kneecap). Next, the worn-out cartilage and bone is removed using the jigs. The ends of the bone are fashioned to perfectly fit the new components. Dummy components are placed to ensure that the new knee replacement is placed in the right alignment, the knee bends smoothly and the soft tissues that control knee movement are balanced.



Once Dr Lawrie is happy that the dummy knee replacement is functioning properly then the real UKA is put in place.

The tibial component is cemented in place. The cement acts to transfer forces to the tibial bone evenly from the knee replacement. The tibial component may be a combination of a titanium base plate with a snap in bearing surface made of very hard plastic, or it may be an all plastic component depending on what implant is used.



The Femoral component is then cemented in place. This is made of a metal alloy of chrome-cobalt or sometimes a special alloy called Oxinium which acts like a ceramic and is very smooth so reduces wear of the component.

A final check is made to ensure that the knee is functioning perfectly. The soft tissues of the knee are then repaired with sutures and a firm bandage is applied to the knee. Sometimes a drain is put in the knee to prevent bruising.

Your anaesthetist will withdraw your anaesthetic.

A catheter will be placed in your bladder at the end of the operation to prevent any problems with the bladder post-operatively.

The recovery

You will be wheeled into recovery and the nurse will monitor your blood pressure, pulse and breathing as you recover from your anaesthetic. The nurse will check on the sensation and circulation of your limbs.

After surgery

Dr Lawrie will see you and explain the operative findings to you. A copy of the operative report will be given to you and sent to your local doctor.

After surgery - cont'd

On return to the ward you will have a drip in your arm that will keep you well hydrated till you are eating and drinking normally.

Your blood level will be checked and you may need a blood transfusion.

You will have tight stockings around both legs, which help to prevent blood clots.

These need to be worn for six weeks from the time of your surgery.

Foot pumps on your feet also help with clot prevention.

Your usual medications will be given to you.

You will be placed on antibiotics through the drip for 24hrs to reduce the risk of infection.

Aspirin will be added to your medications and you should continue to take this for six weeks from the time of surgery to help prevent clots.

You will be given morphine type medication for pain relief. This can make you drowsy and nauseated. Your anaesthetist will keep a close eye on your pain relief and will endeavour to keep you comfortable. Commonly, patients will be given a PCA (Patient Controlled Analgesia), which allows you to control the amount of painkiller that is administered through your drip.

An x-ray will be taken of your knee following your surgery to check on the position of your components.

Your blood level will be checked the following day.

A physiotherapist will visit you following your surgery and will be in charge of your mobility following surgery.

The most important thing you can do on return to the ward is to get moving as soon as possible. This helps to prevent clots and to maximise your new knee's flexibility and minimise muscle weakness post surgery.

This starts with toe wiggling immediately after surgery and progresses quickly to standing out of bed and bending the knee the day of your surgery and walking with the aid of a frame or crutches a day or two following your surgery.

You will be given a number of exercises by the physiotherapist, which will aid in getting back your muscle strength and getting you back on your feet.

You will be ready to leave when you can bend the knee to 90°, walk about 30 metres on your own, get in and out of bed, access the toilet and shower, and get up and down stairs successfully.

Your physiotherapy

A knee replacement involves a lot of physiotherapy and a lot of hard work. Patients are often surprised at how hard it is to get their new knee working following surgery. UKA's generally are quite a deal easier to get going. However the same principles still apply. You must get the knee moving as quickly as possible. If you are not mentally prepared for the hard work following surgery then it is very difficult to get your knee moving.

Depending on the time of day you return to the ward the physiotherapist will have you out of bed the day of your surgery as well as work on muscle strengthening and range of motion. This will continue throughout your stay.

The knee will be sore despite the pain relieving medications and you have to work through the pain in order to get the pain to settle down.

Your physiotherapy - cont'd

Regaining control of the quadriceps muscles at the front of your thigh is very important and the physiotherapists will continue to exercise this area.

The keys to a good result post-operatively are:

- ❖ getting control of your pain
- ❖ obtaining good quadriceps function
- ❖ then working on knee bending.

Your physiotherapy will continue when you go home and will continue for 6-12 weeks; depending on your progress.

When you get home

Mild pain in the knee is normal on returning home. The knee is often sore for the first 6-12 weeks. Simple painkillers such as Panadiene Forte should control this. Movement, swelling and pain should all steadily improve over the next 6-12 weeks. If any of these are not improving then contact Dr Lawrie.

You will need to see a physiotherapist for the first 6-12 weeks to ensure your knee gets the best possible result.

Once you have had your knee replacement and completed your recovery your knee should have a range of motion of 100-120°, UKA's may give a little more movement on occasion. This should be sufficient for your routine daily activities such as walking and climbing stairs.

UKA's as well as Total Knee Replacements usually gives excellent pain relief, with little or no pain. Most people with UKA's can do recreational walking, swimming, golf, driving, light hiking, recreational biking, ballroom dancing and stair climbing without difficulty.

The new knee often clicks as the knee is moved and weight bears.

There will be a numb patch of skin on the outside of the knee that is permanent. This is because the small nerves that supply this area must be cut by the incision that is needed to put the knee replacement in.

It is very important to treat any infections of other areas aggressively such as the urinary tract or dental infections. Many invasive procedures require antibiotics prior to the procedure. It is always best to warn your doctor beforehand that you have a UKA. The consequences of an infected replacement can be dire. Surgery on infected joint replacements is extremely difficult and not always successful at eradicating the infection.

Activities to avoid

Once you have your new UKA it is up to you to take care of it. Although the new UKA may feel much like a normal knee it is not. It is much like the bearings in a car and can wear out if too much force is applied to it. Avoiding excessive and undue stresses on the new knee will give it the best chance of having a long life.

Your knee should feel very good and it can be tempting to return to all the activities you have missed out on because of your knee condition. However, the UKA is not designed for high impact activities.

The longevity of your UKA is very dependant on how you treat it. If the knee is abused it may wear out quicker than expected. You should definitely avoid running or jogging, contact sports and high impact aerobics. You should try to avoid vigorous walking or

Activities to avoid - cont'd

hiking, aggressive skiing, competitive tennis, repetitive lifting exceeding 20kgs. The UKA is not designed for manual labour.

How long will your UKA last?

There is about a 1% chance per year that you will require a revision knee replacement. Knee revisions are much more difficult, tend to have more complications and have a less successful outcome than the original surgery. That is why it is so important to look after your new knee for evermore. By looking after your knee, you will be able to substantially improve the longevity of your new knee and hopefully avoid the need for a revision knee replacement in the future.

Commonly asked questions

What are the risks of surgery?

The risks of UKA surgery can be thought of as general risks of the procedure and local risks to the knee and leg:

General Risks (very rare)

- ❖ Death is possible from the procedure
- ❖ There is a risk of having a problem with the heart such as a heart attack, heart failure or arrhythmia
- ❖ There is a risk of having a stroke

More Common

- ❖ Clots in the legs may occur with pain and swelling of the legs. Rarely parts of the clots can break off and travel to the lungs. This can be fatal. Many steps are taken to avoid this happening.
- ❖ Small areas of the lungs can collapse following surgery that may cause infection in the lungs requiring antibiotics and physiotherapy.
- ❖ Bladder and prostate problems can be exacerbated by your surgery. A catheter is routinely placed in your bladder at the time of surgery to avoid this. This will be removed once you are comfortable and mobile.
- ❖ The bowel may become paralysed after surgery. This may result in pain, bloating, nausea and vomiting for a time.

Local Risks

Infection after UKA:

This can occur at any time. Therefore it is very important to be vigilant for the risk of infection. Infection often requires further difficult surgery that may result in revision knee replacement. A revision knee replacement is sometimes not possible and the knee needs to be fused or surgically stiffened. If the knee is fused straight and cannot bend at all; this is permanent. Sometimes the infection cannot be eradicated even with further surgery.

A small percentage of UKA's can fail early due to specific problems unique to UKA's. Fracture of the tibia or femur can occur which may require further surgery or even revision to a full knee replacement.

The tibial component can subside into the tibial bone and hence lose the alignment necessary for a good result. This typically results in revision surgery.

The plastic insert may dislocate also needing further surgery.

The most common reason to need further surgery is arthritis in the other compartments of the knee which have not been replaced.

All the above complications are uncommon but may occur.

Local Risks - cont'd

Infection after UKA:

The knee may be stiff and or painful following the surgery. Sometimes the cause of this cannot be identified.

A small proportion of patients will need to return to the operating theatre within three months to have a manipulation to help the knee bend. The patient then needs to stay in hospital for a number of days to continue physical therapy to ensure the knee continues to bend.

The nerves about the knee joint can be injured at the time of surgery. This can result in pain or weakness. This can result in permanent disability. The most common nerve affected is the nerve that supplies the muscles to the top of the foot. Damage here can result in a foot drop.

Rarely the limb can become painful, swollen, red and stiff with abnormal sensation even following a well-performed knee replacement. This is due to an abnormality in the pain system and can be very difficult to treat.

The new knee joint itself may loosen and or wear over time. This can result in pain and instability over time. The femoral component, the tibial component, or the plastic bearing may fail individually or in combination. This may require revision surgery in the future. Sometimes this can result in bone loss about the knee joint. This can result in fracture of the femur or tibia in future years. A number of steps are taken to reduce the risks of this.

There is a risk that the new knee may fail within the first five years. This will require further surgery.

The wound may not heal properly and can become red, thickened and painful. Steps are taken to avoid this.

Possible bleeding into the wound after surgery:

This may become painful and require surgical drainage, or become infected and require antibiotics.

- ❖ There is a risk that the leg may have to be amputated due to poor blood supply or infection
- ❖ There is an increased risk of complications in obese people of
 - wound infection
 - heart and lung complications
 - blood clots
- ❖ There is an increased risk of complications in patients with diabetes.
- ❖ There is an increased risk of complications in smokers.
- ❖ There is an increased risk of complications in patients with multiple medical problems.
- ❖ There is an increased risk of complications in the very elderly and infirm.



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