

UNICOMPARTMENTAL KNEE REPLACEMENT (UKR)

PATIENT INFORMATION

The following information is to help you understand what is going to happen when you have a UKR. It is only a guide and some aspects will vary according to the individual. Should there be anything that is not clear or you wish to discuss anything in more detail then please make contact with me.



Pre-operatively

The decision to undergo a UKR would have been made based on symptoms such as pain, stiffness, deformity, swelling, instability or a combination of these, within one compartment only/mainly. These are all features of degeneration or osteoarthritis.

The aim of the surgery is to diminish, if not, eliminate the above symptoms.

Please note: in certain circumstances consent will be taken for both a total knee replacement and a UKR. In the event that the other 2 compartments are noted to be significantly more damaged than expected, the method of treatment that is most appropriate for your knee may be a total knee replacement. I will have discussed this with you pre-operatively.

Admission – This takes place on the day of the operation. The nurses will take a medical history from you and carry out the routine preparation on admission. If necessary the knee area will be shaved.

All usual medications should be taken prior to the surgery unless you have specifically been advised otherwise. You should be starved from the previous night at midnight. A small sip of water will be acceptable to take your usual medications.

NB If you have any any XRays/scans, please bring them with you.

Pre-operative investigations – in patients over the age of 60 or in patients with chronic medical problems, a few routine tests will have been performed prior to admission. A specialist physician appointment may have been requested.

- Chest XR – this tells us about the state of the heart and lungs
- ECG – the tracing of the heart tells us about the heart rhythm and function.
- Blood tests – tells us about the kidney function, and the thickness of the blood, amongst other things.

On the day of surgery

- You will be seen briefly by the anaesthetist and me where last minute questions can be answered. Your leg will be marked and consent will be taken for the operation.
- The anaesthetist will discuss the anaesthetic procedure. Any anaesthetic concerns can be discussed at this point.
- mostly a “spinal” anaesthetic would be given. This is done by means of a spinal injection, whereafter the legs become numb. We give patients the choice of spinal anaesthetic with or without sedation.

During the operation

- Routine antibiotics will be given to you, and three more doses post-operatively, eight hours apart.
- The operation takes between 1 – 1 1/2 hours.

Post-operatively

- You will wake up in the recovery area quite soon after the operation, but you will still feel quite groggy.
- There will be a white stocking and a “polar-care” cuff, for icing, on the operated leg.
- You will be kept in the recovery area for about ½ hr and then you will be taken up to your room in the ward.
- You may spend the night in the high care unit. This would be advised if there are underlying medical problems or if there is a higher risk than normal, or if the Anaesthetist feels more comfortable with you being there, even if there are no problems. It also depends on the age of the patient.

Some general points :

- The white TED stockings play a role in preventing DVT or deep vein thrombosis (clots in the leg veins). They also reduce swelling by compressing the knee. You will be asked to continue to wear both stockings for 2 weeks and then the one on the operated leg for another 6 weeks.

Blood thinning tablets will be given to you for a total of about 2 weeks, also to prevent DVT

Day 1 - 5

- Mobilization will begin on day one. It will start with bed to chair transferring, then walking with crutches.
- You will be asked to keep your leg up as much as possible, except when specifically doing your exercises. This reduces swelling.
- The padding will be removed after 48 hours, where after icing can be applied to the knee intermittently, to also reduce swelling.
- Pain control is usually achieved with strong medication (Morphine/Pethidine) over the first 24 hours. Tablets can usually manage to control the pain thereafter. There is some individual variation though.

Discharge (usually between 3 - 5 days)

The following should have been achieved prior to your discharge:

- Adequate pain control
- Mobility should be such that you are independent on crutche(s).
- There should be no problems with the wound, like bleeding or infection. This will be assessed prior to your discharge.
- You will be given a pamphlet by the hospital staff explaining what to do with the dressings. It will also contain some general information and advice as well as the contact details for the clinic and me, in case you have any problems.
- You will be asked to make an appointment for 2 weeks post-op.
- Physiotherapy should be arranged within the first week post discharge. Usually your physiotherapist decides how often you need to attend but please remember that a lot depends on you. You will be shown enough exercises and activities to keep you busy with your program of “self help physiotherapy” at home.

Expectations

- Between 4 – 12 weeks, you should be off the crutches, and walking reasonably normally
- You should be able to straighten your knee properly within a few weeks, and your knee bending (flexion) should reach its maximum by about 6 weeks to 3 months. Remember if you had more than about 140deg of bending ability prior to the operation you may lose some of this ability due to the scarring caused by the surgery and the mechanical restrictions of the prosthesis. The usual amount of bend that most patients achieve is about 100 - 140deg.
- You can expect to have a swollen and warm knee for up to 6 months, or sometimes even 1 year post-operatively. This is due to ongoing inflammation in the knee which takes a long time to subside.
- You may feel or even hear the occasional click coming from the knee during certain movements. This is caused by the prosthetic components knocking against each other and is quite normal unless your knee becomes very loose and unstable.
- While most severe pre-operative symptoms are much improved, some patients may still be aware of the occasional ache/pain that limits certain activities and that may require occasional painkillers.
- Improvement can be expected up to about 1 year, after which things usually reach a plateau.
- Non-impact gym activities can usually be commenced at about 4 weeks. These include cycling, swimming and some muscle toning exercises.
- Golf activities can usually be resumed by about 3 months, commencing with the use of a buggy initially, then over the next few months to full golf activity.
- You should be able to walk for about 1km comfortably after about 6w – 3 months.
- I would not recommend activities that put a lot of strain on the knee. It will loosen prematurely. These include: twisting, turning sports, impact or contact sports.

Remember

- Any prolonged activity will flare the knee up. It should be elevated and iced in this situation, and the activity level should be modified for the next time. Pain killers and/or anti-inflammatory tablets may be appropriate in these instances. If you think there is a worse problem than usual please discuss it with your consultant

Results

- The average UKR lasts between 10-15yrs.
- If it fails, the usual course of action is to replace it with a total knee replacement, although, in exceptional circumstances, it can be revised to another UKR
- The cause of failure is usually loosening of the prosthesis which occurs over time.
- Other causes of failure are:
 - Infection (this may cause early failure due to loosening)
 - Fractures (uncommon and due to trauma)
 - Dislocation of the plastic bearing. It can be exchanged sometimes.
 - Breakages of metal or plastic (rare)
 - Instability, where the soft tissues surrounding the knee are lax and the knee feels unstable.
 - On-going pain, and general dissatisfaction with the knee(s) can also be a problem in the occasional patient, where no particular cause can be found.

I also advise patients that the alignment of their knee(s) may be altered due to the “filling in” of the joint space, with prostheses. This may take some time getting used to, but patients usually end up with the physiological or normal alignment, and most patients get used to this.

Some patients with osteoarthritis maintain a good range of movement (bend) in their knees, and in these patients it is possible to lose some bend in the knee, compared to before the operation.

You will probably never be able to sit on your haunches again, but you will have a very good range of movement, to enable you to carry out most daily activities

IT IS ADVISABLE NOT TO UNDERTAKE ANY LONG HAUL AIR TRAVEL FOR 6 WEEKS POST SURGERY (SHORT HAUL – 4 WEEKS). THERE IS A RISK OF DVT (DEEP VEIN THROMBOSIS – CLOTS IN THE VEINS OF THE LEG). PLEASE DISCUSS THESE ISSUES WITH ME IF YOU INTEND TO TRAVEL.

If air travel is essential, then certain precautions are necessary:

1. You may be given “blood thinning” injections around the time of your flights – we will discuss this.

The most important factor that causes DVT is immobility – This results in inadequate venous blood flow to the heart, resulting in

possible clots forming in the calf veins. The following may help to enhance the blood flow to the heart

2. during the flights I recommend TED stockings – these are compressive medical stockings, which may empty out the deep veins in the calf, resulting in less clot formation
3. it is recommended that you do calf pumping exercises during the flight, as often as possible.
4. It is also recommended that you get up and stretch, as well as walk up and down the aisle of the aircraft as often as possible.
5. limit alcohol intake and drink a lot of water. Dehydration plays a role also

I hope this information is useful but please make contact with me should you have any further questions.

Glen Vardi