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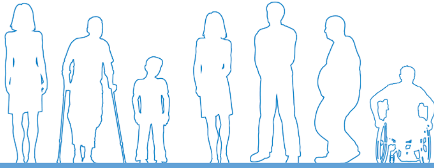
Royal National Orthopaedic Hospital NHS
NHS Trust



A Patient's guide to

Proximal Femoral Replacement

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This leaflet is designed to give you some information about your hospital stay and rehabilitation following a proximal femoral replacement. This is usually performed to remove a tumour, but can also be performed for general orthopaedic conditions. The leaflet is intended to supplement the discussion you have with your health professionals. If you have any questions, please contact your key worker/specialist nurse.

Introduction to the team

Doctors

Senior House Officer – This is the doctor you will see most often. He/she will come and see you once you have arrived in hospital, and discuss the operation with you as well as answer any of your questions. They will ask you to sign a form giving your consent to the operation. After your operation, the doctor will monitor your progress and any medical problems.

Registrar – Senior to the House Officer

Consultant – This is the doctor under whose name you are admitted. The Consultant is the most senior of the medical team and will oversee your care.

Nursing staff

Nurses are on the ward 24 hours a day and will be the team members with whom you have most contact. The nurses' role during your stay in hospital is to provide you with both physical and emotional support in order for you to maintain maximum independence.

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Clinical Nurse Specialists

A Macmillan nurse or specialist nurse may be supporting you if you have a diagnosis of cancer. They will act as your key worker and will be there to support you from the time of your diagnosis to during and after your treatment.

Occupational Therapist

The Occupational Therapist will see you after your operation to optimise your independence in everyday activities, such as bathing, getting in / out of a car, etc. There are certain precautions that you must follow for the first twelve weeks after your surgery; your occupational therapist will show you different ways of doing things to ensure your safety. This may involve suggesting ways of doing things or the use of aids / equipment, and is aimed to ensure your safety and independence in preparation for going home.

Physiotherapist

The Physiotherapist will see you regularly after your operation. They will teach you exercises to gain strength and control in your limb. They will refer you for further physiotherapy at your local hospital once you go home.

What is a proximal femoral replacement?

A proximal femoral replacement involves removing the upper part of the femur (thigh bone) where the tumour is, along with the hip joint, and replacing it with an implanted metal prosthesis.

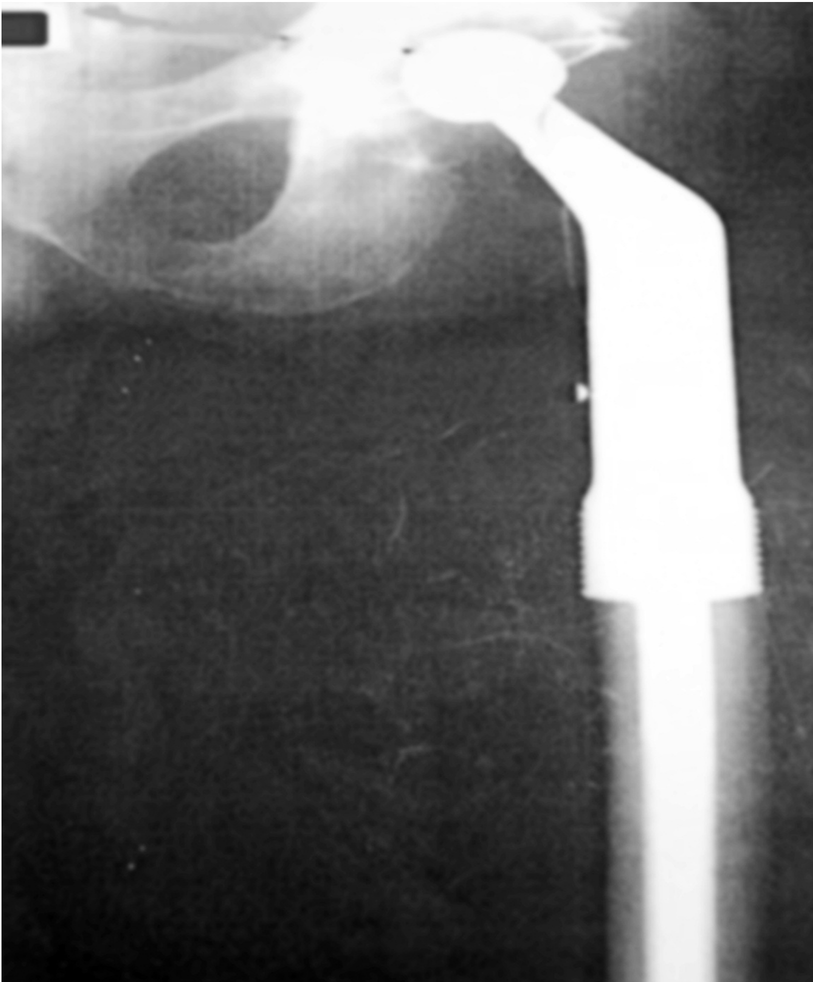
The implant or prosthesis as it is called, replaces the ball and socket of your hip joint and fixes into the centre of the remaining part of the femur. To achieve an even stronger fixation, the end of the prosthesis, which is in contact with your bone, is either cemented or will have a special coating to encourage your own bone to grow around it.

The main metal used in the prosthesis is titanium alloy, known for its strength. It may set off the alarms in security checks at the airport but an explanation of having had an operation is all that appears to be required.

The affected leg may feel warmer to the touch than the leg on the other side because the metal conducts your body heat. This is perfectly normal, providing there are no obvious signs of redness or inflammation.

Young people who are still growing will have a prosthesis that incorporates a telescopic shaft which can be extended as they grow. The majority will also have a small electromagnetic gearbox, inside the prosthesis, which enables them to be lengthened in the outpatients department. This will mean no more MRI scans (apart from exceptional circumstances) as the presence of the prosthesis could damage the scanner. Very young children may need to have the lengthening during a small operation.

Proximal Femoral Replacement



What are the risks of the operation?

There are risks associated with any surgery and these are listed below. The doctor will discuss with you the specific risks involved with your operation.

- Pain relating to the operation – this will be monitored and treated with pain killers
- Bleeding around the operation site – this is minimised by the application of a wound drain at the time of surgery
- Blood clot – prevented by exercising and wearing special socks, and also by having anticoagulant (blood-thinning) injections
- Nerve damage – this may recover or may require a foot brace
- Delayed healing or infection – treated by antibiotics, or occasionally a small operation to wash out the area
- Dislocation- Initially a proximal femoral replacement is not as stable as a normal hip so there is a chance that the hip will dislocate. This means that the prosthesis comes out of position and would require further surgery to correct this.
- Leg length- the operation can result in slightly different leg lengths, which can be corrected with a shoe raise if necessary.

What will happen when I come into hospital?

You will usually come into hospital the day before your operation. This is so that you can meet the doctor, anaesthetist and nursing team. We ask that you bring your medication with you, and any other information that is relevant. The doctor will give you information about the operation and ask you to sign a consent form. Feel free to ask any questions and make sure that you are fully informed. The anaesthetist will ensure that you are well enough to receive an anaesthetic, and will talk to you about pain relief after the operation. Some people like to have a sedative tablet shortly before the operation to make them feel drowsy. This is entirely your choice.

What will happen on the day of my operation?

You will be asked to stop eating from midnight on the day of the operation. You can however drink water or clear fluids up to two hours before the operation. If your operation is scheduled for the afternoon you will be offered a light early breakfast. You will be given an approximate time of the operation, though this can vary. When ready, porters will take you to the operating theatre in your bed. You will meet the anaesthetist again, who will give you the anaesthetic through an injection into your hand. When you wake up, you will be in the recovery room, where you will be monitored until you are well enough to return to the ward. You may spend the first night on the high dependency unit, then return to your ward the next day.

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When you wake up, you will have an oxygen mask over your mouth and nose, and this will remain until you no longer require it. You will either have an epidural or a morphine pump (Patient Controlled Analgesia (PCA), administering your pain relief. This will be monitored closely by the nurses to ensure it is effectively controlling your pain. If you have an epidural, your lower limbs may feel heavy and sometimes numb. This wears off once the epidural is discontinued. You may also experience drowsiness and nausea, particularly if receiving morphine, and may find it difficult to pass urine; if this is the case you will be given a urinary catheter (a small drainage tube inserted into the bladder).

It is usual to have a tube draining excess fluid from the operation site. This will remain for 1-2 days, or longer if necessary. You will also have a 'drip' delivering fluid into your bloodstream. This will remain until you are drinking adequate amounts. Precautions will be taken to prevent the development of a blood clot in your legs. This means that you will be asked to wear special socks and foot pumps, and may receive daily injections. The foot pumps and injections will only be given whilst in hospital, whereas the socks should be worn at all times for six weeks. You will be given an extra pair of socks so that you have a spare pair to wash.

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What will happen after my operation?

Nursing

- Some of the above mentioned 'attachments' will be taken away
- When your epidural or PCA is discontinued you will be given painkilling tablets or medicine
- The wound drain will be removed approximately 2 days after the operation
- You will have staples to close the wound and these will be removed after approximately two weeks. Your nurse will arrange for this to be done locally via your GP surgery
- You will be encouraged to move your legs and feet to help reduce the risk of a blood clot.

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Physiotherapy

- From day one your leg will be positioned in neutral rotation supported in a trough with additional support if required. Static muscle work commences

- Approximately 48 hours after your operation your physiotherapist will start gentle exercises with you whilst you are on the bed. They will use something called 'slings and springs' to increase the muscle strength in your operated leg before you are able to get out of bed

- You may be fitted with a hip abduction brace that will wrap around your waist and thigh to protect your new joint and prevent you from doing any movements that could cause you to dislocate your new joint. You will need to wear the brace at all times when you are out of bed

- It is important that you practice your exercises regularly as advised by your physiotherapist to ensure good mobility and strength in your leg

- You should continue doing these exercises after your discharge.

Most patients normally start to get out of bed on the third or fourth day after their operation. You will usually use a frame to help you walk.
You will be allowed to put your full weight through your operated leg (unless you are told otherwise by the team). During the next few days you will gradually increase your mobility until you are able to be independent.

Before your discharge your physiotherapist will practice climbing the stairs with you should you need to do this at home. It is advisable for you to have a pair of sturdy slippers or shoes for safety, and loose comfortable clothes.

Occupational Therapy

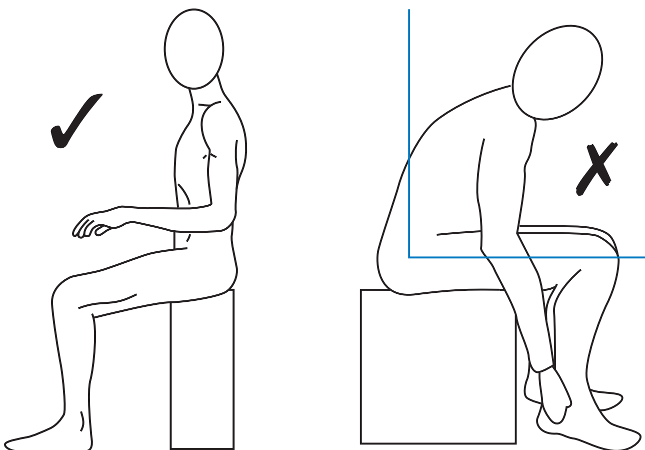
You will routinely be seen by an occupational therapist (OT) who will teach you how to put on and take off your brace yourself and how to manage your daily activities whilst adhering to your precautions. S/he can advise you on the use of adaptive equipment. If you require additional help, you will be referred to social services by the nursing staff.

Precautions

Following a proximal femoral replacement the surrounding muscles and tissues need time to heal and it is important that you avoid certain movements after the operation to reduce the risk of dislocation.

IT IS ESSENTIAL THAT YOU AVOID THE FOLLOWING MOVEMENTS FOR THE FIRST 12 WEEKS:

- Do not bend your hip beyond a 90 degree shape



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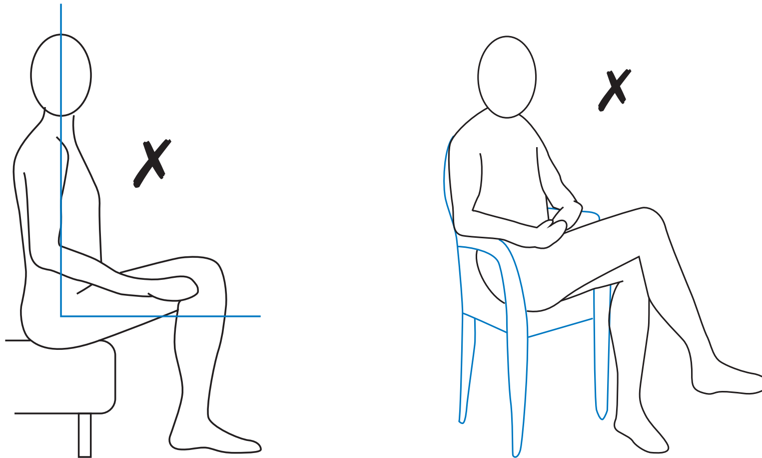
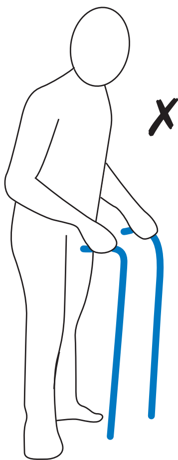
- Do not cross your legs or move your operated leg across the imaginary line down the centre of your body



- Do not twist on your operated leg



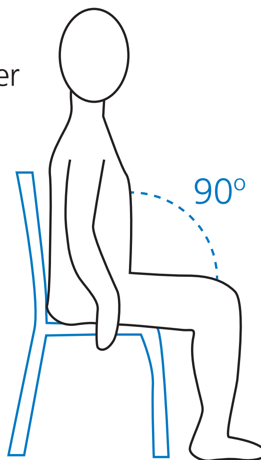
Putting your precautions into practise

Your occupational therapist will issue you with a form to fill out the measurement of your furniture heights at home. Please fill this out and return it to us as soon as you can so that we can make sure that you can follow your precautions on your return home. If possible, we will send this out prior to your admission.

Sitting

Choose a firm, upright chair, preferably with arms. The ideal height of your chair will depend on your height and the length of your leg from the back of your knee to the floor. The minimum sitting height will be the latter measurement plus 2" / 5 cm. If you do not have a suitable chair you may need to borrow one or use firm cushions to raise the height of the chair. Avoid low, soft armchair and sofas.

The correct way to sit:
your knees must not be higher than your hips:



To get out of a chair push yourself to the front edge, place your operated leg slightly forwards and push up on the arms of the chair taking most of your weight through your un-operated leg.

Regain your balance and then get your crutches or sticks. Reverse this procedure to sit down.

The same method is required to get on and off the toilet. You may require a raised toilet seat or other equipment as assessed by your occupational therapist.

Sleeping

Again the ideal height of your bed will be dependent on your height. If it is too low you could place another mattress on top to raise the height.
It is advisable to sleep on your back for the three months after your operation. After this, you may sleep on the operated side if it is not too tender. You should avoid sleeping on your non affected side as this could put you at risk of dislocation.

Your bed should be firm.

When getting on and off the bed avoid twisting your hip. Try to keep your toes pointing towards the ceiling as you move your operated leg across the bed. It is safer to get out of bed leading with the operated leg so that you do not cross the imaginary line down the centre of your body.

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Bathing

During the time when you have to wear your brace (the first twelve weeks), we advise that you should strip wash at the washbasin, as you have to wear the brace at all times when you are out of bed. The occupational therapist will show you ways of washing your lower half safely, such as using long handled aids to reach your feet. However you will be likely to require assistance with the special compression socks that you will have to wear for the first 6 weeks after your surgery.

Dressing

Your occupational therapist will teach you how to dress your lower half, putting your brace on underneath your clothing. You will be taught how to avoid bending forwards to reach your feet or bending the knee of your operated side towards your chin. The occupational therapist will show you how to use a stocking or sock aid, long handled shoe horn and a helping hand. Remember to dress your operated side first, undress it last and wear good supportive shoes with low heels. You may find slip on shoes easier to manage or elastic laces.

What do I need to achieve before I can be discharged home?

There are obviously times where these may be different depending on individual circumstances. Prior to discharge it is our aim that you will be able to move around indoors independently with a suitable walking aid. The usual length of stay in hospital is approximately 12-16 days.

You should be:-

- Walking safely with crutches (or whatever walking aid you and your physiotherapist have decided is best for you). You will probably need to use these for at least 12 weeks depending on the speed of your recovery
- Able to climb stairs (if needed for your home or social circumstances)
- Be independent with an exercise programme at home
- Comfortable with your medication
- Your wound should be healing well
- Able to manage personal care tasks independently using long handled aids. If not, then suitable help needs to have been organised

- Able to manage school/domestic tasks as appropriate
- Able to take your brace on and off independently.

How can I help myself?

There are lots of things you can do to aid your recovery, and here are some of them:

- Eat and drink well
- Carry out exercises regularly
- Ask for pain killers if needed
- Stop smoking, or try to reduce the number of cigarettes you smoke
- Think about your home environment and make arrangements so that it will be ready for you when you leave hospital
- Make arrangements for someone to collect you from hospital and take you home.

How will I be followed up after my discharge?

Clinic Review

Before you go home the doctors will tell you when they wish to review you in clinic. The most common time is approximately 6 weeks after the operation. However this can be different for individual patients. If it is possible to make you a clinic appointment before you go home, the nurses will inform you of the date, time and venue (it may be either at Stanmore or Bolsover Street – do check which!). If this is not possible, an appointment will be sent to you at home. Make sure you check which way you are going to receive your appointment before you go home as it is essential you are monitored after your discharge.

The nurses will also arrange for any necessary nursing appointments (e.g. staple removal) to be done either by your district nurse or the nurse at your GP's surgery. If you are resuming chemotherapy, you will need to liaise with your clinical nurse specialist.

The physiotherapist will refer you to your local physiotherapy department (or RNOHT if that is more convenient for you) for ongoing physiotherapy. In most cases your local physiotherapist will contact you at home to give you an appointment. If you require chemotherapy immediately after your discharge we will also refer you to the physiotherapist at your chemotherapy hospital.

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If you require further treatment for your cancer, this will be coordinated by your clinical nurse specialist. She will keep you informed and liaise between the different treatment centres.

Following your initial check-up, you will continue to be reviewed by your doctor for many years. This is to check your leg for tumour recurrence and check the prosthesis for loosening and infection. You will undergo X-Rays of your leg as well as a physical examination. As always, should you have any concerns in between these appointments please contact your clinical nurse specialist.

Please note that you need to take care if you have any acute infections such as dental infections or tonsillitis in the future – you will need antibiotic cover to protect your prosthesis.

What can I expect to be doing after discharge?

Each patient is treated as an individual. The surgery differs with each patient and therefore a definite outcome can not be predicted. However, these are some average goals to expect.

Mobility and Function

- Walking without stick or crutch (this may take up to a year or more)
- Progress to being able to wean off wearing the hip brace after twelve weeks
- Have good muscle strength in your leg (it may not quite equal your opposite leg)
- Be able to climb stairs normally (when you have gained adequate strength and movement)

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Returning to Activity

- Be independent in your day to day activities

- Be back to your normal job, school, college etc (except in some very exceptional circumstances). When you are able to do this will depend on your recovery. You may want to discuss this with the team

- Have returned to your hobbies and sports, except high impact or competitive sports or ones that involve excessive twisting or impact. This is to protect your prosthesis. Most sports can not be considered until 6 months to a year after your operation. It is advisable to discuss your specific requirements with your consultant and physiotherapist

- Be able to return to driving once you are able to manage without your brace and you have enough hip control, range of movement and strength e.g. to be able to do an emergency stop with confidence. Your insurance company may need to be informed; please check with them prior to driving again.

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Information and Support

Sarcoma UK
http://sarcoma.org.uk/

Macmillan Cancer Support
www.macmillan.org.uk
Call free on: 0808 808 00 00

The London Sarcoma Service
www.londonsarcoma.org

If you have any comments about this leaflet or would like it translated into another language/large print, please contact the Clinical Governance Department on 020 8909 5439/5717.

Royal National Orthopaedic Hospital NHS Trust
Brockley Hill
Stanmore
Middlesex
HA7 4LP

Switchboard: 020 8954 2300

www.rnoh.nhs.uk

Twitter: @RNOHnhs

13-178 © RNOH
Date of last review: September 2013
Date of next review: September 2015
Author: Jo Coleman