Post Operative Instructions

Hip Arthroscopy

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Bandages & Ace Wrap:

Your post-operative dressing has three layers you need to understand in order to properly care for your hip for the two weeks following surgery. Your two arthroscopic incisions were closed with a single stitch, which were covered with small white tapes called Steri-Strips. Your Steri-Strips should be left in place until your sutures are removed 10 to 12 days after surgery.

The second layer is a large white fluffy dressing that is tapped to your hip. Since arthroscopy is performed with water, this second layer can absorb some water that will leak from your hip for the first couple hours after surgery. Occasionally, there will also be a small amount of blood mixed with this water, which is nothing to worry about.

Leg Rotation Exercises:

Beginning the day following surgery you will be responsible for a set of exercises done 3 times a day to prevent scare tissue from forming around the hip joint. To complete these exercises you are positioned flat on your back with the legs out straight. An assistant (family member) will lift your leg by your heal off the bed about 15 degrees up and about 20 degrees outward and then rotates the leg 10 time clockwise and 10 times counter clockwise. The assistant will then lift you leg 70 degrees up and 30 degrees out and repeat the same rotations. This is repeated three times. If you have any questions about how to do this – have you Physical Therapist review this with you.

Washing & Bathing:

You should be careful to keep the wound clean and dry for the first 48 hours after surgery. Beginning on the third day after surgery it is OK to shower directly over your Steri-Strips (they won't come off). It is also OK to use soap on your leg and over the Steri-Strips. This shower should be quick. I would prefer that you do not take a bath until one week after surgery. It is OK to go into a swimming pool a week after surgery, but no lakes or ocean until two weeks after surgery.

The yellow discoloration you will find on your leg is a long lasting surgical prep called DuraPrep. This is used because it kills bacteria on your skin hours longer than old fashion iodine surgical preps. This yellow discoloration will not come off with soap and water; instead you will need rubbing alcohol to remove it. This can be done the day after surgery unless it is causing your leg to itch, then it can be removed sooner.

Ice & Elevation:

One important goal following surgery is to minimize swelling around the hip. The best way to achieve this is with the frequent application of ice and by keeping the leg elevated. This

is most important the first 48 hours following surgery. The ice pack should be large (like a big zip-lock bag) and held firmly around the hip. We follow the "one to four" rule - which means that for every hour your leg is down (like sitting in a chair or walking) it takes four hours to reverse the swelling.

Walking & Crutches:

One of the wonders of arthroscopic surgery is the very fast recovery that we expect. Remember that we did not perform any major repairs during surgery so there is nothing that can pull apart. We allow you to walk as soon after surgery as it feels comfortable. Remember that there is nothing in your hip that you can permanently hurt by walking. In fact, the sooner your gait returns to normal the faster your recovery will begin. If necessary, it is fine to use your crutches for a day or two if needed, but keep testing how you can do without them. Almost all patients are off crutches within a week of surgery.

Physical Therapy

Your physical therapy appointment should have been made for you before your surgery day. It is important to start physical therapy within two to three days after surgery. The goal of physical therapy is to first assess how your hip responded to the surgical procedure, therefore they will remove your dressing and look at your wound. They will re-introduce you to your hip so that you feel comfortable with your surgery and aren't afraid to start doing things. Your therapist will start range of motion, gait, and strength exercises on your first visit. If they find anything unexpected they will let Dr. Joyce know right away.

Follow up appointment:

We try to give all of our patients a follow-up office visit at the same time we schedule your surgery. Sometimes I find things, or do things, I didn't anticipate during your surgical procedure; therefore I may want to see you in the office sooner than originally planned.

Typically I want to see my patients in the office 10 to 12 days after surgery if they are going to physical therapy at HealthSouth, and 2 to 3 days after surgery if they are going to any other physical therapy facility.

Medications:

I will usually prescribe two medications for the control of your post-operative pain. During surgery I will often inject a painkiller, like novocaine, that will give some pain relief for several hours after surgery. It is important to begin to take your pain pills before this medicine wears off.

This first medication I use is Vicodin (hydrocodone) which is a strong narcotic pain medication. It will begin to work within 15 minutes after taking it with a maximal effect in one to two hours. For some sensitive patients, when taking the first few doses of Vicodin you may experience nausea or an episode of vomiting. The best way to prevent this is to take the medicine with a little food, start with just one pill, and be patient while the medicine begins to

work. Usually, after the first few doses the nausea will go away. If the nausea persists, it is possible that a similar response will occur with other narcotic pain pills, therefore we should try the Anaprox as the main medication to control your pain. It you take a full dose of this medication for more than 4 or 5 days it can lead to constipation. Normally, Vicodin is taken every 6 hours but if the pain is severe, it can be used every 4 hours.

The second medication I prescribe is Anaprox, which is a non-narcotic painkiller in the NSAID class. The advantage of this medication is that nausea is a very infrequent side effect and it can also be taken with the Vicodin for even better pain control than any pain medication alone. This medication should be taken with food.

Many patients end up taking the Vicodin at night and the Anaprox during the day. Whatever combination works best with you is fine with me.

DVT Prophylaxis – Prevention of Blood clot following surgery:

The risk of a leg blood clot following minor surgery is very rare. The majority of patients that suffer this complication usually have a prior history of a blood clot, or a positive family history of DVT. The medical literature is unclear what method of prevention is best, and you will find that each surgeon does this a little different. Upon my review of the medical literature I recommend for patients with no prior risk factors, over the age of 40, to take one baby aspirin (81mg) once a day for 45 days following surgery.

What to watch out for:

- Pain that is increasing every hour in spite of the pain medication.
- Drainage from the wound more than 2 days after surgery.
- Increasing redness around the hip
- Pain or swelling in your calf
- Fever greater than 101°
- Increasing pain with walking.
- Locking or catching within the hip that is getting worse not better.
- Unable to keep food or water down for more than one day.

Who To Call for Questions and Problems:

If you are having problems or there are questions you need answered then please call our office at 860-652-8883 and our nurse will help you. We are open between 8:30 and 4:30 pm, Monday to Friday.

We realize the after surgery some problems or questions are urgent and can not wait until normal working hours. Under these circumstances please call 860-652-8883 anytime (24 hours a day, 7 days a week) and the doctor on-call, or myself will return your call. If you do not receive an answer within 20 minutes there may be a problem with the beeper so please call again.

If an emergency were to occur you can always go straight to the emergency room for immediate attention.

Wishing you - All the Best,
Michael Joyce, MD