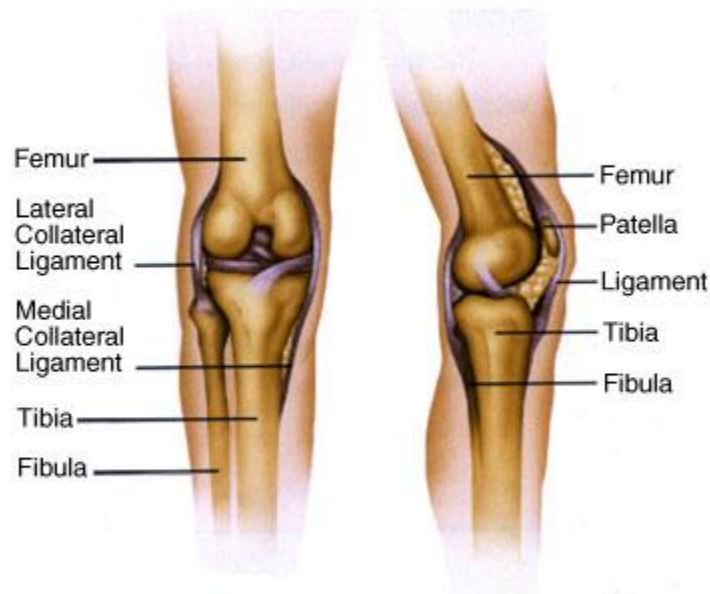


The Knee Joint

The knee is the largest joint in the body. This joint is formed by the end of the femur (thigh bone), your tibia (shin bone), and patella (knee cap). The femur rotates on the tibia while the patella glides in a groove on the femur, creating knee motion. There are many surrounding tissues, ligaments and tendons that stabilize this large joint. The main muscles used in knee motion are the quadriceps, located in the front of the thigh, and the hamstrings, located in the back of the thigh. These muscles provide the knee with its main movements: flexion (bending) and extension (straightening).



The joint surfaces on the end of the femur, top of the tibia, and back of the patella, are covered by a layer of tissue called articular cartilage. This very important cartilage cushions the bones and allows the joint to move smoothly. Healthy articular cartilage is hard, smooth and shiny. The joint is also lined by a thin membrane, synovium, which produces synovial fluid, a thick substance that lubricates the knee joint and decreases friction. In a healthy knee, the bones, muscles, and tissues work together in harmony. But disease can disrupt the harmony, resulting in pain, stiffness, deformity, and decreased function.



Arthritis

The most common cause of chronic knee pain and disability is arthritis. This condition is caused by an injury to the articular cartilage in the joint. As the articular cartilage deteriorates, the joint space between the bones narrows. With progression, the cartilage is worn away and the bones react by becoming thicker and creating bone spurs, known as osteophytes. The synovium (joint lining) becomes inflamed and thickened, producing extra fluid in the knee joint, called an effusion. In advanced cases, the articular cartilage is completely worn away allowing the bone ends to rub on each other and further advance the degenerative process. This also can cause a noticeable deformity. As the arthritis progresses, patients may notice they are bow-legged (genu varus) or knock-kneed (genu valgum).

The most common types of arthritis present in three main forms: osteoarthritis, rheumatoid arthritis and traumatic arthritis. Osteoarthritis is a degenerative process in the bone and cartilage where progressive wearing of the joint surface causes pain, stiffness and deformity. This process is a natural result of time and “wear and tear.” Rheumatoid arthritis (RA) is an autoimmune disease affecting the joint lining. The chronic inflammation of RA can erode the healthy cartilage and bone, resulting in severe pain, stiffness, inflammation, swelling and joint destruction. Post-traumatic arthritis is seen after an injury where the cartilage has been affected. Over time, the cartilage wears and patients develop pain and decreased motion.

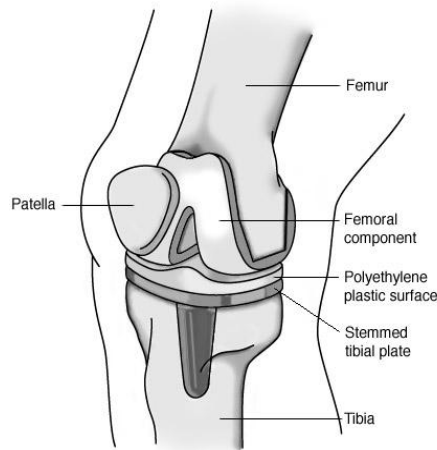
Treatment Options



Conservative treatments such as non-steroidal anti-inflammatory medications, physical therapy and weight loss are recommended as first line treatments. **Physical therapy** can treat stiff and weak joints by improving knee motion and strength. Oral medications such as **anti-inflammatories** improve pain by decreasing the inflammation in the joint associated with arthritis. More invasive treatments include intra-articular or joint injections. Some patients may benefit from a **steroid**

injection, which is a powerful anti-inflammatory medication that can relieve a patient of their arthritic symptoms for two to six months, on average. Patients with mild to moderate arthritis may be candidates for **joint fluid therapy**. This is a series of weekly injections into the knee joint. The thick substance, hyaluronan, is a chemical naturally found in the joint tissues and synovial fluid. It improves the quality of the fluid in the knee joint to increase its lubricating effect.

If a patient has failed the above treatment options or their arthritis is so advanced, a **joint replacement** is considered. During surgery, the diseased bone ends of the femur and tibia are cut away and replaced by a smooth, metal covering, called a prosthesis. A plastic liner is placed between the metal components acting like a shock absorber. The arthritis on the back of the patella is also removed and replaced with a small piece of plastic. All of the metal and plastic components are fixed into place with special bone cement, allowing the patient to walk on the surgical knee immediately after surgery.



Surgical Risks and Possible Complications

With any surgical procedure, there are always risks associated. It is important that you are aware and understand the risks associated with a total knee replacement.

- **Infection:** Every precaution is taken to ensure that your new prosthetic joint will not become infected during or immediately after surgery but on average, 1-2% of total knee replacement patients develop an infection. This may require additional surgeries to treat the infection, including, removing the entire prosthesis and treatment with 6 weeks of intravenous antibiotics before placing a new knee joint.
- **Blood clot (Deep Vein Thrombosis):** Patients undergoing orthopedic procedures, especially hip and knee replacements, are at increased risk of developing blood clots in their lower extremity. A small piece of a clot may dislodge and travel to the lungs causing a pulmonary embolism. After surgery, you will be treated with blood thinners, compression stockings and mobilization to help prevent blood clots.
- **Neurovascular damage:** There is a very small possibility that an important structure such as a nerve or vessel is injured during surgery. If so, this may leave you with a neurologic deficit, such as numbness or tingling, or poor circulation after surgery.
- **Loosening of the prosthesis:** With time, the cement wears, can crack and the prosthesis may become loose, requiring a revision surgery.

- **Death:** Any time anesthesia is administered, there is the risk of death either during surgery or after due to medical complications.

A total knee replacement is an elective surgery. Only you, the patient, can decide when your pain and loss of function is so great as to warrant a surgical procedure. You will make the final decision to proceed with surgery.

Surgical Preparations

Once you have made the decision to proceed with surgery and have chosen a date for your knee replacement, it is time to start planning for the procedure and your recovery. It is best to prepare early. Arrangements should be made to meet with the following people before your surgical date:

Orthopedic Surgeon: Your surgeon will meet with you a few days before your scheduled surgery to finalize plans and answer any remaining questions you may have. The procedure, including risks and benefits, will be explained thoroughly to ensure complete understanding.

Sun Health Total Joint Replacement Class: This very important class is held every Friday at Del E. Webb Hospital. You will have a chance to meet the surgical, nursing, and therapy staff, who will assist in your care during your hospitalization. This informational session will walk you through your hospital stay, expectations, goals and discharge planning. You will feel more prepared for surgery and many of your questions will be answered.

Primary Care Physician: We would like you to see your primary physician for medical optimization and clearance before your surgical procedure. Your primary doctor will review medical risk factors you have for surgery, discuss your medications and make appropriate changes. Please call for an appointment with your primary physician after choosing a surgical date. You will need laboratory tests and other studies before surgery. If you have questions about what tests you need before surgery, our surgical schedulers can help you.

In the hospital, your primary physician is invited to assist in your care after surgery. If your doctor is not available at the hospital, a covering doctor may see you.

Pre-anesthesia Interview: A surgical nurse who is specially-trained to prepare you for surgery will talk with you within a week of surgery and answer any questions about anesthesia. The nurse will review your medical information, test results and preoperative orders to ensure you are medically ready for your surgical procedure.

Social Worker: For some patients, it may be helpful to meet with a social worker or case manager before surgery. This will be arranged on an individual basis. If you have a concern which is best addressed by a social worker, please inform your surgeon's staff.

Home Planning

Recovery is a gradual process and made easier by planning ahead. Consider the following items in preparing for your return home before your surgical procedure:

- Ask your spouse, children, friends or neighbors if they can assist you for a few weeks after your surgery.
- To simplify cooking, prepare a few meals in advance and freeze them.
- Place all kitchen utensils, bathroom supplies, wardrobe necessities in an easy to reach place so than you will not need to bend or reach to retrieve them.
- Remove throw rugs and clutter from traffic paths.
- Arrange your bedroom to allow extra space to get in and out of bed while using your walker, cane or crutches.
- Place a sturdy chair, not a recliner, with a firm seat cushion and arms near a table for reading material, television remote, telephone, and other supplies you may want. It is also helpful to have a footstool to elevate and straighten your knee.
- Ensure your safety during showering with a safety bar or hand rail in the shower and a bench or chair to sit on.
- If you have a low toilet, a toilet seat riser with arms will make getting on and off the toilet much easier.

Medications

There are some medications which are important to stop before surgery. If you are taking any of the medications below, please discontinue them as indicated, unless otherwise discussed with your surgeon. Some medications can not be stopped due to medical conditions; your surgeon and primary physician will address this.

- **Aspirin and aspirin containing products:** 10 days before surgery
- **Non-Steroidal Anti-Inflammatory (NSAIDs):** seven days before surgery
 - This includes: Ibuprofen, Advil, Naprosyn, and Aleve
 - This does **NOT** include: COX-II inhibitors such as Bextra or Celebrex
- **Coumadin (Warfarin):** usually five days before surgery. **This needs to be discussed with your primary physician.** For some patients, “bridge therapy” with low- molecular weight heparin injections may be beneficial between the time you discontinue your Coumadin and a day before surgery. A blood sample may be drawn the morning of surgery to check your blood’s clotting ability.
- **Steroids and Immunosuppressant’s (e.g. Prednisone, Arava, Enbrel, Methotrexate, etc.):** Optimal to discontinue before surgery, but this will be discussed between you, your surgeon, and your primary physicians.

Stop Smoking

If you are a smoker, we recommend you stop smoking before surgery and continue to not smoke until your wound is healed or give up smoking all together. Smoking affects your body in many negative ways, including: decreasing your body’s ability to heal your wound, fight infection, and prevent medical complications.

Change in Medical Condition

If there is any change in your medical condition before surgery, such as: fever, cough, vomiting, diarrhea, skin breakdown, or other concerns, please notify your primary physician and your surgeon.

The Night before Surgery

Do's and Don'ts

- Do take a shower the night before surgery; lightly scrub your affected knee and entire leg with the chlorhexidine scrub that your surgeon provides you. Wash the rest of your body with anti-microbial soap and water. Do not apply any lotion or ointments to the skin on your affected leg.
- Do eat a light meal the night before surgery.
- Do pack a hospital bag with your necessities such as your personal care items, non-skid slippers, a comfortable robe, and an outfit to wear home. A jogging suit, sweat pants, or loose fitting slacks would be most suitable. It's also a good idea to bring some reading material or activities to do during your hospital stay.
- Do bring all of your medications in their bottles to show your nurse.
- Do remove all nail polish.
- Do bring your walker to the hospital before discharge to trial with the therapist.
- Do NOT shave the area of surgery. If necessary, your surgeon will take care of it in the operating room.
- Do NOT eat or drink anything after midnight. When you arise in the morning, you may take your morning medications with a small sip of water.
- Do NOT bring any jewelry, cash, credit cards, or important items with you to the hospital. It is best these stay safe at home.
- Do NOT take your own medications in the hospital unless specifically told to do so.

The Day of Surgery

Morning of Surgery

Complete your usual morning routine the day of surgery including taking your instructed medications with a small sip of water. It is best to leave your skin clean and not apply make up or any heavy lotions. Arrive at the hospital at your instructed time, ready for surgery.

At the Hospital

You will be checked in by the surgical staff and brought to the preoperative area to prepare for surgery. Here you will be asked to change into a hospital gown with support stockings. All your personal items will be marked and placed in a bag for you after surgery.

Once you are dressed, your nurse will take a complete set of vitals including blood pressure, heart rate, temperature, respiratory rate, and oxygen level. An intravenous line will be placed to administer fluids into your vein. Because you have been fasting, your body will require fluid supplementation through this intravenous line. It is also an access to administer medications during and after surgery.

The anesthesiologist will meet with you in the preoperative area. They will discuss with you the available types of anesthesia, recommendations, and answer any questions you may have.

Before being transported to the operating room, your surgeon will mark your operative site. It is also a good idea to empty your bladder before going to the operating room.

There will be a designated area for your family and friends to wait while you are having surgery. A surgical communicator will be available to keep your family and friends aware of your progress. Your surgeon will contact them shortly after the completion of surgery.

Operating Suite

Once you have been prepared in the pre-operative area, you will be brought back to the operating suite. Here you will meet many faces, all whom play an important part in your surgery. The operating room personnel will help you onto the operating table and make you comfortable. Your surgeon's staff will be present to ensure proper positioning and to prepare your knee for surgery. Once the anesthesiologist starts your anesthesia, you will fall asleep. If you have chosen to receive a spinal instead of general anesthesia, this will be performed. You will then receive sedating medications to keep you relaxed.

Post-Anesthesia Care Unit

After your surgery has been completed, you will be transported to the post-anesthesia care unit (PACU). Here, the nursing personnel will place you on monitors to follow your blood pressure, heart rate, oxygen level, alertness, along with your pain level. An important part of the PACU is to ensure that you are comfortable and stable after surgery. Pain medications will be administered as needed through your IV line. Often patients are nauseated after surgery and your nurse can give you medications for this. Oxygen will be administered through a facemask upon arrival and will be removed as you become more alert. Warm blankets are available to keep you warm and comfortable.

The average stay in the PACU is one to two hours, but can be longer. Your family and friends will be notified of your progress. Once transfer criteria has been met and your nurse feels you are ready to leave the PACU, you will be brought to your hospital room. Your family will be notified and can then meet up with you in your hospital room.

Arrival on the Orthopedic Floor

After surgery and your PACU stay, you will be transferred to your hospital bed on the orthopedic floor. Here, highly-trained nurses and staff who specialize in orthopedic patients will care for you. Upon arrival to the floor:

- A nurse will meet you in your room
- A set of vital signs will be taken
- Your surgical dressing will be checked
- If a surgical drain is present after surgery, this will be monitored frequently.
- Your foot will be closely monitored for warmth, pulse, sensation and movement. If you experience any numbness or tingling in your foot, heel pain, or increased discomfort, you should alert your nurse.
- The IV will keep you hydrated.
- Your pain will be closely monitored and treated as necessary with oral pain medications and intravenous narcotics as needed.
- A compression stocking (TED) will be placed on your non-operative leg along with a squeezing device to promote circulation.



Your Hospital Stay

Many people will participate in your care after surgery. There is direct communication between all providers including your surgeon and their staff, the medical doctors, nurses, therapist, and the case manager. If you have any concerns or questions at any time, please discuss these with any of your healthcare providers who will then address it appropriately.

Pain management

After surgery, it is normal to have pain or discomfort. Inform your nurse if you are uncomfortable and they can administer appropriate medications. You may be asked to rate your pain on a scale of 1-10, with 10 being the worst pain ever. If your pain is not being relieved with the ordered medications, your surgeon should be notified. The goal is to control your pain so that you can begin aggressive therapy immediately after surgery and start on the road to recovery.

If you are not nauseated after surgery, you will be able to start on oral pain medications immediately. Otherwise, you may receive intravenous medications. By postoperative day one, we would like to have your pain managed by oral pain medications. With new surgical techniques including smaller incisions, less invasive surgery, and local anesthesia, patients have less postoperative pain that can be treated with lower dose pain medications. This allows you to feel less groggy and be more active with therapy.

Antibiotics

Antibiotics will be administered through your IV before and after surgery. Usually patients will receive antibiotics for the first 24-48 hours after surgery. Antibiotics are important to reduce your risk of infection after surgery.

Diet

Once you are alert and feeling well, you may begin taking oral liquids such as ice chips and water. If you tolerate this without nausea, you can order a light meal the night of surgery or the following day. It is important to advance your diet slowly. If you do become nauseated or vomit, you should stop eating and notify your nurse who can administer medications to relieve this. Restart with liquids once you are feeling better. You must tolerate a regular diet before you leave the hospital.

Breathing

After surgery, it is important to exercise your lungs. You will be given an incentive spirometer upon arrival to the hospital floor and instructed on its use. Take a slow, deep breath in, hold it for a few seconds and then breathe out. You should feel your lungs expanding. The spirometer will help you monitor the volume of air you are taking in. Work on increasing this volume daily. It is important to exercise your lungs frequently throughout the day. You will be encouraged to use your incentive spirometer 10 times every hour that you are awake.

Circulation

It is important to promote circulation after any surgery, especially after orthopedic surgery. This will help decrease your chance of forming a blood clot. Immediately after surgery you will have a surgical dressing on your operative leg and a support stocking (TED hose) on your non-operative leg. On postoperative day two, your surgical dressing will be removed and your new dressing held in place by a TED hose. You should wear your support stockings (TED hose) throughout your hospital stay and for the following six weeks. Another circulatory aid is a compression device, which will also be used after surgery. The sequential compression device (SCD) is a sleeve that wraps around your lower leg, routinely inflating to promote circulation. When you are resting in bed, the SCD should be used. If you experience discomfort, tingling or numbness, you should notify your nurse immediately.

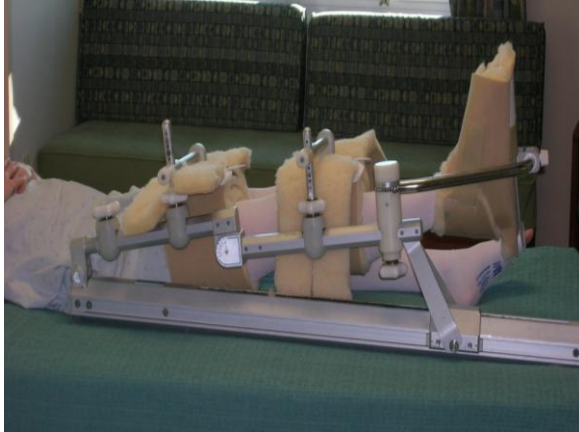


A blood thinner will also be started after surgery to reduce your risk of blood clots. Starting the day after surgery, you will receive a superficial injection of a blood thinner in the skin on your abdomen. This will continue while you are in the hospital. You will be discharged from the hospital on either 325 mg of aspirin twice a day or Coumadin (Warfarin), depending on your other medical conditions and your risk of blood clots. These medications are continued for six weeks, or until you have returned to an active lifestyle.

An easy way to help prevent blood clots is to increase your circulation with activity. Work on your exercises a minimum of three times a day and walk regularly after surgery. It is important to remain as active as possible. This is also good for your overall health.

Activity

The evening of surgery, the nursing staff will help you get out of bed and up in a chair. They will discuss activities you can do on your own to encourage motion and promote circulation. The physical therapist will also see you the evening after surgery and help you ambulate. You will be fitted for an appropriate gait aid such as a walker or cane to assist you during recovery. If you have these items at home, please bring them to the hospital.



This same evening, you will begin your therapy in a continuous passive motion (CPM) machine. This special device attaches to the end of your bed and slowly moves your knee to increase your knee motion and prevent stiffness. Your leg will be positioned in the device to allow your knee to bend and straighten slowly. The machine will be closely monitored by the nursing staff and adjusted as your motion advances. You should not adjust the CPM machine yourself. If you experience any increase in discomfort, numbness or tingling in your foot, you should notify your nurse immediately. You will utilize the CPM machine daily to improve and retain the motion of your surgical knee. Most patients do not need a CPM after they are discharged from the hospital.

Throughout your hospital stay, you will be encouraged to work on your exercises in your room and ambulate through the halls. In the beginning, you will likely need assistance when transferring from the bed, completing your daily tasks, and ambulating. The nursing staff is available to help you. Your family and friends may also participate in your care and help you with your activities.



Postoperative Therapy

Therapy is an important part of your hospital stay and vital to your overall success after surgery. The physical therapy staff will work with you twice a day starting the evening of surgery. They will assist you with mobilization and ambulation, increasing your knee motion, and improving your strength and overall condition. The therapist will also instruct you on a regular exercise program that you will do in the hospital and should continue after your discharge.

<u>Therapy Schedule</u>	<u>Out of Bed</u>	<u>Ambulate</u>
Evening of surgery	once minimum	25 feet with therapy
Postoperative day one	three times minimum	50 feet in am, 100 feet in pm
Postoperative day two	three times	150 feet in am, 200 feet in pm
Postoperative day three	three times	greater than 200 feet

After your discharge from the hospital, you will need to continue with aggressive physical therapy. This can be done with home therapy or as an outpatient. These options will be discussed with you by the case manager and all arrangements made before you leave the hospital. It is very important that you continue to work hard on your exercises and advance your activity after discharge. The goal range of motion of your new knee is 0 to 90 degrees at your two week recheck visit and 0 to 110 degrees at eight weeks after surgery. Your therapist will help you work toward and maintain these goals.

Recovery

The goal of recovery is to help you become as independent as possible and return to an active lifestyle. You will be encouraged throughout your hospital stay to participate in your healthcare and therapy. It is also important to involve your family and friends in your care. If you have any special needs or requests, please feel free to ask.

Care after Surgery

Surgical Incision

You have a surgical wound that requires daily attention and monitoring. You should keep a clean gauze dressing over your wound, changing it daily after discharge. You can use your compression stocking to secure your dressing. Please keep your incision clean and dry at all times. Five days after surgery you may shower, lightly washing your incision with an anti-bacterial soap and water. If your incision is draining or does not appear to be healing well, do not shower and notify your surgeon. Do not immerse your incision in water for a total of six weeks after surgery. This includes pools, hot tubs, lakes, and bath water. You don't need to apply any special creams or ointments to your incision unless prescribed by your surgeon. Your healed wound is new skin and should be protected from the sun with sun block for the first year after surgery, then as needed.

Monitor your incision daily for signs and symptoms of infection which may include: redness, swelling, warmth, drainage, increase in pain, or a fever over 101 degrees. If any of these arise, please notify your surgeon immediately. It is normal to have some redness, swelling, and warmth after a knee replacement, but if it seems to increase or worsen, this should be evaluated.

A follow-up appointment for a wound check and staple removal will be made for you two to three weeks after surgery. You will be discharged from the hospital with your surgeon's card and phone number to The CORE Institute. Please call to arrange your follow-up appointments.

Blood Clot Prophylaxis

After an orthopedic procedure, patients are at an increased risk for developing blood clots or DVT (deep venous thromboses) in their lower extremities. A systemic complication of a DVT is a pulmonary embolism (when a piece of clot breaks off and travels to your lungs). In order to minimize the risk of blood clots, patients are treated with low molecular weight heparin injection (Fragmin), a blood thinner, immediately after surgery followed by aspirin therapy. Upon discharge you should take one 325 mg enteric-coated aspirin twice daily for six weeks total. Alternatively, some patients may be discharged on warfarin (Coumadin), a prescription blood thinner. This medication requires frequent monitoring of blood levels and patients will receive specific follow-up instructions if they are taking this medication. You should also wear your compression stockings that were given to you in the hospital for six weeks after surgery. These stockings should be worn at all times, with the exception of showering and sleeping at night. Remain as active as reasonably possible, as this also helps decrease your chance of blood clot formation and improves your overall health. Let pain be your guide when deciding on appropriate light, low-impact activities.

Please monitor for potential signs and symptoms of a deep venous thrombosis or pulmonary embolism, which may include: swelling or tenderness in the calves or legs, shortness of breath, heart palpitations, chest pain, or increased heart rate. If any of these symptoms arise, you should notify The CORE Institute immediately and present to the emergency room.

Pain Management

After a major orthopedic procedure, most patients will require prescription pain medications, including narcotics, to treat their postoperative pain. Medications such as Percocet (Oxycodone), Vicodin (Hydrocodone), Darvocet (Propoxyphene), and Codeine are all controlled narcotic pain medications that need to be monitored closely. With chronic use, they pose a risk for addiction. Patients should treat their pain only as needed with these medications and wean off of the narcotics in the first few weeks following surgery. These medications can cause many side effects,

which may include nausea, lightheadedness, confusion, sedation, urinary retention, and constipation. To avoid constipation, please take an over-the-counter stool softener such as Docusate or Senna.

If you require a refill on your narcotic pain medication, please notify your surgeon early. Federal law prohibits the renewal or refill of most narcotic pain medications by phone, therefore requiring a written prescription. Please allow sufficient time for your surgeon to complete a new prescription that may be either mailed to you at your home or picked up in person. Narcotic pain medications can NOT be renewed after hours or on the weekends. If you have questions regarding your prescriptions, pain, or find that your pain is not relieved by your prescription medication, please notify your surgeon.

Activity

You will receive therapy instructions before your discharge from the therapy department. Please follow these recommendations. Allow time a minimum of three times a day to aggressively work on your therapy at home. The first six to eight weeks are the most crucial for obtaining good motion in your new knee. Most patients will be referred to outpatient physical therapy after their hospital stay. A few patients may benefit from inpatient rehabilitation and this will be discussed on an individual basis. Your goal will be to reach at least 0 to 90 degrees by your two week wound check visit. The more energy you put into your own rehabilitation, the better the results. The CORE Institute wants you to enjoy an active and healthy lifestyle. Feel free to contact your therapist or your surgeon at any time regarding your therapy progress.

As your therapy advances, you will be able to quickly put aside your gait aid and walk without difficulty. We encourage you to exercise daily, whether this is walking, swimming (after six weeks), bicycling, or golfing (after six weeks). Avoid high impact activities such as jogging, basketball or heavy weight lifting. We recommend you do not repetitively lift over 40 to 50 pounds. Ease into activities slowly to see how your knee will respond.

You may begin driving if you are able to get in and out of the car, move about in the seat, and react quickly, moving your foot to and from each pedal. You should be able to put all your weight on your knee and not require the assistance of a walker, cane or crutch.

Antibiotic Prophylaxis

You now have an artificial joint which is at risk for bacterial infection. Anytime you have a bacterial infection, it should be treated immediately with an appropriate antibiotic. Viral illnesses do not require antibiotics.

Antibiotics should be taken before any dental, genitourinary, or gastrointestinal procedures such as: dental cleanings, oral surgery, bladder scopes, urinary catheterizations, colonoscopy, and/or flexible sigmoidoscopy. If there is any question if you should take an antibiotic or not, it is always safer to do so. But, feel free to call The CORE Institute. The recommended antibiotic regimen is:

- **Two grams of oral Amoxicillin one hour before a procedure**

Penicillin allergic patients may take either two grams of Cephalexin or 600 mg of Clindamycin. A card outlining this will be given to you. Please ask your nurse or surgeon if you have not received this wallet-sized card.

Respiratory

You will receive an incentive spirometer in the hospital. This is to help exercise your lungs after surgery. Take this device home with you and continue to use it regularly. The incentive spirometer along with daily activity will help prevent respiratory complications such as pneumonia. If you develop a cough, shortness of breath, thick and copious sputum, or a fever greater than 101 degrees, please notify your surgeon and primary care physician.

Physical Therapy after Discharge

Therapy is an important aspect of your recovery after surgery. You need to concentrate on your therapy exercises a minimum of twice a day and attend therapy sessions three times a week the first few weeks after surgery. Walking is a great activity after surgery along with completing your range of motion exercises. While in the hospital, the case manager will work with you to set up your therapy appointments for after discharge. Most patients will be referred for outpatient physical therapy, which takes place at a therapy center. Some patients may qualify for home physical therapy, in which a home health agency will come into your home to help you advance your therapy three times a week. The CORE Institute promotes outpatient physical therapy when at all possible. We have our own physical therapy center which is set-up to help you achieve your therapy goals. We want you to get back to your normal daily activities.

Goal range of motion after total knee replacement:

0 to 90 degrees two weeks after surgery (minimum)

0 to 110 degrees eight weeks after surgery (minimum)

If you have questions about your therapy schedule after discharge, please call:

The CORE Institute Therapy Department at 623.537.5600,
or the case manager on 4C at Del E. Webb Hospital at 623.214.4044.

Ongoing Care

A member of the surgical team would like to see you back two to three weeks after surgery for a wound check and staple/suture removal. At approximately eight and 16 weeks postoperatively, you will return for radiographs followed by an examination. If needed, your surgeon may ask you to return for a recheck at a time other than stated above. Each patient is an individual and may require a different follow-up schedule. Your first follow-up visit is usually arranged before surgery. If you did not receive an appointment or are unsure of your follow-up, please call our office.

Questions

The CORE Institute is dedicated to your outcome. We are here to answer any question or concern that may arise after your surgery.

Please do not hesitate to contact us at: 1.866.974.2673.