Timing and Patient Preparation for Joint Replacement

"Don't ask the barber if you need a haircut" – Warren Buffet

The Alternatives-Risks-and-Benefit Equation of Medical Therapeutics

Most patients whose hip, knee, or shoulder is worn to the point that there is "bone-on-bone" contact greatly benefit from joint replacement and few gain durable relief from a lesser operation. However, about 3% of patients that choose to have a joint replaced will experience a major complication, which may place them in worse straits than they were before the operation.

There is always the option not to operate and many patients obtain partial relief of arthritic symptoms by improving their general fitness, weight loss, activity modifications, physical therapy, medications and supplements, or joint injections.

Most insurance companies now insist on a three-month trial of conservative care before issuing authorization for a hip, knee, or shoulder replacement. This is a reasonable prerequisite because even if the non-operative intervention does not provide a durable result that preempts joint replacement, it likely will expedite postoperative recovery.

The risk of a major complication can be minimized and the postoperative recovery can be expedited by preoperative preparation. The degree of "pre-hab" varies, based upon the physical and psychological condition of the patient and their social circumstance.

For the younger "fit" patient, the preparation might be limited to the following:

1. A one-hour "joint camp" session at the hospital where the procedure will be performed.
2. One to two sessions of physical therapy to preview postoperative rehabilitation and safe mobility.
3. Planning for 1-2 night stay post-operatively and 2-4 weeks off work with the close support of a friend or family member for the first week after surgery.

For the elderly or medically complex patient, additional preparation might entail:

1. A medical clearance and optimization by their primary medical provider or medical specialist.
2. Arranging for the support of close family member or friend for 3-6 weeks postoperatively or, when that level of support is not available, consideration for placement in an assisted living facility or skilled nursing facility after 2-3 nights of acute hospital stay.
3. "Pre-hab" of 6-12 weeks to improve fitness for surgery.
4. Optimal medical management of depression.

Patients that use nicotine can reduce complications by being abstinent of all nicotine sources (cigarettes, chew, snuff, cigars, patches, inhalers, or gum) for a month before surgery and for several months afterward.

Patients that regularly use narcotic medications can reduce their risk of complication by tapering their medications, under the supervision of their pain management physician, to less than the equivalent of 10mg of oxycodone a day.

Patients with a mood disorder ought to have that problem optimally managed by their primary provider before surgery and may require close observation, support, and management by friends, family, and their primary medical provider for several months after surgery.