As soon as you feel comfortable and safe you can go on one crutch and then no support. The period of using crutches differ from patient to patient from one day to four weeks, there is fixed period and crutches should be used as needed.

On discharge you should be self-sufficient; you would be able to dress, take a shower and make a cup of tea. You can drive a car as soon as you feel confident doing so, and on average it will take 2-4 weeks.

We will give you an exercise program which you can do at home and in most case we found it to be sufficient. However if you do not progress or feel unsure about your knee please get help from a physiotherapist.

Expect your knee to be warm and swollen for at least 6-12 weeks after the surgery.

LONG-TERM
We expect that you will be able to walk well within 4-6 weeks after the surgery. It is important to realise that complete healing is a slow process which will continue for up to 18 months. In the long term we expect that you will become unaware of your knee.

You will probably be aware of some clicking in your knee, this is normal and caused by the metal hitting the hard plastic.

You will have a numb feeling on the outside of the scar, this cannot be prevented but will slowly decrease although a small area might have permanent numbness.

Long haul, international flights should preferably be avoided in the first three months post surgery; local flights are not a problem. The prosthesis will set off metal detectors at the airport, wear loose fitting clothes allowing you to show the surgery scar to the security personnel.

Should you develop any septic area or a tooth abscess it is important to have it seen to and take the necessary antibiotics. We recommend the following: Cepalexin (Keflex), Cephradine (Cefril), Amoxicillin (Amoxil, Augmentin) – if you are allergic to Penicillin you can use Clindamycin (Dalacin C).

We would suggest that no injection or aspiration is done on your knee except by an orthopaedic surgeon.
WHAT IS A TOTAL KNEE REPLACEMENT?
In your knee the joint surface, so called articular cartilage, is totally worn away with the result that you are walking bone on bone. Typically this causes pain and restricted function with weight bearing activities like walking, standing and getting up and at times even pain at rest. With a knee replacement the worn surfaces on the upper leg (femur) are replaced with a metal surface of 9 mm and the lower leg (tibia) and kneecap (patella) with polyethylene, a hard type of plastic also 9mm thick. To do this a thin part of the joint surface have to be removed to make space for the 9 mm linings as the original worn away surface was only 4 mm and the new artificial joint surface should sit at the same level.

In our practice, based on 30 years of experience with more than 6,000 knee replacements we expect the prosthesis to last for 20–25 years or even longer. If necessary, it is possible to redo a knee replacement although that is not the aim.

INDICATIONS FOR A KNEE REPLACEMENT
The reasons for replacing the knee is that the joint surface is worn away resulting in function loss and pain. We can determine the grade of wear by clinical and radiological examination but believe that you are in the best position to decide, according to your impairment and pain, when it should be done. From our point of view it is never urgent. From an activity point a replaced knee should allow you to walk and hike as much as you want, play golf and social double tennis; you will be able to run but we recommend that running be restricted to running away as it cause high loads over the replaced joint.

THE PROSTHESIS
We use three different prosthesis, all of them have a good international track record and also a good record in our practice over the long term.

POSSIBLE COMPLICATIONS
Like with all surgical procedures there is a possibility of getting a complication with knee replacement surgery. In our practice, spanning a period over 30 years and more than 5,000 replacements, the incidence of complications are five in a thousand (0,5%). We are specifically concerned about infections (0,3%), restricted range of motion (0.1%) and systemic complications (0.1%).

PRE-OPERATIVE
To reduce the possibility of complications we ask the pathologist to do the following examinations two weeks preoperative - full blood count, urea and electrolytes, urine examination and a nose swab. You should report any septic lesion like in grow toenails, tooth abscess etc. to us as they might need treatment before we can do a knee replacement. If indicated we might ask the anaesthetist to evaluate you two weeks or more preoperatively and if necessary he might refer you to a specialist physician or cardiologist.

MEDICATION
We would like you to stop the use of anti-inflammatory drugs (Celebrex, Voltaren, Brufen, etc.) at least 3 days preoperative as their use increase the risk of bleeding. Platelet inhibitors like Disprin, Plavix etc should be stopped 10 days before surgery. However in some cases it might be necessary that you continue with these medications notwithstanding the surgery and in that case you should contact us before stopping the medication.

If you are on Warfarin it should be stopped 4 days before surgery and replaced by other medication like heparin (Clexane, Fraxiparine). Women should stop hormone therapy at least 3 day preoperatively and not take it till at least 2 weeks after surgery.

If you take a regular drink it is important that you carry on as before in both frequency and volume, it will accelerate your recovery and decrease the use of sedative medicine. The hospital does not provide drinks, please bring your own supply.

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