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ORTHOPAEDIC SURGERY**

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Date:

Name:

DOB:

Dear ,

You are scheduled for **total knee replacement**. This document summarizes the discussion that you and I had about the benefits and risks associated with this procedure. Please read this document carefully, then acknowledge your understanding and agreement by initialling on the line provided before the various points. This will help ensure that you fully understand the implications of the decision to undergo this operation.

Please review the following points:

 1/ Purpose of operation. The primary purpose of this procedure is relief of pain. Secondary purpose of this procedure is to enhance walking ability. Tertiary purpose is to restore anatomy as closely to normal as possible. The prosthesis is designed for walking, even brisk walking. It is not designed to allow running etc.

2/ Risks of operation. It is not difficult to see how this operation may be beneficial to you. However, all of surgery carries inherent risks. Risks pertinent to this operation include the following:

 -*Risk of anesthesia*, general or spinal anesthetic. You will have the opportunity to discuss this further with the anesthesiologist.

 -*Risk of infection*. The infection risk is approximately 1:50 to 1:100. Superficial infection can be managed by antibiotics, and/or washout of the wound and surgical site. On occasion, the prosthesis will become infected. In this scenario, removal of the prosthesis, temporary placement of an antibiotic loaded spacer, and definitive placement of a new prosthesis after approximately two or three months would be necessary. This is a very grave complication, and is fortunately rather rare. Surgery to replace an infected prosthesis would normally be carried out in a university hospital. Extremely rarely, the infection cannot be controlled and a definitive prosthesis cannot be placed. This may lead to a 'flail knee', knee fusion ('stiff leg') or even amputation. Death from uncontrolled infection is extremely rare, but possible. The risk of infection is increased in the presence of smoking, diabetes, rheumatoid arthritis, and other conditions affecting the immune system. Of note, late infection can occur when bacteria circulate in the bloodstream, In situations such as invasive dental work, urology/gynecology procedures,

bowel procedures etc.. If possible, a discussion with the treating practitioner regarding the need for protective antibiotics should be carried out prior to performing these procedures.

_____ -*Injury to the neurovascular structures.* Important nerves and blood vessels are located around the surgical site. Great care is taken throughout the operation to avoid damage to these structures. However, on occasion damage to nerves can occur, possibly leading to numbness an/or weakness, possibly paralysis. This is very rare. Damage to the blood vessels is very rare as well. However, such injury could lead to rapid blood loss, and may lead to blood transfusion during surgery. As well, vascular repair could be necessary, ordinarily performed by a vascular surgeon on an emergent basis. This would require emergency transfer to a hospital providing vascular surgery. Fortunately, major vascular injury is extremely rare.

_____ -*Deep venous thrombosis/pulmonary embolism* and the need for anticoagulation. This operation can lead to development of a blood clot in the deep veins of the operated and/or non-operated leg. This impairs the circulation in the legs. Furthermore, parts of this blood clot can be released into the bloodstream, these can reach the heart and lungs and cause severe shortness of breath, even sudden death. In order to minimize this risk, you will be asked to start walking as soon as possible after the surgery. You will receive a blood thinner, low molecular weight heparin, for approximately one week. It is my preference that this is followed by another five weeks of aspirin use, 325 mg per day. As well, if tolerated, the compression stockings that will be provided to you in the hospital, should be worn for a total of six weeks. Under these circumstances, the risk of death from pulmonary embolism appears to be well below one in thousand. On occasion, this régime is modified based on other health concerns, which may necessitate assessment by a specialist in internal medicine. If a blood clot develops in the legs, this may lead to prolonged treatment with a blood thinner. If heart/lungs become involved, intensive care treatment may be required. These complications would ordinarily be treated by an internist.

_____ -*Possibility of a blood transfusion.* This operation will lead to some blood loss. Usually, this is between 100 and 500 ml. Most often, blood transfusion is not necessary. However, sometimes blood transfusion is offered when a combination of sleep deprivation, pain medication and blood loss prevent progression of the rehabilitation program. A blood transfusion may act as a 'boost', to allow mobilization, avoiding complications related to prolonged bed rest, such as development of a blood clot, pneumonia, etc..

3/ Expected postoperative course.

_____ -Mobilization after surgery is important to prevent complications, and to resume independent self-care as soon as possible. The degree of weight bearing that is allowed immediately after surgery is decided upon by the surgeon during surgery, depending on the achieved firmness of the fixation. With a non-cemented prosthesis, protected weight-bearing may be necessary for approximately six weeks, to allow on-growth of bone onto the prosthesis, leading to secure long-term fixation, without compromise of the position of the prosthesis.

_____ -Hospital stay is dependent on achieving pain control through medication by mouth, as well as achieving safe, independent, mobilization. Depending on circumstances, this usually means 1-5 days of hospital stay. Home care nursing is available within the first week, to ensure that the blood thinner régime is completed, and that no untoward complications occur. Dressing changes will be performed as necessary.

_____ -Physiotherapy starts immediately after the operation while in hospital. This is continued in the outpatient department after discharge from hospital. Most often, the final range of motion achieved is similar to the range of motion prior to surgery. Usually, arrangements for staple removal are made at the two-week mark, in the daycare department of Peace Arch hospital after a physiotherapy appointment.

_____ -I explained that, initially, residual discomfort and swelling are common. Numbness may be present around the knee. These issues usually settle in approximately six months, occasionally a year. Rarely, these can persist. Through use of less invasive surgery, I attempt to minimize residual pain from disrupted soft tissues.

_____ - Further standard follow-up will be at 8 weeks, 6 months, and one year. After this, yearly follow-up with X-rays is recommended, to allow early detection of possible problems with the prosthesis.

If after reading this, you fully understand the issues and wish to proceed, your signature on this document will confirm the previously obtained consent for surgery and blood transfusion.

Patient's signature:

Sincerely,

Arno Smit, M.D., F.R.C.S.C.

Cc: chart

OR-booking