

PATIENT INFORMATION BOOKLET

Total Hip Replacement Surgery

Piriformis-Sparing Posterior Approach

with Fast Recovery Programme

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1. Understanding Your Hip Joint

The hip is one of the largest and most stable joints in the human body. It is a ball-and-socket joint that allows a wide range of movement while supporting the full weight of your upper body. Understanding the anatomy of your hip will help you appreciate why hip replacement surgery is sometimes necessary and how the operation restores normal function.

Anatomy of the Hip

The hip joint is formed by two bones: the femur (thigh bone) and the pelvis. The rounded head of the femur (the ball) fits snugly into a cup-shaped socket in the pelvis called the acetabulum. Both surfaces are covered with a smooth layer of articular cartilage, which is approximately 3-4mm thick. This cartilage provides a near-frictionless surface that allows the bones to glide smoothly against each other during movement.

The joint is surrounded by a strong fibrous capsule that contains synovial fluid, which lubricates the joint and nourishes the cartilage. A ring of fibrocartilage called the labrum deepens the socket and helps to stabilise the femoral head within the acetabulum.

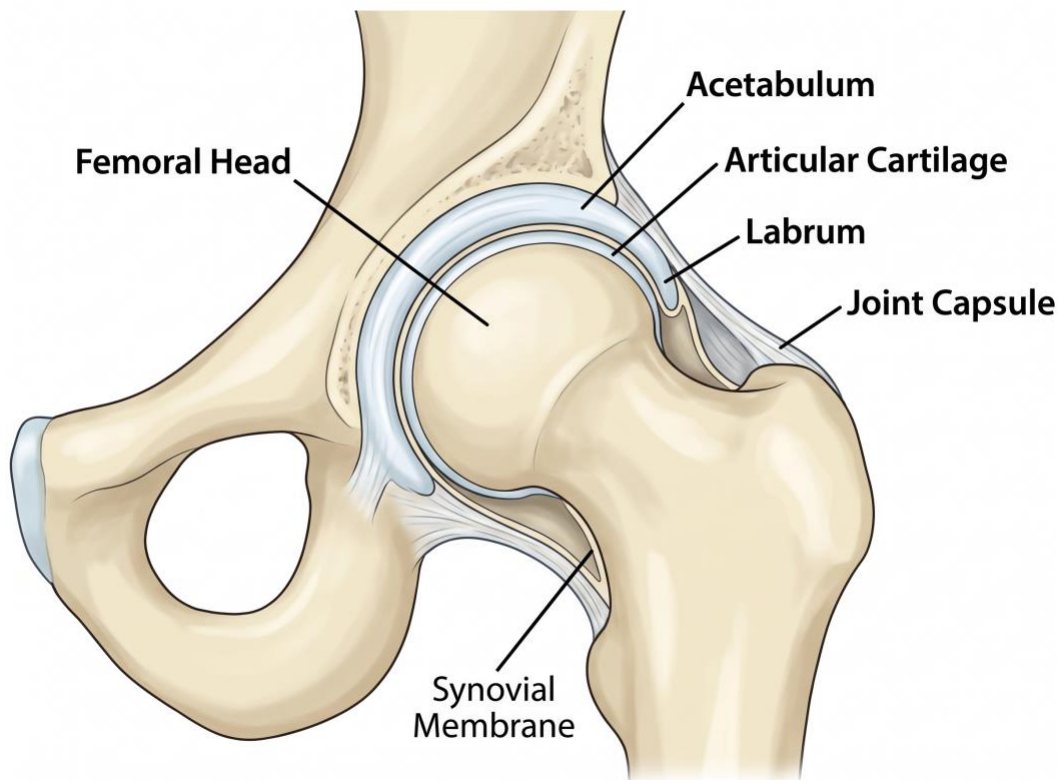


Figure 1: Normal hip joint anatomy showing the femoral head, acetabulum, articular cartilage, labrum, and joint capsule.

The Short External Rotator Muscles

Behind the hip joint lies a group of small but critically important muscles known as the short external rotators. These muscles — the piriformis, obturator internus, superior gemellus, inferior gemellus,

obturator externus, and quadratus femoris — work together to rotate your leg outward and provide essential posterior stability to the hip joint. They act as a dynamic muscular sling that prevents the femoral head from dislocating backwards.

The Piriformis Muscle

The piriformis muscle deserves special mention. It is the most superior of the short external rotators, originating from the anterior surface of the sacrum and passing through the greater sciatic foramen to attach to the top of the greater trochanter. It is a key landmark during hip surgery and plays a critical role in hip stability — it mechanically restricts internal rotation during weight-bearing and helps hold the femoral head within the acetabulum during flexion. Research has shown that preserving the piriformis intact during hip replacement significantly reduces the risk of dislocation and improves early functional outcomes.

Mr Dehne uses a piriformis-sparing posterior approach, which preserves the piriformis tendon intact while carefully detaching only the lower short external rotators (obturator internus and gemelli). Combined with separate repair of the capsule and remaining rotators, this creates a triple-layer stabilising structure that provides maximum hip stability from day one.

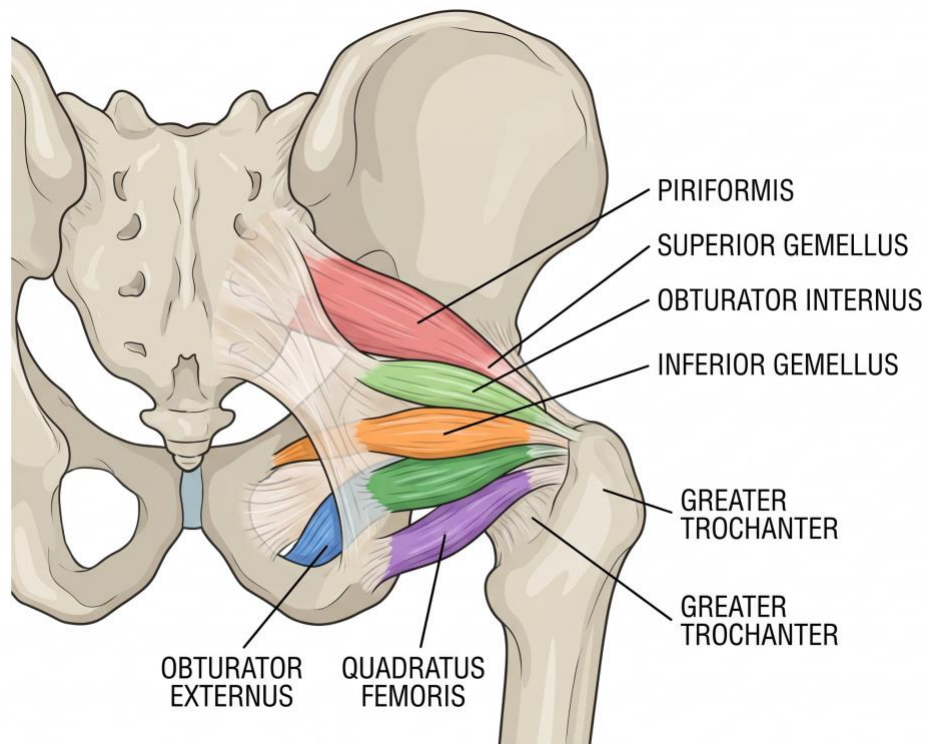


Figure 2: Posterior view of the hip showing the short external rotator muscles that provide stability to the joint.

Hip Movements

Your hip joint allows six types of movement: flexion (bending forward), extension (straightening back), abduction (moving the leg outward), adduction (moving the leg inward), internal rotation (turning the foot inward), and external rotation (turning the foot outward). A healthy hip allows approximately 120 degrees of flexion, 45 degrees of abduction, and 45 degrees of rotation. After hip replacement with Mr Dehne's technique, the goal is to restore full, unrestricted movement.

2. When Hip Replacement Is Needed

Hip replacement surgery is considered when the cartilage lining the joint has worn away, causing bone to rub against bone. This results in pain, stiffness, and progressive loss of function that significantly affects your quality of life.

Common Conditions Leading to Hip Replacement

Condition	Description
Osteoarthritis	The most common cause. Gradual wear of cartilage over time, often age-related.
Rheumatoid Arthritis	An autoimmune condition causing inflammation and cartilage destruction.
Avascular Necrosis	Loss of blood supply to the femoral head, causing bone death and collapse.
Hip Fracture	A break in the femoral neck that damages the joint beyond repair.
Post-Traumatic Arthritis	Arthritis developing after a previous hip injury.
Dysplasia	Abnormal hip development causing premature wear.

Signs That Surgery May Be Appropriate

Mr Dehne will discuss hip replacement with you if you experience several of the following:

- Persistent hip or groin pain that limits your daily activities
- Pain that disturbs your sleep despite medication
- Difficulty walking, climbing stairs, or putting on shoes and socks
- Stiffness that prevents you from lifting your leg or bending
- Pain that has not responded to physiotherapy, injections, or medication
- X-ray evidence of significant joint damage

The decision to proceed with surgery is always made together with you, taking into account your symptoms, functional limitations, general health, and personal goals.

3. The Surgical Technique

Mr Dehne performs total hip replacement using the piriformis-sparing posterior approach with a meticulous separate repair of the posterior capsule and remaining short external rotator muscles. This pioneering technique combines the excellent surgical exposure of the posterior approach with triple-layer stability: the preserved piriformis tendon, the repaired capsule, and the repaired lower rotator muscles.

The Posterior Approach

The posterior approach is one of the most widely used and well-established approaches for hip replacement surgery worldwide. It provides excellent visualisation of both the acetabulum and the femur, allowing precise placement of the prosthetic components. The incision is made on the back of the hip, following the line of the buttock crease, and is typically 10-15cm in length.

The key advantage of the posterior approach is that it does not damage the abductor muscles (gluteus medius and minimus) on the side of the hip. These muscles are essential for walking without a limp, and preserving them intact means patients can walk normally much sooner after surgery.

What Makes Mr Dehne's Technique Different: The Piriformis-Sparing Approach

The traditional concern with the posterior approach has been a slightly higher dislocation rate compared to other approaches. In the conventional posterior approach, all the short external rotator muscles — including the piriformis — are detached from the greater trochanter to access the hip joint. Even when repaired, studies have shown that 70-80% of these repairs rupture within the first six weeks.

Mr Dehne addresses this through a piriformis-sparing technique combined with separate dual-layer repair of the remaining structures. By preserving the piriformis tendon intact (never cutting it), the hip retains its most important posterior stabiliser from the moment of surgery. The remaining lower rotators and capsule are then repaired as two independent layers, creating a triple-layer stabilising construct:

Layer 1 — Piriformis (Preserved Intact): The piriformis tendon remains attached to the greater trochanter throughout the operation. It provides immediate dynamic stability from day zero, restricting internal rotation and holding the femoral head within the socket.

Layer 2 — Posterior Capsule (Repaired): The joint capsule is repaired as a separate, distinct layer using strong sutures back to the greater trochanter through bone tunnels. This recreates the primary passive restraint against posterior dislocation.

Layer 3 — Lower External Rotators (Repaired): The obturator internus and gemelli muscles are reattached over the repaired capsule as a third layer through bone tunnels. This provides additional dynamic muscular stability as these muscles heal.

PIRIFORMIS-SPARING POSTERIOR APPROACH

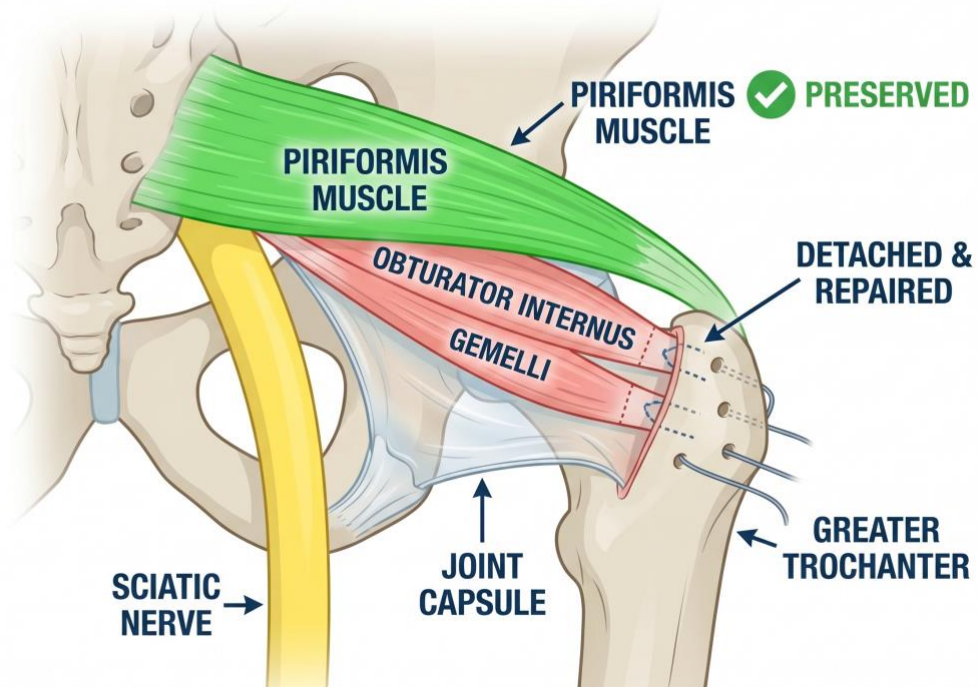


Figure 3: The piriformis-sparing posterior approach. The piriformis muscle (green) is preserved intact while the lower rotators (obturator internus and gemelli) are detached and repaired through bone tunnels in the greater trochanter.

The Surgical Steps

The surgical steps are as follows:

Step 1: Incision and Exposure — A carefully planned incision is made along the posterior aspect of the hip. The gluteus maximus muscle fibres are split along their natural direction (not cut), preserving muscle function.

Step 2: Identification and Preservation of Piriformis — The piriformis tendon is identified at the superior border of the short external rotators. It is carefully preserved intact — it is NOT detached from the greater trochanter. The gluteus minimus is elevated and protected.

Step 3: Detachment of Lower Rotators — The lower short external rotators (obturator internus and gemelli) are carefully detached from their insertion on the greater trochanter, preserving them as a flap for later repair. The piriformis remains untouched above.

Step 4: Capsulotomy — The posterior joint capsule is opened as a separate layer beneath the detached rotators. The capsular tissue is preserved for independent repair.

Step 5: Joint Preparation — The worn femoral head is removed. The acetabulum is prepared with precision reamers, and the femoral canal is shaped to accept the new stem.

Step 6: Component Insertion — The acetabular cup (socket) is press-fitted into the pelvis, followed by a polyethylene or ceramic liner. The femoral stem is inserted into the thigh bone, and a new ceramic or metal head is attached.

Step 7: Piriformis Tension Check — After component placement, the tension of the preserved piriformis tendon is assessed with the hip in slight flexion and neutral adduction. Appropriate tension confirms correct component offset and provides immediate stability.

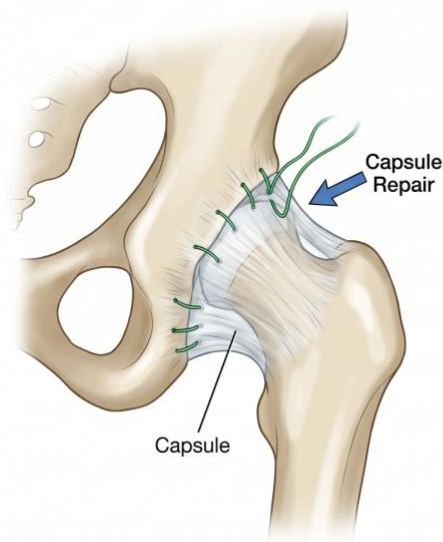
Step 8: Capsule Repair (Layer 2) — The posterior capsule is repaired as a separate, distinct layer using strong sutures back to the greater trochanter through bone tunnels.

Step 9: External Rotator Repair (Layer 3) — The obturator internus and gemelli are reattached over the repaired capsule as a third layer through bone tunnels in the greater trochanter.

Step 10: Stability Testing — Joint stability is confirmed with the hip in 90° flexion and 45° internal rotation. An intact endpoint should be felt, confirming the triple-layer construct is secure.

Step 11: Closure — The wound is closed in layers with absorbable sutures. A waterproof dressing is applied.

Surgical Repair Technique for
Posterior Hip Replacement Approach



Surgical Repair Technique for
Posterior Hip Replacement Approach

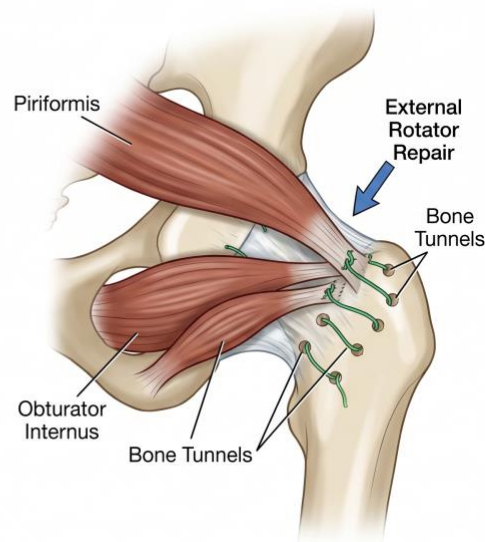


Figure 4: The dual-layer repair of the lower structures. Left: Posterior capsule repaired as a separate layer with sutures. Right: Lower external rotator muscles (obturator internus and gemelli) reattached over the capsule through bone tunnels.

The Hip Replacement Components

A total hip replacement consists of four main components that work together to recreate the natural ball-and-socket mechanics of your hip:

Component	Material	Function
Acetabular Cup	Titanium shell press-fitted into the pelvis socket	Designed for bone to grow into its surface for permanent fixation
Liner	Highly cross-linked polyethylene or ceramic	Provides the bearing surface; extremely low wear rate
Femoral Head	Ceramic or cobalt-chrome ball (28-36mm)	Articulates with the liner; ceramic offers lowest friction
Femoral Stem	Titanium alloy, inserted into the thigh bone	Transfers load from the hip to the femur

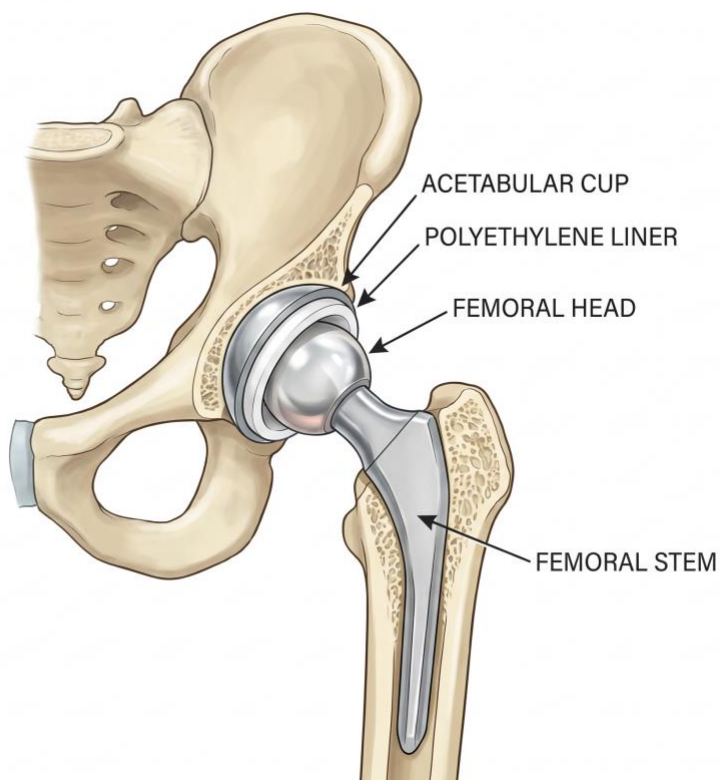


Figure 5: Total hip replacement components in situ — acetabular cup, polyethylene liner, femoral head, and femoral stem.

4. The Evidence: Why This Approach Works

Mr Dehne's technique of separate capsular and short external rotator repair is supported by a substantial body of peer-reviewed evidence demonstrating that meticulous posterior soft-tissue repair dramatically reduces the risk of dislocation and improves functional outcomes.

Key Research Findings

Study	Design	Sample	Key Finding
Mutlu et al. (2025) Medicina	Piriformis-sparing vs conventional posterior approach	350 hips (163 PSPA vs 187 CPA)	0% dislocation in piriformis-sparing group vs 1.6% in conventional group. Ranawat test positive: 89.6% vs 40.1% (p=0.001). Shorter hospital stay: 2.14 vs 2.47 days (p=0.006)
Kenanidis et al. (2025) EFORT Open Reviews	Scoping review of piriformis preservation in THA	57 studies (1980-2023)	PM preservation shows potential benefits in hip stability, dislocation risk reduction, and functional outcomes
Tsai et al. (2008) BMC Musculoskelet Disord	Capsule repair vs no repair	204 hips	Dislocation: 0% with repair vs 7.04% without (p=0.035)
Kim et al. (2008) Clin Orthop Relat Res	Rotator preserved vs repaired vs not repaired	670 hips	Dislocation: 0% preserved, 3.9% repaired, 5.3% no repair (p=0.004)
Zhang et al. (2020) BMC Musculoskelet Disord	Systematic review & meta-analysis of capsule repair	Multiple studies	Capsule repair: lower dislocation, higher Harris Hip Score, less bleeding
Pellicci et al. (1998) J Bone Joint Surg Am	Posterior soft tissue repair	1,000+ hips	Dislocation rate 0% with meticulous capsule and rotator repair

Summary of Evidence

The combined evidence strongly supports Mr Dehne's piriformis-sparing approach with separate capsule and rotator repair. The most recent study (Mutlu et al. 2025) demonstrated ZERO dislocations in 163 patients treated with the piriformis-sparing technique, compared to a 1.6% dislocation rate in the conventional group. The Ranawat internal rotation test — which assesses the integrity of posterior soft tissues — was positive in 89.6% of the piriformis-sparing group versus only 40.1% of the conventional group, confirming that preserving the piriformis maintains posterior stability.

The Kenanidis et al. (2025) scoping review of 57 studies concluded that piriformis preservation is an emerging concept that shows potential benefits in hip stability, dislocation risk reduction, and functional outcomes. Combined with the established evidence for separate capsule repair (Tsai 2008: 0% vs 7% dislocation) and rotator preservation (Kim 2008: 0% dislocation with preserved rotators), Mr Dehne's triple-layer technique represents the most comprehensive approach to posterior hip stability currently available.

This approach achieves dislocation rates comparable to or better than the anterior approach, while preserving the advantages of the posterior approach — namely, intact abductor muscles, less risk of lateral femoral cutaneous nerve injury, excellent component positioning, and no learning-curve complications.

5. Fast Recovery Programme

Mr Dehne utilises an Enhanced Recovery After Surgery (ERAS) programme — also known as Fast Recovery — which is a comprehensive, evidence-based approach designed to accelerate your return to normal function while minimising complications. This programme encompasses every stage of your journey: before, during, and after surgery.

Principles of Fast Recovery

Principle	What This Means For You
Preoperative Optimisation	Prehabilitation exercises, nutritional support, anaemia correction, patient education
Minimally Invasive Surgery	Tissue-sparing technique, preservation of muscles, meticulous haemostasis
Multimodal Analgesia	Combination of local anaesthetic infiltration, nerve blocks, and oral medications to minimise opioid use
Early Mobilisation	Standing and walking within hours of surgery, not days
Criteria-Based Discharge	You go home when you meet functional milestones, not after a fixed number of days
Proactive Complication Prevention	Tranexamic acid to reduce bleeding, DVT prophylaxis, infection prevention bundle

What Fast Recovery Means in Practice

With Mr Dehne's fast recovery programme, most patients are able to stand and take their first steps within a few hours of surgery. The majority of patients are discharged home within 1-2 days of their operation, walking independently with crutches. Some patients are suitable for same-day discharge.

The key to fast recovery is that the piriformis-sparing posterior approach preserves both the abductor muscles AND the piriformis tendon completely. Because these critical muscles are not damaged during surgery, patients have immediate posterior stability and can weight-bear fully from day one without developing a limp. The Mutlu et al. (2025) study confirmed that piriformis-sparing patients had a significantly shorter hospital stay (2.14 vs 2.47 days, $p=0.006$) compared to conventional posterior approach. Combined with effective pain control and early physiotherapy, this allows a dramatically faster return to independence compared to traditional protocols.

Expected Recovery Timeline



Figure 6: The four phases of hip replacement rehabilitation under the Fast Recovery Programme.

Timepoint	Expected Milestone
Day of Surgery	Stand and walk with frame/crutches within hours
Day 1-2	Walk independently with crutches, manage stairs, discharge home
Week 2	Wound check, remove dressing, increase walking distance
Week 4-6	Wean off crutches, return to driving (usually 6 weeks)
Week 6-12	Swimming, cycling, return to most daily activities
3-6 Months	Full recovery, return to sport and leisure activities

6. Preparing for Your Surgery

Proper preparation before your hip replacement is an essential part of the fast recovery programme. The better prepared you are physically and mentally, the smoother your recovery will be.

Prehabilitation

In the weeks before surgery, you should begin a programme of gentle exercises to strengthen the muscles around your hip and improve your general fitness. This is called prehabilitation. Stronger muscles before surgery lead to faster recovery afterwards.

- Quadriceps strengthening (straight leg raises, mini squats)
- Gluteal strengthening (bridging, clam exercises)
- Core stability exercises
- Walking or swimming for cardiovascular fitness
- Ankle pumps and calf raises for circulation

Pre-Operative Checklist

Item	Details	When
Pre-assessment clinic	Blood tests, ECG, health screening	Hospital guidelines.
Medications review	Stop blood thinners as advised, continue regular medications	Hospital guidelines.
Dental check	Treat any dental infections before surgery	Hospital guidelines.
Home preparation	Raised toilet seat, grab rails, remove trip hazards	Hospital guidelines.
Skin preparation	Wash with antiseptic soap the night before and morning of surgery	Hospital guidelines.
Fasting	No food for 6 hours, clear fluids until 2 hours before	Hospital guidelines.
Carbohydrate drink	Special pre-operative drink to reduce hunger and anxiety	Hospital guidelines.

Medications to Discuss with Mr Dehne

Medication	Guidance
Aspirin	Usually continue unless advised otherwise
Warfarin / DOACs	Stop before surgery, consult hospital guidelines.
Clopidogrel	Stop before surgery, consult hospital guidelines.
Anti-inflammatory drugs (NSAIDs)	Consult hospital guidelines.
Metformin	Stop before surgery, consult hospital guidelines.
Herbal supplements	Stop 2 weeks before, consult hospital guidelines.

7. Your Hospital Stay

Day of Surgery

You will arrive at the hospital on the morning of your surgery. After final checks and consent, you will be taken to the anaesthetic room. Mr Dehne performs hip replacement under spinal anaesthesia (an injection in your back that numbs you from the waist down) combined with sedation, so you will be comfortable and relaxed throughout. General anaesthesia is available if preferred.

The operation typically takes 60-90 minutes. Afterwards, you will be taken to the recovery area where your observations will be monitored. Once you are comfortable and alert, the physiotherapy team will help you stand and take your first steps — usually within 3-4 hours of surgery.

Pain Management

Effective pain control is central to fast recovery. Mr Dehne uses a multimodal approach that combines several methods to control pain while minimising the need for strong opioids:

Method	Details
Local Infiltration Analgesia	A cocktail of local anaesthetic, anti-inflammatory, and adrenaline injected around the joint during surgery
Spinal Anaesthesia	Provides complete pain relief for the first 4-6 hours after surgery
Regular Paracetamol	Taken every 6 hours as a baseline pain reliever
Anti-inflammatory (if suitable)	Reduces inflammation and swelling around the joint
Opioids (if needed)	Short-acting oral opioids available for breakthrough pain only
Ice Therapy	Applied to the hip to reduce swelling and provide comfort

Discharge Criteria

You will be discharged when you can safely meet the following criteria (typically Day 1 or Day 2):

- Walk independently with crutches for at least 30 metres
- Manage stairs safely (if applicable to your home)
- Get in and out of bed independently
- Pain controlled with oral medications
- Wound dry and intact
- Passed urine normally
- Understand your home exercise programme

8. Post-Operative Instructions

Wound Care

Your wound will be closed with absorbable sutures beneath a waterproof dressing. The dressing should remain in place for 10-14 days. You may shower with the dressing on — simply pat it dry afterwards. Do not soak the wound in a bath or swimming pool until it is fully healed (usually 3 weeks).

A small amount of oozing through the dressing in the first 24-48 hours is normal. If the dressing becomes saturated, soiled, or lifts at the edges, it should be replaced with a clean waterproof dressing. Your wound will be checked at your 2-week follow-up appointment.

Activity Guidelines

Activity	Guidance	When
Walking	As much as comfortable with crutches; increase distance daily	Day 1 onwards
Stairs	One step at a time: good leg up first, operated leg down first	Day 1 onwards
Sleeping	Sleep on your back or on the non-operated side with a pillow between knees	First 6 weeks
Sitting	Use a firm, high chair; avoid low sofas	First 4 weeks
Driving	When you can safely perform an emergency stop (usually 6 weeks)	6 weeks
Swimming	Once wound fully healed	3-4 weeks
Cycling	Stationary bike first, then outdoor cycling	4-6 weeks
Sexual activity	When comfortable, typically 4-6 weeks	4-6 weeks
Return to work	Desk job 4-6 weeks; physical work 3 months	4-12 weeks
Sport	Low-impact sports from 3 months; discuss specific activities with Mr Dehne	3-6 months

Hip Precautions

Because Mr Dehne preserves the piriformis intact AND repairs both the capsule and the remaining external rotators as separate layers, the hip has triple-layer stability from day one. This means the hip is inherently more stable than with any other posterior technique. However, while the repaired soft tissues heal (first 6 weeks), we recommend the following sensible precautions:

- Avoid crossing your legs
- Avoid bending your hip beyond 90 degrees (e.g., reaching to the floor)
- Avoid twisting your operated leg inward
- Use a raised toilet seat for the first 4 weeks
- Use a long-handled shoe horn and sock aid

After 6 weeks, when the capsule and lower rotator muscles have healed (the piriformis never needed to heal as it was preserved intact), these precautions are progressively relaxed. Most patients have no

movement restrictions by 3 months. The preserved piriformis provides continuous stability throughout the healing period.

9. Rehabilitation Programme

Rehabilitation is a crucial part of your recovery. The exercises below are designed to restore strength, flexibility, and confidence in your new hip. Progress through the phases at your own pace — the timelines are guides, not rigid rules. Consult with hospital and physio guidelines as following is general indications.

Phase 1: Early Mobilisation (Days 0-14)

Goals: Reduce swelling, maintain circulation, achieve independent walking with crutches.

Exercise	Description	Repetitions
Ankle pumps	Pump feet up and down briskly	20 reps every hour
Static quadriceps	Tighten thigh muscle, push knee flat into bed	10 reps x 3 sets
Gluteal squeezes	Tighten buttock muscles and hold 5 seconds	10 reps x 3 sets
Heel slides	Slide heel towards buttock, bending knee	10 reps x 3 sets
Straight leg raise	Tighten quads, lift leg 15cm off bed	10 reps x 3 sets
Walking with crutches	Gradually increase distance	Little and often

Phase 2: Progressive Recovery (Weeks 2-6)

Goals: Wean off crutches, restore normal walking pattern, increase hip range of motion.

Exercise	Description	Repetitions
Standing hip flexion	Lift knee towards chest while standing (hold support)	10 reps x 3 sets
Standing hip abduction	Lift leg out to the side while standing	10 reps x 3 sets
Standing hip extension	Push leg backwards while standing upright	10 reps x 3 sets
Mini squats	Bend knees to 45 degrees, keeping back straight	10 reps x 3 sets
Step-ups	Step up onto a low step (10-15cm), lead with operated leg	10 reps x 3 sets
Stationary cycling	Low resistance, gradually increase duration	10-20 minutes daily
Walking	Increase distance; aim for 20-30 minutes by week 6	Daily

Phase 3: Return to Activities (Weeks 6-12)

Goals: Full weight bearing without aids, return to driving, swimming, and normal daily activities.

Exercise	Description	Repetitions
Single leg balance	Stand on operated leg for 30 seconds (hold support initially)	3 x 30 seconds
Bridging	Lie on back, lift hips off bed, hold 5 seconds	10 reps x 3 sets
Side-lying abduction	Lie on non-operated side, lift operated leg upward	10 reps x 3 sets
Resistance band exercises	Add resistance to hip flexion, abduction, extension	10 reps x 3 sets
Swimming	Freestyle and backstroke (avoid breaststroke)	20-30 minutes

	kick initially)	
Outdoor cycling	Flat terrain, gradually increase distance	20-40 minutes

Phase 4: Full Recovery (3-6 Months)

Goals: Return to sport, full strength and endurance, no functional limitations.

Exercise	Description	Frequency
Progressive resistance training	Gym-based exercises: leg press, hip abductor machine	3 sessions/week
Advanced balance	Single leg exercises on unstable surfaces	Part of gym routine
Sport-specific training	Gradual return to golf, tennis, hiking, dancing	As tolerated
Cardiovascular fitness	Running (if appropriate), cycling, swimming	30+ minutes x 3/week

10. Risks and Complications

Hip replacement is one of the most successful operations in modern medicine, with over 95% of patients reporting significant improvement in pain and function. However, like all surgery, it carries some risks.

Mr Dehne will discuss these with you in detail before your operation.

Category	Risks
Common (>5%)	Pain and swelling (temporary) Bruising around the wound Temporary numbness around the scar Stiffness in the early weeks
Uncommon (1-5%)	Wound infection (superficial): 1-2% Deep vein thrombosis (DVT): 2-4% (with prophylaxis) Leg length discrepancy (usually <1cm) Temporary nerve irritation
Rare (<1%)	Dislocation: <1% with piriformis-sparing + capsule + rotator repair Deep infection: 0.5-1% Fracture during surgery Pulmonary embolism Nerve or vessel injury Need for revision surgery
Very Rare (<0.1%)	Fatal pulmonary embolism Heart attack or stroke Allergic reaction to implant materials

Warning Signs — When to Seek Urgent Help

Contact Mr Dehne's team or attend A&E immediately if you experience:

- Sudden severe pain in the calf or leg swelling (possible DVT)
- Chest pain or sudden breathlessness (possible pulmonary embolism)
- Increasing redness, warmth, or discharge from the wound (possible infection)
- Fever above 38°C lasting more than 24 hours
- Feeling that the hip has 'popped out' or sudden inability to weight bear
- Numbness or weakness in the foot that does not resolve

11. Frequently Asked Questions

Q: How long does the operation take?

A: The surgery typically takes 60-90 minutes. You will be in the operating theatre for approximately 2 hours including anaesthetic preparation and recovery.

Q: How long will I stay in hospital?

A: Most patients go home on Day 1 or Day 2 after surgery. Some patients are suitable for same-day discharge. Your length of stay depends on meeting the functional discharge criteria, not a fixed timeframe.

Q: When can I drive?

A: You can usually return to driving at 6 weeks, once you can safely perform an emergency stop. This will be confirmed at your follow-up appointment.

Q: When can I return to work?

A: For desk-based work, most patients return at 4-6 weeks. For physical or manual work, 3 months is typical. Mr Dehne will advise based on your specific job requirements.

Q: Will I need physiotherapy?

A: Yes. You will be given a home exercise programme and may be referred for outpatient physiotherapy. Regular exercises are essential for the best outcome.

Q: How long will my new hip last?

A: Modern hip replacements are designed to last 20-25 years or more. Over 90% of hip replacements are still functioning well at 15 years. Factors affecting longevity include activity level, body weight, and implant type.

Q: Can I kneel or squat?

A: Yes, once fully recovered (usually 3-6 months). The triple-layer stability (preserved piriformis + repaired capsule + repaired rotators) provides excellent stability, and most patients regain a full range of movement.

Q: Will I set off airport security?

A: Yes, metal implants will trigger airport metal detectors. You will be given a medical card confirming your hip replacement. Simply inform security staff.

Q: Can I play sport?

A: Low-impact sports such as swimming, cycling, golf, walking, and doubles tennis are encouraged. High-impact activities (running, football, rugby) are generally discouraged as they may accelerate wear of the bearing surfaces.

Q: What if I need the other hip done?

A: If both hips are affected, the second hip can usually be replaced 3-6 months after the first, once you have fully recovered.

12. Your Appointments

Please use the table below to record your appointment dates and any notes from your consultations.

Appointment	Date	Notes
Initial Consultation	___/___/___	
Pre-Assessment Clinic	___/___/___	
Surgery Date	___/___/___	
2-Week Wound Check	___/___/___	
6-Week Follow-Up	___/___/___	
3-Month Review	___/___/___	
1-Year Review	___/___/___	

Personal Notes

Use this space to write down any questions or notes for your appointments:

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