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Queensland Government

Total Knee Arthroplasty (Knee Replacement)

The Prince Charles Hospital

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

A. Interpreter / cultural needs

An Interpreter Service is required? ☐ Yes ☐ No

If *Yes*, is a qualified Interpreter present? ☐ Yes ☐ No

A Cultural Support Person is required? ☐ Yes ☐ No

If *Yes*, is a Cultural Support Person present? ☐ Yes ☐ No

B. Condition and treatment

The doctor has explained that you have the following condition: *(Doctor to document in patient's own words)*

.....

This condition requires the following procedure. *(Doctor to document - include site and/or side where relevant to the procedure)*

.....

.....

Left knee ☐ Yes ☐ No

Right knee ☐ Yes ☐ No

The following will be performed:

A total knee arthroplasty is the surgical removal of the diseased joint and replacement with a metal hinge joint (prosthesis) that is attached to the thighbone (femur) and the shinbone (tibia). In most cases, bone cement is used to fix the prosthesis to the thigh and shin bone.

C. Risks of a total knee arthroplasty (knee replacement)

There are risks and complications with this procedure. They include but are not limited to the following.

General risks:

- Infection can occur, requiring antibiotics and further treatment.
- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Asprin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).
- Small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.
- Heart attack or stroke could occur due to the strain on the heart.
- Blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.
- Death as a result of this procedure is possible.

Specific risks:

- Wound infection. This may require antibiotics, further surgery and possibly the new knee joint to be removed, and possible the leg amputation.
- The knee joint can dislocate. Re- operation is required to correct this.
- The bones around the joint may break during or after surgery. A plaster may be required to repair the break or further surgery may be required.
- The artificial joint may fail or wear out. Surgical revision of the knee joint replacement may be required.
- Numbness at the side of the cut can happen. This may be temporary or permanent.
- Damage to the peroneal nerve around the knee during surgery. This may be temporary or permanent. Further surgery may be necessary.
- Damage to the blood vessel behind the knee during surgery. Surgery on the blood vessel will be needed and sometimes leg amputation.
- Damage to the nerves may cause a burning pain and inability to straighten the leg. A nerve block may be used to relieve the pain and the leg manipulated.
- Stiffening of the knee after the surgery causing difficulty in walking and sitting and pain on movement. Manipulation and possibly further surgery may be required.
- In some people, healing of the wound may be abnormal and the wound can be thickened and red and the scar may be painful.
- Infection to the prosthesis via the bloodstream in the following years after replacement surgery. The knee joint may have to be removed. To prevent this, you will need to have antibiotics before other procedures and dental work.

D. Significant risks and procedure options

(Doctor to document in space provided. Continue in Medical Record if necessary.)

.....

.....

E. Risks of not having this procedure

(Doctor to document in space provided. Continue in Medical Record if necessary.)

.....

.....

F. Anaesthetic

This procedure may require an anaesthetic. *(Doctor to document type of anaesthetic discussed)*

.....

DO NOT WRITE IN THIS BINDING MARGIN

PROCEDURAL CONSENT FORM

v5.00 - 04/2011

SW000

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Queensland Government

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G. Patient consent

I acknowledge that the doctor has explained;

- my medical condition and the proposed procedure, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.
- the anaesthetic required for this procedure. I understand the risks, including the risks that are specific to me.
- other relevant procedure/treatment options and their associated risks.
- my prognosis and the risks of not having the procedure.
- that no guarantee has been made that the procedure will improve my condition even though it has been carried out with due professional care.
- the procedure may include a blood transfusion.
- tissues and blood may be removed and could be used for diagnosis or management of my condition, stored and disposed of sensitively by the hospital.
- if immediate life-threatening events happen during the procedure, they will be treated based on my discussions with the doctor or my Acute Resuscitation Plan.
- a doctor other than the Consultant may conduct the procedure. I understand this could be a doctor undergoing further training.

I have been given the following Patient Information Sheet/s:

- ☐ **About Your Anaesthetic** *OR*
- ☐ **Epidural & Spinal Anaesthetic**
- ☐ **Total Knee Arthroplasty (Knee Replacement) TPCH**
- ☐ **Blood & Blood Products Transfusion**

- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand I have the right to change my mind at any time, including after I have signed this form but, preferably following a discussion with my doctor.
- I understand that image/s or video footage may be recorded as part of and during my procedure and that these image/s or video/s will assist the doctor to provide appropriate treatment.

On the basis of the above statements,

I request to have the procedure

Name of Patient: .....

Signature: .....

Date: .....

Patients who lack capacity to provide consent

Consent must be obtained from a substitute decision maker/s in the order below.

Does the patient have an Advance Health Directive (AHD)?

☐ Yes ► Location of the original or certified copy of the AHD: .....

☐ No ► Name of Substitute Decision Maker/s: .....

Signature: .....

Relationship to patient: .....

Date: ..... PH No: .....

Source of decision making authority (tick one):

- ☐ Tribunal-appointed Guardian
- ☐ Attorney/s for health matters under Enduring Power of Attorney or AHD
- ☐ Statutory Health Attorney
- ☐ If none of these, the Adult Guardian has provided consent. Ph 1300 QLD OAG (753 624)

H. Doctor/delegate Statement

I have explained to the patient all the above points under the Patient Consent section (G) and I am of the opinion that the patient/substitute decision-maker has understood the information.

Name of Doctor/delegate: .....

Designation: .....

Signature: .....

Date: .....

I. Interpreter's statement

I have given a sight translation in

.....

(state the patient's language here) of the consent form and assisted in the provision of any verbal and written information given to the patient/parent or guardian/substitute decision-maker by the doctor.

Name of Interpreter: .....

Signature: .....

Date: .....

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Family name:

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Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Strike out this section if not applicable.

I have read and understand the information on implantable devices and material tracking.

I DO/DO NOT authorise the Health Insurance Commission to release my **Medicare** data to The Prince Charles Hospital Health Service District.

I understand that the date will be used solely for the purpose of tracking…… Device.

I understand that The Prince Charles Hospital Health Service District will have access to my Medicare data.

I understand that I can withdraw my consent to the release of my Medicare data by telephoning:

The Prince Charles Hospital (07 3350 8111)
or
Health Insurance Commission (02 6203 6891).

I will also complete a form supplied by The Prince Charles Hospital Health Service District and return it to the Hospital with a copy to the Manager, Program Co-ordination and Data Access, PO Box 1001, Tuggeranoung, ACT, 2901.

Signature of Patient/Parent/Guardian ----------

Date ----------

Doctors Notes

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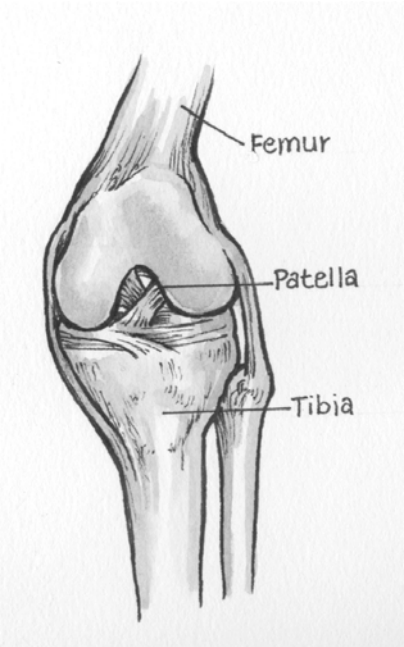
Queensland Government

Consent Information - Patient Copy
Total Knee Arthroplasty (Knee Replacement)

The Prince Charles Hospital

1. What do I need to know about this condition?

The knee is a hinge joint, formed by the end of the thighbone (femur) and the end of the shin bone (tibia). The bones are coated in cartilage, which acts as a cushion between the two bones and allows the knee to move. In front of these bones is the kneecap (patella) which glides in a groove on the end of the thigh bone.

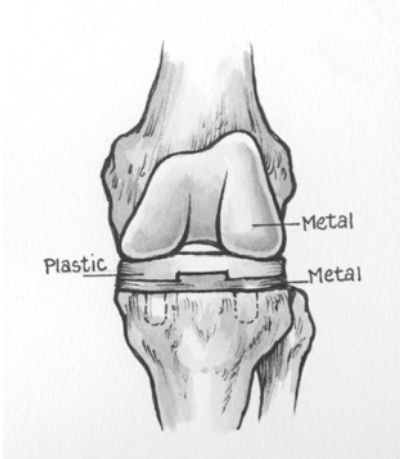


A knee joint

Total knee replacements are usually performed for people who have arthritis that is getting worse and is no longer responding to other treatments. The most common type of arthritis is osteo-arthritis, which happens with aging or previous injury to the knee joint.

2. What do I need to know about this procedure?

Total Knee Replacement is the surgical removal of the diseased joint and replacing it with an artificial joint that is attached to the thighbone (femur) and the shinbone (tibia). This is known as a prosthesis.



An artificial knee joint

In most cases, bone cement is used to fix the artificial joint to the thigh and shinbone. Your surgeon will discuss with you the most suitable type of prosthesis for your condition and health. The operation takes 2 – 4 hours.

At the time of surgery and for a short period after your surgery, you will be given antibiotics and a form of therapy ie injections or tablets, to thin your blood. Please tell your doctor at least one week before your surgery if you are taking Aspirin, anti - inflammatory drugs or blood thinning agents, e. g Warfarin.

3. What are the benefits of having this procedure?

The pain should gradually improve making it possible to take up activities, which could not have been done prior to surgery because of pain and stiffness in the knee joint.

4. What are the risks of not having this procedure?

The pain may become so severe that independence with every day activities such as showering, walking, shopping, gardening, climbing stairs, getting out of a chair, may be lost or difficult to do alone.

5. My anaesthetic

This procedure will require an anaesthetic.

See **About Your Anaesthetic** OR **Epidural and Spinal Anaesthetic** for information about the anaesthetic and the risks involved. If you have any concerns, discuss these with your doctor.

If you have not been given an information sheet, please ask for one.

6. What are the risks of this specific procedure?

There are risks and complications with this procedure. They include but are not limited to the following.

General risks:

- Infection can occur, requiring antibiotics and further treatment.
- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Asprin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).
- Small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.
- Heart attack or stroke could occur due to the strain on the heart.
- Blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.
- Death as a result of this procedure is possible.

Specific risks:

Continues over page ►►►

The risk	Why it happens	What it causes
Clots in the legs	Blood clots can form in the legs. If untreated, this can happen in 1 in 5 people.	The clots can break off and travel to the lungs in 1 in 100 people, and can cause death in 1 in 3,000 people.
Wound infection	Wound infection in about 1 in 100 people.	Infection is a major complication and may require further surgery and possibly the new knee joint to be removed and possibly the leg amputated.
Dislocation of the knee joint	The knee joint/patella can dislocate because muscles and ligaments have not yet repaired themselves to provide support to the joint.	Re-operation is required.
The bones around the joint may break	The bones around the joint may break during or after surgery. This can occur in 1 in 40 to 1 in 3001 cases depending on bone strength.	A plaster may be required to repair the break or further surgery may be required.
The kneecap may break	The kneecap may break in 1 in 650 people.	Further surgery may be required to repair the knee cap.
The artificial joint will loosen or wear out	This can happen over a period but 9 out of ten knee joint replacements are still working after 10 years.	Surgical revision of the knee joint replacement may be required.
Numbness by the cut	Numbness at the side of the cut can happen	This may be temporary or permanent.
Numbness/ paralysis of the foot.	Damage to the peroneal nerve around the knee during surgery in 1 in 300 people.	This may be temporary or permanent. Further surgery may be necessary.
Loss of blood supply to the leg	Damage to the blood vessel behind the knee in 1 in 300 to 1 in 500 people.	Surgery on the blood vessel, and sometimes leg amputation.
Temperature disturbance to the operated leg	Damage to the nerves may cause a burning pain and inability to straighten the leg in 1 in 125 people.	A nerve block to relieve the pain and manipulation of the leg.
Stiff knee joint	Stiffening of the knee causing difficulty in walking and sitting and pain on movement in 1 in 60 people.	Manipulation and possibly further surgery.
Infection around the prosthesis years later	Infection can spread to the replaced joint via the bloodstream for years after replacement surgery (1 in 300 people).	The knee joint may have to be removed. To prevent this, you will need antibiotics before other procedures and dental work.
Increased risk in smokers.	Smoking slows wound healing and affects the heart, lungs and circulation. Giving up smoking before operation will help reduce the risk.	An increased risk of wound infection, chest infection, heart and lung complications, thrombosis.
Death	**Death is extremely rare due to knee replacement**	

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An exercise program can strengthen the muscles around the knee joint and sometimes improve positioning of the knee and relieve pain.

Nonsteroidal anti-inflammatory drugs, or NSAIDs. Some common NSAIDs are aspirin, ibuprofen and cerebrex.

Corticosteroids such as prednisone or cortisone reduce joint inflammation but can cause further weaken the bones in the joint.

Side effects from corticosteroids are increased appetite, weight gain, and lower resistance to infections.

Osteotomy. The surgeon cuts the bone away at a point from the damaged joint and restores the joint to its proper position, which helps to load weight evenly across the joint.

For some people, an osteotomy relieves pain. Recovery from an osteotomy takes 6 to 12 months. The function of the knee joint may get worse and the patient may need more treatment.

7. What do I need to know about my recovery from this procedure?

After the operation, the nursing staff will closely watch you until you have recovered from the anaesthetic. You will then go back to the ward where you will recover until you are well enough to go home, usually 7-10 days after surgery. If you have any side effects from the anaesthetic, such as headache, nausea, vomiting, you should tell the nurse looking after you, who will be able to give you some medication to help.

- Pain

You can expect to have pain in the operation site. You will have either:

- An injection into your spine – an epidural - which may be connected to a fine tube and a pump which sends painkiller into your spine. This can cause headache and soreness at the injection.
- A patient controlled analgesia which, when you press a button, releases a painkiller into your IV drip. This can cause nausea and vomiting, sleepiness, and/ or trouble emptying your bladder.

These pain-killing devices will stay in for 24 – 48 hours depending on the amount of pain you have.

- Diet

You may have a drip in your arm. The drip will be removed by the second day after your operation. To begin with, you can have small sips of water, then slowly take more until you are eating normally.

- Wound

Your wound will be a cut about 20 to 30 cms down the front of your leg from above to below the knee and will be closed with either stitches or clips. The stitches or clips will stay in for 10 to 14 days.

A dressing will cover the cut and you will have a drain to drain any blood and fluid from the wound into a small bag. This is removed 24 to 48 hours after operation – or once the drainage has stopped. You can shower 1 or 2 days after surgery.

A waterproof dressing will be put on over the top. Your dressings will be changed as ordered by the surgeon. You may go home with a dressing covering your wound until your stitches or clips are removed.

Continue to keep your wound clean and protected until healed and no seepage is present.

- Your lungs and blood supply

It is very important after surgery that you move as soon as possible. Pump your feet backwards and forwards and bend and straighten your non- operated leg at the knee. This prevents blood clots forming in your legs and possibly travelling to your lungs. This can be fatal.

You will be shown which of your pre–operation exercises to continue after surgery. You will start walking the second day after surgery with the use of walking aids. You will be told when you can put your full weight on your new knee.

Also, you need to take ten deep breaths every hour, to prevent secretions in the lungs becoming stagnant. If this happens, you may develop a chest infection. At all costs, avoid smoking after surgery as this increases your risk of chest infection.

- Exercise

You will feel tired for a few weeks after surgery. You need to take things easy and return to normal duties, as you feel able to. It takes about 3 months to recover.

- You will be given exercises to do for a month after your surgery. You will also be shown how to safely climb stairs, shower, dress and toilet yourself. There are a number of movements to avoid;
- Avoid jumping - even from low surfaces.
- Avoid sudden jolts to the leg (e.g. stepping off kerbs).
- Avoid gaining weight, which puts extra stress on your joint.
- Keep to low - key activities at work and at recreation.
- Avoid kneeling on your new knee joint.
- Be careful in slippery, cluttered or uneven areas so that you don't fall.

You will be told about these before you go home.

8. How do I look after my knee joint?

Joint replacements can become infected at any time after the surgery from the first post-operative day to many years down the line. You can take the following steps to help prevent infection:

- Take antibiotics before dental or any medical procedure.
- See your doctor to treat all suspected urinary tract infections.

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- Look for signs of infection in the knee including pain, redness, swelling or increased warmth.
- Your new joint replacement may trigger airport metal detector alarms. We will give you a certificate that verifies that you had a knee replacement.
- Keep in mind that you need to protect your knee replacement to ensure a long lasting, successful result. Follow all instructions concerning any activity restrictions.

9. What do I need to tell my doctor?

Tell your doctor if you have:

- redness, swelling or warmth around the cut
- leakage from the cut
- fever and chills
- severe knee pain that is not relieved by prescribed painkillers
- sudden sharp pain and clicking or popping sound in the knee joint
- loss of control over leg movement
- loss of leg movement
- further surgery planned for the future i.e. dental work, bladder catheterisation, examinations of the bowel, bladder, rectum or stomach

Notes to talk to my doctor about: