



Total Hip Replacement

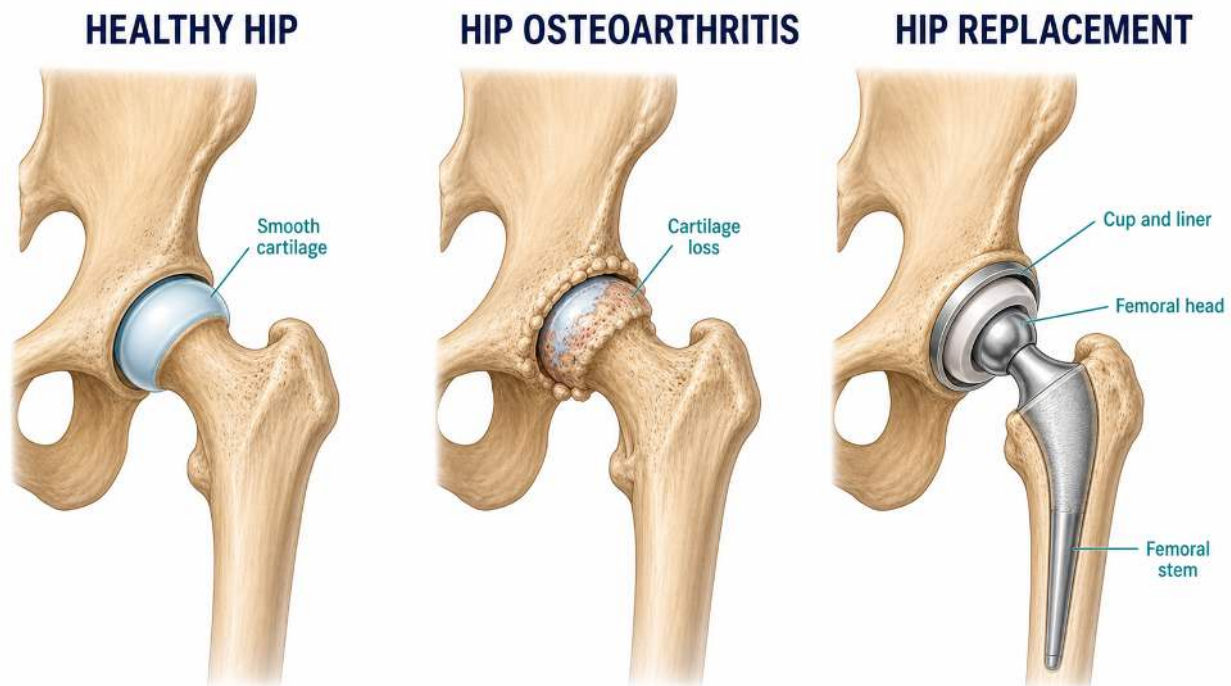
CT-planned primary hip replacement through a posterior approach

Why you have been given this sheet

This guide explains why hip replacement may be recommended, how the operation is planned and performed, and what recovery usually involves. It supports your discussion with the surgical team and complements—but does not replace—the formal consent process. Your operation and recovery plan will be tailored to you.

When is hip replacement considered?

A total hip replacement is considered when hip pain is persistent, difficult to control and substantially affects walking, sleep, independence or quality of life despite appropriate non-operative treatment. Osteoarthritis is the most common reason, but avascular necrosis, inflammatory arthritis, dysplasia and selected fractures can also damage the joint.



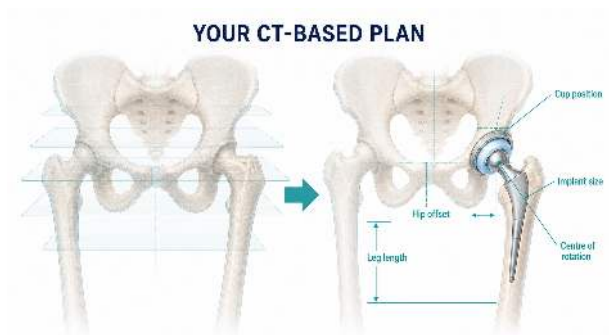
A healthy joint has smooth cartilage. Arthritis removes this low-friction surface; replacement substitutes the damaged ball and socket with engineered components.

The decision is based on the whole picture

- Pain and loss of function—not the X-ray alone—are the main reasons to proceed.
- Exercise, medication, walking aids and injections may help, but they cannot restore worn cartilage.
- The aim is durable pain relief and better function; no operation can promise a completely normal or pain-free hip.

A replacement planned around your anatomy

CT planning helps the surgical team prepare component size, position and reconstruction targets before entering theatre.

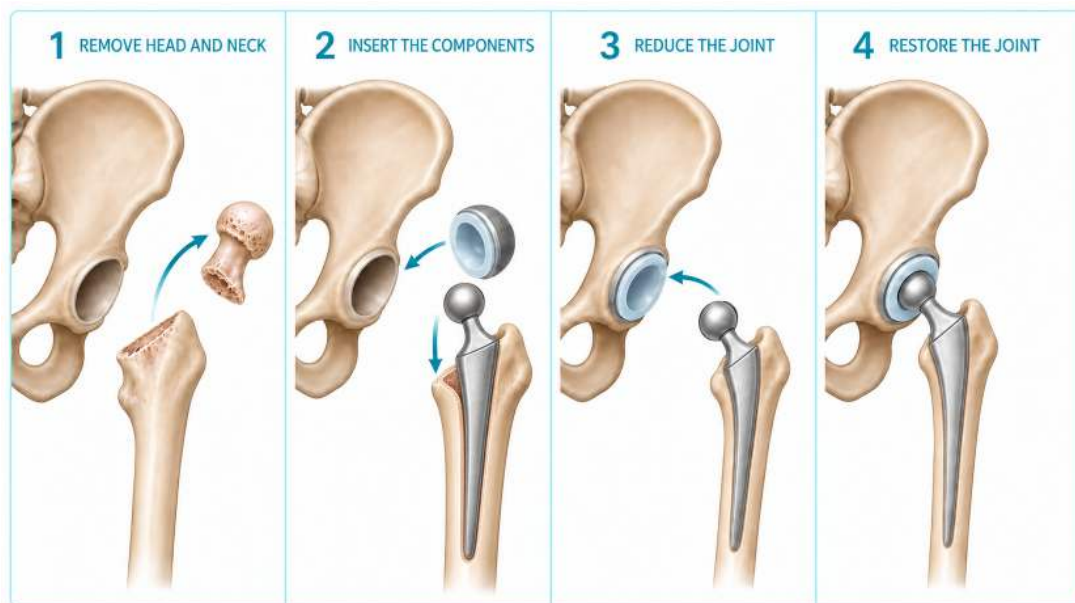


WHAT THE CT PLAN ASSESSES

- Cup size and orientation
- Femoral stem size and fit
- Centre of rotation and hip offset
- Leg-length targets
- Bone shape, defects and quality

Three-dimensional planning can improve the accuracy of component positioning and leg-length reconstruction. It reduces uncertainty but does not eliminate every intraoperative decision or guarantee exact leg-length equality; the final plan is confirmed safely during surgery.

What happens during the operation?



- Through a posterior approach, the damaged femoral head is removed and the socket is prepared while preserving healthy bone where possible.
- A new acetabular shell and bearing are inserted. A stem is placed in the femur and connected to a new ball.
- Components are selected according to the CT plan, anatomy, bone quality and findings during surgery.
- Most primary hips are uncemented so bone can grow onto the implant. Cemented fixation may be safer when bone quality, age or anatomy makes press-fit fixation less reliable.

Anaesthetic and duration

The operation usually takes about 1 hour. Spinal anaesthesia is commonly used with sedation, so you remain comfortable while breathing for yourself. The anaesthetic team confirms the safest plan for your health.

Moving early and rebuilding confidence

Most patients can place full weight through the operated leg from the beginning, using support as needed.

Your usual pathway

Within hours Stand and walk with the nursing and physiotherapy team, usually with a walker or crutches.

Day 1 Physiotherapy practises safe walking, transfers and stairs before discharge.

1–2 nights Most patients go home after one or two nights, depending on medical recovery, mobility and home support.

2 weeks Wound review. Walking aids are used only as long as needed—commonly around 2–4 weeks.

6 weeks Surgeon review with X-rays, progression of strengthening and a more individual return-to-activity plan.

Protecting the healing posterior capsule

For approximately 6–8 weeks, avoid the combined position of deep hip flexion, bringing the knee across the body and turning the thigh inward (FADIR). This is a focused precaution—not a request to remain inactive. Walk regularly and follow the movement advice provided by your team.

Blood-clot prevention

Early walking, hydration and an individually selected blood-thinning plan reduce the risk of deep-vein thrombosis and pulmonary embolism. An expert physician assesses your personal clotting and bleeding risk, medical conditions and other medicines before recommending the agent and duration.

Driving, work and sport

- Driving resumes only when you are off sedating medication, can enter and exit safely, and can perform an emergency stop. Timing varies—especially after a right hip—and should be confirmed at review.
- Desk-based work often resumes before heavy manual work; the exact timing depends on symptoms, commute and job demands.
- Light, low-impact sport commonly begins around 8–12 weeks if strength and balance allow. More demanding activity is usually considered around 3–6 months after review. Published studies show return continues to improve through 6–12 months, so these are progression targets rather than deadlines.

Full weight bearing does not mean full recovery

The implant is mechanically stable from the operation, but the wound, capsule, muscles, balance and confidence still need time to recover. Increase activity progressively rather than testing the hip with sudden extremes.

What Australian patients report

The figures below come from the Australian Orthopaedic Association National Joint Replacement Registry and describe large patient groups—not an individual guarantee or a Signature-specific result.

92.2% satisfied or very satisfied at 6 months	96.7% reported being much or a little better
21.0 to 41.4 mean Oxford Hip Score at 6 months	66.0 to 80.9 mean EQ-VAS health score at 6 months

Australian longevity benchmark

For modern primary hip replacements, the 2025 AOANJRR benchmark cumulative revision rate is 4.2% at 10 years and 6.0% at 15 years—equivalent to approximately 95.8% and 94.0% remaining unrevised. Implant longevity varies with diagnosis, age, activity, fixation, component choice and other patient factors.

Possible complications

- Expected or usually manageable: wound pain, bruising and swelling; nausea, constipation or urinary retention; temporary weakness; leg-length awareness; stiffness; minor wound problems.
- Less common: infection, dislocation, fracture, blood clot or pulmonary embolism, nerve or vessel injury, bleeding or transfusion, ongoing pain, implant loosening or wear, unequal leg length, or later revision surgery.

Seek urgent medical advice

Contact the treating team urgently for fever, increasing wound redness or drainage, sudden severe hip pain or deformity, new calf swelling, chest pain, shortness of breath, or new neurological symptoms.

Your surgical team

Dr David Edis | Orthopaedic and Spine Surgeon | MBBS, FAOrthA, GradDipHealthAdmin

David has performed hip replacement surgery for more than 20 years, bringing extensive knowledge and consistently excellent clinical results. He leads the surgical team and uses patient-specific CT planning, a posterior approach and contemporary fixation principles for primary hip replacement. The plan is refined to restore a stable hip, appropriate leg length and offset while respecting your individual anatomy and bone quality.

Selected references

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Maryvale • Warragul • Peninsula • Rosebud

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