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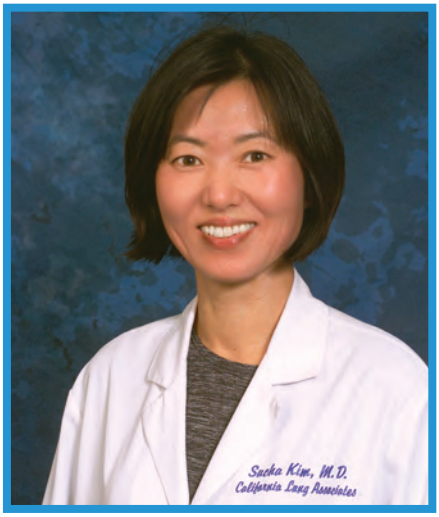
What To Do With Your Medications Prior To Surgery

by Sucha Kim M.D.



Sucha Kim M.D.

As you prepare for your surgery, you may have many questions and concerns regarding your medical care during your hospitalization. In order to minimize post op complications, all patients are seen by primary care physicians for medical clearance prior to surgery. At least 50% of patients undergoing surgery take regular medications. Therefore, it is important that you bring your list of medications and their correct doses at that time. Before and after your surgery, some of your medications will need to be adjusted. Unfortunately, there is very little hard data regarding this part of medical care. Here are some general guidelines.

If you have high blood pressure, do not take any blood pressure medications on the day of your surgery. The exception to this rule is beta blockers which are taken with a small sip of water in the morning of the surgery. Due to blood loss and anesthesia, most people experience low blood pressure after the surgery. Your medications will be resumed when your blood pressure is above normal.

If you are diabetic (type 2) and only take pills, please do not take them on the day of your surgery. If you take long or medium acting insulin we want you to take only half the dose on the day of your surgery. If you take insulin only once a day, the last dose prior to surgery should be halved. Your diabetic medications will be resumed when you are able to tolerate food. While you are in the hospital, your glucose will be monitored 4 times a day. We place all diabetic patients on sliding dose of insulin while they are in the hospital. This does not mean you are going be on insulin forever.

Continued on page 2

The Dorr Arthritis Institute
Medical Associates
Good Samaritan Hospital
✦
637 S. Lucas Ave.
Los Angeles CA 90017
Information
213-977-2280

New Patient Appointments
213-977-2280
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Paul K. Gilbert M.D.
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✦

Table of Contents

Save The Date October 23, 2010
The Dorr Institute for Arthritis Research and Education
Annual Fund Raiser
For more information please call 213-977-2511

What To Do With Your Medications Prior To Surgery

Continued from page 1

All blood thinners, such as Coumadin (warfarin), Plavix (clopidogrel) or equivalent medications, will be stopped before surgery. **There are no exceptions to this rule if you are having a joint surgery**. Some patients may be converted to injected blood thinner prior to surgery depending on their underlying diagnosis. This will be stopped at least 12 hours prior to surgery. After the surgery, all blood thinners will be resumed when cleared by your surgeon.

If you take nonsteroidal anti-inflammatory medications for any reason, please stop them at least 5 days prior to surgery. Unless you can not live without it, we also recommend you stop Celebrex prior to surgery as well. If you take baby aspirin for preventive treatment, this will need to be stopped 7 days prior to surgery. If you take aspirin for known heart disease, peripheral arterial disease, or stroke, we would like to continue with baby aspirin until the day of your surgery.

If you have rheumatologic disease and take immunosuppressive medications (such as methotrexate, Arava (leflunomide), Humira (adalimumab), etc), please discuss specific details with your doctor. Some medications, such as Arava will be continued up until surgery while some are stopped at least a week before surgery and not started until your wound is healed.

If you take birth control pills (BCP), these will need to be stopped at least 4 weeks prior to surgery since they increase the risk of thromboembolic disease (blood clot formation). Hormone replacement therapy will also need to be discontinued at least 4 weeks prior to surgery although the risk of thromboembolic disorder is less than that of BCP.

Many of the herbal medications can interact with medications given during the surgery. For simplicity, we recommend all herbal supplements be stopped at least 1 week prior to surgery.

I hope this information will be helpful as you prepare for your upcoming surgery. If you have any questions regarding your medications, please talk to your doctor.

Closed Manipulation Of The Knee Following Total Knee Replacement

by William Long M.D.

William Long M.D.

What is closed manipulation of the knee?

Closed manipulation is a procedure that is performed after total knee replacement for a patient who has difficulty bending the knee. The procedure is called closed ‘because there is no surgical incision. Manipulation refers to the hands-on technique performed by the orthopaedic surgeon. In an operating room an anesthesiologist administers an intravenous sedative to make the patient sleep. While the patient sleeps the surgeon slowly bends the knee until the stiff tissues stretch and the knee achieves the desired amount of flexion. The procedure takes several minutes to complete. Before waking the patient a local anesthetic is injected into the knee.

Some patients go home on the same morning as the procedure. Other patients receive an epidural catheter to assure painless postoperative motion, but this requires that the patient stay in the hospital overnight. The decision to stay overnight is usually made by the physician and the patient but some medical insurance companies will not approve or pay for an overnight stay. Very little pain or discomfort is expected after closed manipulation with or without the epidural.

One advantage to insertion of the epidural catheter is that it helps some patients gain confidence. The patient can see improved flexion and control of knee motion without associated pain. If a patient previously experienced severe pain dur-

Continued on page 3

ing physical therapy they may become sensitized. The mere thought of maximally bending the knee might cause fear and anxiety as the patient anticipates painful motion. The epidural catheter facilitates immediate knee motion by eliminating pain and minimizing anxiety. Some patients have difficulty bending the knee but their stiffness is not associated with pain. These patients may not need an epidural catheter or an overnight stay. Little or no pain medication is needed after a closed manipulation. After the closed manipulation the patient should resume range of motion exercises with physical therapy within a few days.

When the surgeon recommends closed manipulation does that mean that something is wrong with the knee replacement operation?

Closed manipulation is recommended when the surgeon believes that there is no problem with operation. The implants should be the right size and they must be aligned properly and solidly attached to the bone. The procedure should not be done when lack of flexion is caused by a fracture, infection, loose implants, or parts that are the wrong size. The procedure is recommended when the surgeon believes that the soft tissues surrounding the knee became stiff because they did not bend enough during the first six weeks after the operation.

There is no absolute number of degrees of flexion that dictates when manipulation should be done. Traditionally surgeons followed a general guideline that recommends manipulation when the knee bends less than 90 degrees six weeks after the operation. Ultimately 110 degrees of flexion was considered the desirable amount of knee flexion. Today because of smaller incisions, better implant designs and improved postoperative pain control some surgeons are reconsidering these general rules. If a patient has 130 degrees of flexion with one knee replacement and only 100 degrees of flexion with the other should the stiff knee be manipulated? Should a knee be manipulated two months when the same range of motion can be achieved by two or three months of continued physical therapy? The correct answer depends on the individual patient, their desires and circumstances. One patient may decide that they want to avoid returning to the hospital and the operating room at all cost. Another patient with the same range of motion may not want to go through the time commitment and discomfort of a long course of therapy. Some individuals just want the doctor to decide for them.

In an operating room while the patient sleeps Dr Long slowly bends the knee until the stiff tissues stretch and the knee achieves the desired amount of flexion.

Who fault is it that I got stiff ?

When a knee does not bend enough after total knee replacement then far too often a blame game begins. Sometimes the surgeon blames the physical therapists because it is their job to help the patient move the knee after surgery. The surgeon may believe that if the therapist pushes the knee hard enough it will bend. The physical therapist sometimes blames the patient. The therapist may believe that the patient is not trying hard enough or that they are simply a wimp with poor pain tolerance. If the patient would simply follow instructions the flexion will be achieved Ultimately, the patient holds the surgeon responsible. It is the surgeon who must diagnose the problem that caused stiffness and solve the problem. The surgeon must decide if it is best to simply stay the course, adjust the pain medication and modify the therapy regiment, or recommend closed manipulation. The surgeon must also recognize when there is a serious problem that will not be solved without an operation.

What are the Risks Associated with Closed Manipulation?

The most common cause of failure is the return of stiffness. Most patients can expect to gain improved flexion immediately and by simply using the new range of motion and doing a few exercises they can maintain

Continued on page 4

Closed Manipulation

Continued on page 3

the range of flexion.
If the patient never bends the knee during the course of the day then the knee will lose the range of motion.

Fracture of the femur is a much more serious complication. Tearing of the tendons, ligaments or skin has been reported when too much force is applied. The longer the knee has been stiff and the weaker the bone then the higher the risk of a fracture. After more than 15 years of performing closed manipulation the author has not caused one of these complications, but it is certainly possible that this could happen one day. To avoid this complication the surgeon must be willing to stop pushing on the leg if too much force is required. The range of motion is not achieved and the only solution may involve an open operation, but the traumatic injury is avoided. The experience of the surgeon determines when to push harder and when to accept the range of motion that is achieved with reasonable force.

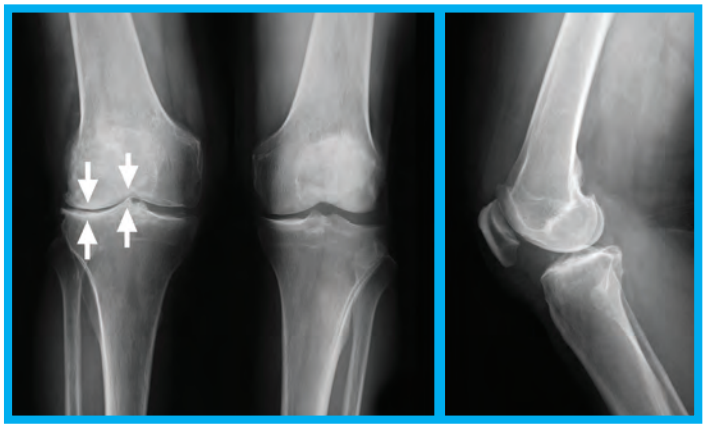
Summary

Closed knee manipulation is a procedure that can be very useful and effective in helping the patient achieve knee flexion rapidly and without severe pain. It is safe in most instances especially when performed by an experienced surgeon. The indications for closed manipulation are determined by the desired range of motion and the philosophy of the treating physician. The goals and expectations of the patient, the quality of bone and the length of time that the knee has been stiff must all be taken into consideration. Although there is no surgical incision, the decision to perform a closed knee manipulation should not be taken lightly. Understanding the complexities if this relatively simple technique is important because it gives the surgeon the best chance of making the correct recommendation.

X-Rays Are Important Tools For Making An Accurate Diagnosis

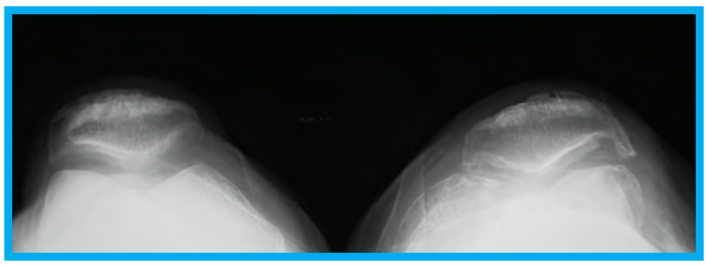
by Paul K. Gilbert M.D.

We at the Dorr Arthritis Institute are blessed by having patients who trust us enough to come from other facilities for our expertise. They often are seen first by other physicians and turn to us for a second opinion or further care.



Standing radiographs reveal the loss of bone cartilage and the subsequent reduction of the joint space (bone on bone).

They bring their X-rays with them to optimize our analysis of their particular needs. X-rays are extremely important to a comprehensive examination and consultation, especially in regard to knee issues. While many practitioners simply shoot two views--one from the front and one from the side--more extensive pictures are requisite to truly appreciate the extent of any existing disease. Standing X-rays shot from the front are essential; these give a basic understanding of the amount of cartilage left between the bones. It is also frequently beneficial to take a standing film with the knee bent 45 degrees, which provides further insight as to cartilage status at this position on the femur. Judicious X-ray evaluation is critical and indispensable for the proper diagnosis and planning of appropriate treatment intervention.



“Sunrise” view of Patella Femoral joint space

Leg-Length Discrepancy

by Jennifer Okuno P.T.

Jennifer Okuno P.T.

Many total hip replacement candidates present with leg-length discrepancy before surgery because of the loss of hip joint space due to arthritis, previous congenital deformity or trauma. As a result, patients develop soft tissue contractures and begin to lose flexibility or range of motion in the affected hip. For example, simple activities such as putting on shoes and socks become difficult. They also begin to show an impaired gait by reducing their stride lengths, limping, waddling side-to-side, walking flat-footed or using alternating movement patterns to advance the leg forward. Some patients may also experience low back or knee pain.

Surgeons attempt to restore the leg lengths when performing a primary total hip replacement. They first carefully examine the preoperative X-rays and the soft tissues surrounding the hip to correctly discern what actions need to be taken both during and after surgery. Immediately following the procedure, patients often feel that the subject leg is longer. This is called an apparent leg-length discrepancy. This perception will gradually subside by three months because of soft tissue healing, strengthening and the eventual stretching of the surrounding hip musculature. Patients are instructed in a home exercise program to facilitate the aforementioned strengthening and stretching of the muscles after the total hip arthroplasty. It is also critical to incorporate a heel-to- toe walking program in order to regain a normal, efficient gait.
There are other conditions that contribute to apparent leg-length discrepancy besides the aftereffects of surgery. Among those are pelvic obliquity, degenerative spine, degenerative scoliosis and muscle contractures.

In some situations the surgeon cannot equalize the difference in leg lengths. There are many reasons for that, including the fear of strain in the surrounding soft tissues and causing possible nerve injury. In these instances, the patients may be required to attach a heel lift directly to the sole of the shoe on the subject leg to create equilibrium. Or they may simply be told to insert a heel lift inside the opposite shoe for balance.

These leg-length differences can often be successfully accommodated by altering the gait, strengthening and stretching the muscles and/or the integration of a shoe lift. Your physical therapist will be indispensable in helping you adjust to your new hip and in reestablishing not only an optimal gait, but also the comfort and ease of movement so necessary to a stress free and active daily life.

Insurance And Healthcare Reforms

by Paul K. Gilbert M.D.

Recent developments in regard to insurance company premium changes have grabbed the attention of the media, the public and physicians. Extremely troubling is the alarming marked increases in premiums charged to the patients for their healthcare, while excessive corporate profits are recorded. What's a person to do?

What I see in this contentious situation is a tremendous opportunity for insurance companies to step up and provide essential healthcare coverage while keeping premiums at a reasonable, ethical level. While this may impact ultimate profits to their shareholders, this approach would garner priceless positive branding and most important of all, demonstrate social responsibility; what a turnaround! This would foster goodwill, temper antagonisms and promote an attitude of cooperation between providers, patients and insurance companies to improve healthcare in general in this country. Some companies should consider this for these reasons and also simply because it is the right thing to do.

Meet The Staff

Sang Ra R.N

Sang Ra R.N. is one of the charge nurses on 7 north. Sang has worked at Good Samaritan Hospital for 22 years, and enjoys working on the orthopedic ward. "I've been working at Good Sam since 1988. I graduated Seoul National University, College of Nursing in 1977 in Korea. I immigrated to America with my husband in 1978. Before joining Good Sam, I worked in several hospitals in Washington State where I started my new life in America.

I have been involved with several health volunteer works in Korean community in Los Angeles. Recently in April of this year, I took a position of the first chair-woman of KAGNA, (Korean American Good Sam Nurses Association), which was organized this year and has more than 80 members of Korean Nurses working in Good Samaritan Hospital."

Sang's hobbies include hiking and traveling. She recently worked on Operation Walk Vietnam with her Good Samaritan nursing colleagues

Yancy Clark has work with the Dorr Arthritis Institute for over 20 years. Yancy is responsible for storage and organization of all x-ray films taken of our patients. This is a big job considering our surgeons have operated over 10,000 patients!
X-rays are stored for many years and referenced frequently for studies. There is a constant pull and re-file of films as doctors measure and compare past and current x-rays to determine how implants function in the body over many years. Yancy is organized and detailed in managing his work area.
He also helps transport patients.
His hobbies include restoring vintage automobiles, flying his pigeons and spending time with his family. He recently benched pressed 300 pounds! He's always willing to help patients with difficulty in transfers. His size and strength are reassuring to those who have limitations due to arthritis!

Yancy Clark

Save The Date October 23, 2010

The Dorr Institute for Arthritis Research and Education Annual Fund Raiser

This years event will feature a fabulous meal prepared by special guest chef Leon Galatoire from Galatoires in New Orleans.

Letters To The Editor

Dear Dr. Dorr,

I thought you might enjoy this photo of me and my ski buddies, Jessica and Judith from Singles Ski. It was taken in Mammoth. I had just won a Gold Medal in the Far West Championships on Slalom months after bilateral hip surgery.

My friends are fast racers. I haven't raced since the 1989-90 season, but they said "just do it!". Now they think they created a monster! I just love racing. In fact I am on my way now to ski near Bishop for 4 days.

I attribute my success to my 4 time a week regime at the gym, doing strengthening exercises, yoga or Pilates, and to the fine surgery and supportive recovery given to me by you and your staff.

I am forever grateful to Earl and Davida Racina for sending me to you for surgery. When Davida found out how nervous I was about surgery, she had Earl call me. He said "only go to Dr. Dorr, he's the best in the world" he was right!

Sincerely,

Marie "Two Hip" Layfayette

Medications Record

Please carry a record of all medications, vitamins and supplements you are currently taking any time you visit the Arthritis Institute or any physician.

The record should be kept current with any changes in dosage clearly noted. Our staff will ask to see your list at each visit.

Dear Dr. Dorr,

As you can see from the enclosed photograph, here I am, 11 years and 1 month later, standing on top of Bald Mountain in Sun Valley, Idaho.

My surgical procedure went extremely well, and as you promised six months from surgery I was able to stand in a fast, moving stream and trout fish. One year after surgery, almost to the day, I was able to resume skiing, and here I am 11 years later with no problems.

This is a true testimony to your surgical skills.

Thank you again.

Sincerely,

David A. Bray, MD

PS: None of my orthopedic surgery friends can tell that I've ever had a hip replacement, and when told they cannot identify which side had been replaced and which side is my original hip.

JOIN US AT OUR FREE TUESDAY NIGHT SEMINARS

Please come join us at one of or up coming Tuesday night seminars. Experts from the Dorr Arthritis Institute Medical Associates at Good Samaritan Hospital will discuss some of today's most advanced hip and knee replacement techniques. During this free seminar, you will learn how new computer and robotic precision guided surgery is offering patients a less invasive and longer lasting option for joint replacement.

Registration 6:00 to 6:30 pm
Program begins at 7:00
For more information call 1(213) 977-2511

June 22, 2010
Embassy Suites Arcadia
211 East Huntington Drive
Arcadia, CA 91006

July 24, 2010
Arthritis Health Day at Good Samaritan Hospital
Registration begins at 8:00 am.
Program runs from 8:30 am until noon

Sept 14, 2010
Radisson Los Angeles Westside
6161 W. Centinela Avenue,
Culver City, CA 90230

Please RSVP to 1 (800) GS Cares ✦ 1 (800) 472-2737
Seating is Limited

www.dorrarthritisinstitute.org

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