Personal Papers

Getting two new hip joints

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It was with a slight feeling of envy that I read Professor Rhodes's article "Getting a new hip joint" in September 1983.¹ I had played competitive tennis until my mid-40s, but over the next three to four years had increasing difficulty in walking. My gait was described affectionately by my husband as that of a "ruptured duck." Doctors' symptoms are often decidedly non-textbook. After considering a variety of different referrals with my family doctor I came to the conclusion that if I was not suffering from multiple sclerosis my symptoms must have a hysterical basis. As time went on I could walk a diminishing distance each day; breakfast time was no problem, by lunch I was struggling, and the evenings became increasingly impossible. Recovery occurred during the night. This had the added disadvantage that when seen by my colleagues during meetings, at lunch time, etc, I did not seem too disabled. My poor family told another story.

Matters came to a head in the spring of 1983 when I was unable to straighten up after interviewing a patient in the cells at the local police station. What the police thought of the duty psychiatrist I can only imagine. Another x ray and a visit to an orthopaedic surgeon showed absence of joint space in both hips—perhaps due to congenitally poor positioning—with bony changes on the left side: a joint replacement was suggested.

It is interesting, yet somewhat traumatic, going through the emotional phases known to occur in patients facing major surgery. The relief when something concrete is found changes quickly to "why me," "why a doctor," "why so young," and then you experience general recoil at the thought of two long scars—all television programmes seemed to portray leggy women with high cut bikinis at that time—together with the incorporation of lengths of metal and polyethylene sockets into your body. But when you cannot walk and modern surgery offers an escape there is no alternative. The above fears need to be faced and worked through. The anxiety state so common after emergency surgery results from the lack of time to do this.

The first fortnight in July 1983 was carefully selected as being after the annual meeting of the BMA in Dundee, and a locum was arranged. This was, in fact, a bad choice as it coincided with the hottest weather in Britain for 200 years, and to crown everything my locum had a myocardial infarction the weekend after my admission.

A somewhat undesirable experience

Being at the receiving end of the National Health Service is a useful, if somewhat undesirable experience. You realise the

importance of communication, and the completely unrealistic ideas and emotional lability that bedevil all patients. After the operation my left leg felt two inches longer than the other one, probably due to preoperative compensatory pelvic tilt. I knew that this was untrue but had vivid mental pictures of walking with three inch high boots like those given in the 1930s to patients who had had polio. My long suffering surgeon produced a tape measure, but I was unconvinced. An unguarded remark from my nearest and dearest resulted in a flood of tears.

For 48 hours after the replacement you can move nothing, apart from the ankle, below the waist on the side with the new joint. This should be emphasised to all patients; otherwise they will wonder in horror what they have sanctioned. Each day after this is rewarding as individual groups of muscles realise in turn that they can now move metal as easily as bone. Like Philip Rhodes's my sacrum quickly became sore, but this may have been partly due to loss of weight—I had purposely gone from 10 to nine stone but lost another stone unintentionally.

It was reassuring to know that the new hip had been taken to 90° in the theatre so that anything less than this was unlikely to cause problems. Looking at the postoperative x ray film helped, and I especially appreciated being shown an actual joint with its range of movement, etc. I qualified in 1957 before artificial joints had made an appearance. A special reaching aid supplied by the hospital to retrieve objects from the floor was useful, and I found a short stick with a hanging hook at one end and a stationer's rubber thimble at the other so useful that I brought a homemade version back into hospital with me the second time, as it was invaluable for reaching television knobs and light switches.

There were plenty of amusing episodes. The occupational therapist, a shy elderly man, was covered in embarrassment when asked if his "stocking gutter" would be suitable for pants: "no lady ever asked that before." There were the giggles of two patients outside the door who wondered if "doctors as patients look the same as anybody else." A "get well card," which hoped that I was enjoying my "new ball," produced comments like "so you are the psychiatrist who has come in for a sex change." It is embarrassing the way that premedication alters your inhibitions. I cheerfully recognised a psychiatric patient in a member of staff on my way to the theatre, an inexcusable faux pas that merited an apology at the first opportunity.

Within a month my new left hip became the better one. Because of my age and family history of longevity I was advised to try and get further "milage" from my right hip. Why do men always describe things in terms of motorcars. Even my milkman commented that I seemed to have failed my Ministry of Transport test.

My right hip seemed to deteriorate rapidly over the next few months. Whether this would have happened anyway or was accelerated by its supporting the other hip after the operation I do not know, but before my three month discharge date I was struggling. Slopes became an impossibility—it is amazing how many ramps there are at hospital entrances when you are conscious of them—and stairs were difficult. I dreaded home visits in case

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my patient had retired upstairs to bed. My inpatients looked out for me and manhandled me up four steps that had no rail at the back of the hospital—not the most dignified way for a consultant to arrive on her ward. Anti-inflammatory drugs were useless and produced a facial rash; dihydrocodeine tartrate helped when I had a social commitment or was on call. I dreaded the weekends. Work was the only thing that kept me going provided that I could park outside the wards. My new worry was that I would damage the hip already done as I toppled sideways coming down stairs. It is so difficult to be the “good” patient and accept advice. Colleagues and indeed relatives find it hard to know how bad the problem is and may give conflicting advice. I felt strongly all along that I wanted my life “now” and might be dead from something else in 20 years’ time. I wanted to shop with my children, attend sports days, entertain occasionally and do my job competently.

Second hip five months later

The second hip was replaced five months after the first; I remember as a student being told that hip x ray films are deceptive and give little idea of what is going on inside the joint. This proved to be true at the second operation. I had had much more bother from this right hip, with its lack of bone disease, than I ever had from the first. Looking back, I think that my advisers were right to fight to save the second joint. I might have felt that they were “knife happy” if they had gone in at once as I had initially requested. Patients need a few months for the first hip to be able to take over as the “good” leg. Unlike Professor Rhodes, I could not have survived without a bath or shower, and you need a good leg to get you in and out. A general surgeon confided to me that no surgeon likes to operate until “pushed.”

What had I learnt when it came to the second time around? Like the sunny summers of childhood, you tend to forget the bad bits. Most importantly I did not get depressed. I knew that each problem was temporary, each muscle would work eventually, if not to Olympic standards then certainly to competent doctor, housewife, and mother ones. I knew that I could get off my stick within a fortnight from the six week check up, that stairs would cease to be a problem within another few weeks, and that I would be back at work eight weeks after the operation. Driving was no problem then, but you need to have a slightly quicker movement from the right leg than the left. Early swimming is a great boon. We are lucky to have a sports centre at the end of the road where they run a “disablement night” once a week. This has the added advantage of making you ashamed of ever complaining of anything as you improve and most of the other swimmers remain the same or deteriorate. Lying on your side causes few problems, probably due to preservation of trochanteric integrity. It certainly is easy to develop a limp, and concentration is required on standing up, especially at lunch time in front of your colleagues.

The same premedication that had knocked me out the first time had no effect the second; I could have driven home, and almost considered doing just that while waiting in the theatre annex. Other things that made the second time easier were the presence of a newly appointed partner whom I knew would run our “patch” competently and “embolic” stockings, invaluable for preventing ankle oedema that had necessitated constant resting after the first operation. A sheepskin blanket made all the difference to sacral pressure and should be routine equipment. The overhead handle on a fracture bed had helped movement after the first operation, and its use in elevation certainly improved the micturition angle. But the ordinary bed (if hospital beds can ever be called ordinary) was easier to get in and out of on my second admission.

The importance of early movement impressed me. I will now think hard before allowing patients to remain immobile; even a few days in bed can produce considerable muscle weakness. Thankfully, catatonic states are rarely seen today. Physiotherapy is a vital part of rehabilitation. I was determined the second time round to keep both knees bendable because I had been so stiff after the first operation. In spite of this resolve, the quadriceps on the operated side with its two short term drains was too painful initially.

Remembering how light headed I had been when put from lying to standing after a week, and being forbidden to sit, I dangled my lower legs over the bed unobserved to get at least some circulatory effect. Sex still remains one topic that no one seems happy to discuss.

You learn all sorts of dodges with a stick. I became adept at filling the washing machine with it, though was unable to stop three pints of milk slipping off the doorstep and emptying themselves down the path. Using the alternate hand for the second hip caused no problems after a few tentative steps. The overlying increased heat (I believe that the cement reaches a temperature of 90°) is interesting, but all patients should be told to expect it and not equate its development with infection, which seems to be the greatest threat. Certainly, the antiseptic used in the theatre was powerful. On both occasions my skin peeled off to a demarcation line after the operation. Waking with what seemed to be an accessory nipple (from a cardiac monitor) impressed on me the care that my colleagues had gone to. I was less happy receiving blood and had to remind myself firmly that the acquired immune deficiency syndrome is mainly confined to the other side of the Atlantic.

Early morning television is a great boon if you are woken early, but I found the exercises of the Green Goddess and Mad Lizzie frustrating.

The worst bits and the future

What were the worst bits? Each time I needed one dose of a powerful analgesic the night after the operation, followed by distalgic as required. After the first operation one day of nausea was misery, but an antiemetic took care of this the second time. The excessive heat in the summer added to the general discomfort. One drain did not wish to be removed and felt like a ball of string being unwound from around the joint when it was eventually dislodged. The “normal” ward laxative produced a day of uncertainty with six “results,” another reason why a bendable knee is essential for elevation on and off bedpans. Insomnia was something of a problem. Nitrazepam on the first admission caused rebound anxiety and little extra sleep so was declined the second time round. The scars ached sometimes. Interrupted and continuous sutures heal equally well, but the latter are more uncomfortable when being removed. Your legs sometimes feel “odd.” Really, all these are fairly minor afflictions. Frustration and dependency on others were worse than any pain. Progress often seemed slow, I suppose as a doctor you expect to be able to grit your teeth and walk away.

Surely the NHS should concentrate resources on conditions that are not only treatable but in which the quality of life can be so vastly improved.

What of the future? I do not know what it holds, and at present I am more than happy to leave it in God’s hands. Each day now is a special bonus to be enjoyed to the full, and for which I am profoundly grateful.

PS It is now nine months since this article was accepted. During these months life has returned to “normal.” It is a matter of balancing overprotectiveness with foolhardiness. I have ridden camels and explored subterranean caves on holiday, gone on walking tours of Victorian Manchester and the garden festival in Liverpool, and out with the pilot launch from Spurn Point. The only times that I am aware of being what my husband describes as his bionic wife is going upstairs if I am tired and clambering about on different levels on my rockery. It is easy to forget not to run (forbidden) for a bus, and not to catch a closing door or a pot that is boiling over. I have come to a complete impasse only once, trying to leave a fixed bench at a picnic table from between two fat uncooperative men who were enjoying their lunch.

Reference

- 1 Rhodes P. Getting a new hip joint. *Br Med J* 1983;287:747-8.