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Hip & Knee

A guide for patients with hip or knee arthritis

This booklet is general information to read at your own pace. It is not medical advice and does not replace a consultation. Treatment differs from person to person — please discuss what is planned for you with your treating team. Appointments: (02) 9052 1883.

Hip & knee

A five-part guide for people with hip or knee arthritis — from understanding what is happening in the joint, through every option short of surgery, to the operation itself and recovery.

Most people who see an orthopaedic surgeon about a hip or a knee have the same few questions. What is actually wrong with the joint? Is surgery needed, or can this be managed another way? If surgery is needed, what does the operation involve — and what will recovery really be like?

This guide answers those questions in order, across five short chapters. It is written for you to read at your own pace, before or after your consultation. Nothing here replaces a consultation about your own joint — every hip and knee is different, and so is every set of circumstances around it.

Two things are worth saying at the start.

First, **most hip and knee arthritis is managed without an operation.** Exercise, weight management and simple medicines help more people than surgery does. Those options are always considered first, honestly, and given a fair trial.

Second, when a joint replacement is the right choice, it is one of the most reliable operations in modern surgery. Australia keeps a national registry of every joint replacement performed here, so we can tell you — with real numbers rather than reassurance — how long these implants last and how often things go wrong.

Start with the first chapter below, or jump to the one that matches where you are.

SOURCES

- 1 Australian Orthopaedic Association National Joint Replacement Registry (AOANJRR), Annual Report 2023 — <https://aoanjrr.sahmri.com/annual-reports-2023>
- 2 OrthoInfo — patient education from the American Academy of Orthopaedic Surgeons — <https://www.orthoinfo.org/>

Understanding arthritis

What osteoarthritis is, why joints wear, what the symptoms mean, and how we work out how advanced it is.

What a joint is, and what wears out

The hip is a ball-and-socket joint: the ball at the top of your thigh bone sits in a socket in the pelvis. The knee is a hinge between the thigh bone and the shin bone, with the kneecap gliding in front. In a healthy joint, the ends of the bones are covered by cartilage — a smooth, slightly springy layer that lets the surfaces glide over each other almost without friction.

Osteoarthritis is the gradual loss of that cartilage layer. As it thins, the joint becomes stiffer and less forgiving. In advanced arthritis the cartilage can wear away completely, so that bone rubs on bone. The body reacts by forming extra bone at the edges of the joint (bone spurs), and the joint can slowly change shape.

Osteoarthritis is not simply "wear and tear" from using the joint too much, and it is not your fault. It is a disease of the whole joint, and several things make it more likely:

- Age — it becomes more common from mid-life onwards
- Family history
- Previous injury to the joint, such as a fracture or a torn ligament or meniscus
- Body weight — extra load accelerates wear, particularly in the knee
- The shape of the joint you were born with, such as hip dysplasia

What it feels like

Arthritis usually announces itself gradually. Common symptoms are:

- Pain in or around the joint — hip arthritis is often felt in the groin or thigh, and sometimes in the knee
- Stiffness, especially first thing in the morning or after sitting
- A grinding, clicking or catching feeling
- Reduced movement — difficulty with socks and shoes, stairs, or getting out of a low chair
- A limp, or a change in the way you walk

Symptoms often come and go. Many people have months that are manageable and flare-ups that are not. A bad fortnight does not necessarily mean the joint is deteriorating quickly.

How we assess it

At the consultation, Dr Broadhead will ask about your pain, what it stops you doing, and what you have already tried, and will examine the joint — how it moves, where it is tender, and how you walk.

A plain X-ray, taken standing, is usually the only test needed. It shows how much cartilage space remains and whether the joint has changed shape. The X-ray matters less than you might expect, though: **it is the person that is treated, not the picture.** Some joints look poor on X-ray and cause little trouble; others look moderate and cause a great deal. The decision about treatment is based on how the joint affects your life, not on the image alone.

MRI scans are rarely needed to diagnose arthritis. They are useful for other problems — soft tissue injuries, or when something on the X-ray needs a closer look — and it will be explained if one is worthwhile in your case.

What happens next

Arthritis is not a one-way street to surgery. The next chapter goes through every option short of an operation — what genuinely helps, what the evidence says, and how to tell when those options have been given a fair go.

SOURCES

- 1 OrthoInfo (AAOS) — Osteoarthritis of the Hip — <https://www.orthoinfo.org/en/diseases--conditions/osteoarthritis-of-the-hip/>
- 2 OrthoInfo (AAOS) — Arthritis of the Knee — <https://www.orthoinfo.org/en/diseases--conditions/arthritis-of-the-knee/>
- 3 Australian Commission on Safety and Quality in Health Care — Osteoarthritis of the Knee Clinical Care Standard (2024) — <https://www.safetyandquality.gov.au/standards/clinical-care-standards/osteoarthritis-knee-clinical-care-standard>

Your options

Everything short of surgery — what genuinely helps, what the evidence says about each option, and how to know when it is reasonable to start talking about a joint replacement.

Surgery is the last item on this page deliberately. For most people with hip or knee arthritis, the treatments below — used properly and given time — control symptoms well. They also make surgery safer and recovery faster if an operation is needed later. Nothing here is wasted effort.

Exercise and physiotherapy

Exercise is the single best-supported treatment for arthritis of the hip and knee. That surprises many people — a worn joint feels like something to protect, not to work. But strengthening the muscles around a joint reduces the load going through it, and moving the joint keeps it supple. Australian and international guidelines put exercise first for good reason.

A physiotherapist can build you a program suited to your joint and your fitness, and progress it as you get stronger. It takes weeks to feel the benefit, not days. Expect some muscle soreness at the start; that is different from harm.

Weight management

Each kilogram of body weight puts several kilograms of force through the knee with every step. Losing even a modest amount of weight measurably reduces pain in weight-bearing joints. If you are carrying extra weight, this is likely to be the most powerful thing you can do for your joint — and if surgery is needed later, it also lowers the risk of complications from both the anaesthetic and the operation.

This is easy to say and hard to do. Your GP can help, and there are structured programs that work. It is raised not as a judgement, but because the evidence is strong.

Medicines

- **Paracetamol** helps some people with milder pain and is safe for most when taken as directed.

- **Anti-inflammatory tablets (NSAIDs)** such as ibuprofen are often more effective for arthritis pain. They are not suitable for everyone — they can affect the stomach, kidneys and blood pressure — so check with your GP or pharmacist, especially if you take other medicines.
- **Anti-inflammatory creams and gels** are worth trying for the knee, where the joint is close to the skin.
- **Stronger pain medicines (opioids)** have a poor record in arthritis: modest benefit, significant harms, and real dependence risk. They are not a long-term treatment for joint pain.

Walking aids and simple measures

A walking stick used in the opposite hand takes meaningful load off a painful hip or knee. Firm, supportive shoes help. So does pacing — planning the day so the joint is not asked to do everything at once. None of this is giving in; it is managing a mechanical problem mechanically.

Injections

- **Corticosteroid injections** can settle a painful flare of knee arthritis for weeks to a few months. Relief is temporary and repeated injections give diminishing returns, so they are best used sparingly and with a purpose — settling a flare, or getting you through an event.
- **Hyaluronic acid ("gel") injections and platelet-rich plasma (PRP)** are heavily marketed. The evidence for lasting benefit is weak, and Australian guidelines do not recommend them for routine use. This practice does not offer treatments that cannot be justified from the evidence.

Arthroscopy — a note

Keyhole surgery to "clean out" an arthritic knee was common for decades. Good trials have since shown it does not help osteoarthritis, and it is one of the procedures Choosing Wisely Australia — the profession's own campaign against low-value care — specifically advises against for arthritis. If someone offers to arthroscope your arthritic knee, it is reasonable to ask why.

When is it reasonable to consider a replacement?

There is no X-ray finding, score or age that makes the decision for you. A joint replacement becomes worth discussing when three things line up:

- **The arthritis is advanced** on examination and X-ray.
- **The non-surgical options above have been genuinely tried** and are no longer holding the line.
- **The joint is taking things from your life you are not willing to give up** — sleep, work, independence, the walk you have always done.

If that describes you, the next chapters explain what preparing for surgery involves, and what the operation actually is. Reading them commits you to nothing.

SOURCES

- 1 Australian Commission on Safety and Quality in Health Care — Osteoarthritis of the Knee Clinical Care Standard (2024) — <https://www.safetyandquality.gov.au/standards/clinical-care-standards/osteoarthritis-knee-clinical-care-standard>
- 2 RACGP — Guideline for the management of knee and hip osteoarthritis (2nd edition, 2018) — <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/knee-and-hip-osteoarthritis>
- 3 Choosing Wisely Australia — arthroscopic debridement/lavage is not recommended for knee osteoarthritis — <https://www.choosingwisely.org.au/>
- 4 OrthoInfo (AAOS) — Osteoarthritis of the Hip — <https://www.orthoinfo.org/en/diseases--conditions/osteoarthritis-of-the-hip/>

Preparing for surgery

What happens between deciding on a joint replacement and the day of the operation — consent, costs, tests, the anaesthetist, and what you can do yourself to improve the result.

Once we have decided together that a joint replacement is the right step, a series of things happen in a fairly set order. This chapter walks through them so nothing comes as a surprise.

Consent — understanding the operation

Dr Broadhead will go through the operation with you in detail: what it aims to achieve, what it involves, the risks that matter, and what recovery asks of you. You will sign a consent form, but the form is the least important part. The point is that you can explain the operation in your own words before you agree to it. Bring your questions written down; bring a family member if you like.

Costs, in writing

You will receive a written quotation before any procedure, setting out any out-of-pocket expenses. Dr Broadhead is a member of the Australian Medical Association and uses AMA fee recommendations as a guide. The estimate covers the surgeon, surgical assistant, anaesthetist, hospital and any implants, so you can see the full picture in one place.

If you choose treatment in a **public hospital**, your care is fully covered by Medicare with no out-of-pocket cost. You will be placed on the hospital's waiting list — for a joint replacement this is typically more than twelve months — and as RPA is a teaching hospital, your operation may be performed by a supervised training registrar. If you are treated **privately**, a date can be planned around your schedule.

Tests before surgery

You will have some routine tests so the anaesthetist and surgeon can plan safely: blood tests, a heart tracing (ECG) and sometimes a chest X-ray. Further X-rays or scans of the joint itself may be arranged to plan your implant — this is how "custom" planning is done, whether or not any robotic assistance is used in theatre.

The anaesthetist

Before the operation you will be assessed by the anaesthetist — at a pre-admission clinic, in the rooms, or by phone. Most joint replacements are done under a spinal anaesthetic, a general anaesthetic, or a combination; the anaesthetist will recommend the safest option for you and discuss their fee. If you see a cardiologist or other specialist, bring their letters — it genuinely helps.

What you can do yourself

The weeks before surgery are not a waiting room. Four things measurably improve results:

- **Keep moving.** The stronger the muscles around the joint going in, the faster the recovery coming out. Public patients are invited to the Osteoarthritis Chronic Care Program; private patients can see a physiotherapist for a pre-surgery program.
- **If you smoke, stop or cut down.** Smoking impairs wound healing and raises the risk of infection and anaesthetic complications.
- **If you are carrying extra weight,** losing some before surgery lowers your risk.
- **Deal with infections early.** A skin wound, a bad tooth, or a bladder infection near the time of surgery can seed infection in a new joint. See your GP about any of these before your operation.

Medicines, fasting, and the day itself

If you take blood-thinning medicines — aspirin, clopidogrel, warfarin, apixaban, rivaroxaban and similar — you will be told exactly when to stop them. Do not stop them on your own; do not keep taking them past the date you are given either.

The hospital will contact you the day before surgery with your arrival time and fasting instructions. As a rule you will fast for at least six hours beforehand. Follow the instructions exactly — eating when you should not can mean your operation is cancelled on the day.

What to bring: your medicines (or an accurate list with doses), any allergy details, comfortable clothes, toiletries, and your health fund or Medicare details. Leave valuables at home.

SOURCES

- 1 Current practice information, [drmatthewbroadhead.com.au](https://www.drmatthewbroadhead.com.au) (practice processes; fees per AMA guidance) — <https://www.drmatthewbroadhead.com.au>
- 2 OrthoInfo (AAOS) — Preparing for Joint Replacement Surgery — <https://www.orthoinfo.org/en/treatment/preparing-for-joint-replacement-surgery/>

The operation

What a hip or knee replacement actually is — what the implants are made of, how the surgery is done, what robotic and custom approaches really mean, and the honest numbers on how long implants last and what can go wrong.

What a joint replacement is

A joint replacement removes the worn surfaces of the joint and replaces them with an implant, so the joint moves on smooth artificial surfaces instead of bone on bone. It is resurfacing more than removal — most of your own bone stays.

Total hip replacement (THR): the worn ball at the top of the thigh bone is removed and replaced with a stem and a new ball; the socket in the pelvis is relined with a cup. The new ball glides in the new socket.

Total knee replacement (TKR): the worn ends of the thigh bone and shin bone are trimmed and capped with shaped metal components, with a smooth plastic insert between them. The kneecap surface is sometimes resurfaced as well.

What implants are made of

Implants combine a few well-proven materials: strong metal alloys (titanium or cobalt-chromium) for the structural parts, highly wear-resistant polyethylene (a dense plastic) for the bearing surface, and sometimes ceramic for the ball of a hip. Components are fixed either with bone cement or with coated surfaces your own bone grows into. Which combination suits you depends on your age, bone quality and anatomy — the choice is discussed at consultation, and it will be in your quotation by name.

How the surgery is done

The operation is performed under spinal and/or general anaesthetic and typically takes one to two hours.

For the **hip**, Dr Broadhead uses either the posterior approach (from the back of the hip) or the direct anterior approach (from the front, between muscles rather than through them). Each has advantages, and the honest summary is that both give excellent results in the long run; the anterior approach may make the first few weeks easier for some patients, though the evidence for a lasting difference is mixed. The approach recommended will be the one that suits your anatomy and circumstances, with the reasons explained.

For the **knee**, the focus is on accurate alignment and soft-tissue balance, with an enhanced recovery (ERAS) protocol so you are walking on the new knee within a day.

Robotic and custom approaches, plainly

You will see joint replacement marketed with words like *robotic*, *computer-guided* and *custom*. Here is what they actually mean:

- **Robotic assistance** does not mean a robot does the operation. It is a tool that helps the surgeon execute the pre-operative plan — the cuts and component positions — with high precision. Dr Broadhead has completed additional training in robotic-assisted knee replacement and uses it where it adds value.
- **Custom planning** means your implant sizes and positions are planned on detailed imaging of your own joint before the operation.

These tools improve precision. Whether that precision translates into better long-term results for most patients is still being studied — a fact stated plainly here rather than dressed up as a selling point. What matters most to your outcome is the decision-making, the planning and the execution, with or without a robot in the room.

How long a replacement lasts

Australia's national registry has tracked virtually every joint replacement in the country for over twenty years, so this answer comes from data, not optimism. In its 2023 report, the registry found that at 20 years, the cumulative revision rate — the proportion of joints needing a re-operation for any reason — was **8.1% for conventional total hip replacements** and **7.7% for total knee replacements** performed for osteoarthritis.

Put the other way around: roughly nine out of ten replacements are still doing their job twenty years on.

The risks, honestly

Serious complications are uncommon, but they are real, and you should know them before you consent:

- **Infection.** The most feared complication. Superficial infections may settle with antibiotics; deep infection around the implant can require further surgery, occasionally including removal of the implant.
- **Blood clots.** Clots can form in the leg veins (DVT) and rarely travel to the lungs. You will have blood-thinning measures after surgery to reduce this risk.

- **Dislocation (hip).** The new ball can come out of the socket, most often in the early months. Rarely this needs revision surgery.
- **Loosening and wear.** Over years the implant can loosen and may need revision — this is what the registry numbers above measure.
- **Fracture.** The bone around the implant can crack during or after surgery.
- **Nerve or blood vessel injury.** Uncommon, and usually recovers, but can be permanent.
- **Stiffness (knee).** Some knees stay stiffer than expected despite good rehabilitation.
- **Ongoing pain.** Most patients get excellent pain relief; a small proportion — more often after knee than hip replacement — are left with some persistent discomfort.

Your personal risk profile — age, weight, other conditions — is part of the consent discussion. The surgeon's job is to reduce every risk that can be reduced, and to be honest about the ones that cannot.

SOURCES

- 1 Australian Orthopaedic Association National Joint Replacement Registry (AOANJRR), Annual Report 2023 — cumulative revision rates at 20 years for conventional total hip replacement (8.1%) and total knee replacement (7.7%) performed for osteoarthritis — <https://aoanjrr.sahmri.com/annual-reports-2023>
- 2 OrthoInfo (AAOS) — Total Hip Replacement — <https://www.orthoinfo.org/en/treatment/total-hip-replacement/>
- 3 OrthoInfo (AAOS) — Total Knee Replacement — <https://www.orthoinfo.org/en/treatment/total-knee-replacement/>

Recovery

Week-by-week expectations after a hip or knee replacement, the warning signs that need a call, and realistic timelines for driving, work and sport.

Recovery from a joint replacement is measured in weeks and months, not days — but it starts on day one, and most of it happens at home. The timelines below are typical for a straightforward total hip or knee replacement. Yours will be tailored to you, and the written program you receive after surgery takes precedence over this page.

The first days (in hospital)

You will be helped out of bed and onto the new joint on the day of surgery or the morning after. This is not bravado — early walking is the single best protection against blood clots and chest complications, and the new joint is designed to take your weight immediately.

Physiotherapists will teach you to walk with a frame or crutches, get in and out of bed and a chair, and manage stairs. Most people go home within one to three days, once they are safe on their feet. Some go to a rehabilitation unit first, particularly if home has many stairs or little support.

Expect swelling, bruising and soreness. You will have pain medicines, usually a blood thinner for some weeks, and clear wound-care instructions.

Weeks 1–2

- Walking short distances at home, several times a day, with crutches or a frame
- Doing your exercise program — little and often beats one heroic session
- Swelling and disturbed sleep are normal; ice and elevation help
- Knees: bending is work. The exercises that restore bend matter more than any other part of knee rehabilitation

Weeks 2–6

- Progressing from frame to crutches to a stick as your balance and strength allow
- Walking further outdoors; many people are down to one stick or none by six weeks
- Most of the sharp surgical pain settles; what remains is muscle soreness and stiffness that responds to exercise

Weeks 6–12

- Most people are walking without aids, back at the shops, and largely independent
- Strength keeps building; low-impact exercise — walking, exercise bike, hydrotherapy — is encouraged
- A knee can remain warm and a little swollen for months; this on its own is not a concern

Three months to a year

By three months most people have most of their result. Improvement continues quietly for a full year — the last of the swelling settles, strength returns, and the joint stops announcing itself. It is common to *forget* the joint by the end of the first year, which is the real goal.

Red flags — call rather than wait

Contact the rooms, your GP, or the hospital promptly if you notice:

- **Fever, or chills and feeling unwell**
- **Increasing pain** in the joint after the early pain had been settling
- **Redness, or discharge or leaking from the wound**
- **A hot, swollen calf** — possible blood clot
- **Chest pain or sudden shortness of breath — call 000.** This can signal a clot in the lungs
- A fall onto the new joint, or a sudden change in what it can do

None of these should be watched overnight to see how they go. Early treatment of a wound problem or a clot is simple; late treatment is not.

Driving, work and sport

- **Driving.** You must be off strong pain medicines, able to make an emergency stop without hesitation, and confident controlling the car. For most people this is somewhere between four and six weeks — sooner for a left-side joint with an automatic car. Your surgeon will confirm when it is safe for you; your insurer expects that conversation to have happened.
- **Work.** Desk-based work is often possible from two to six weeks, depending on comfort and travel. Physical work takes longer — usually closer to three months, sometimes with modified duties in between.
- **Sport.** Low-impact activity is encouraged for life: walking, swimming, cycling, golf, bowls, doubles tennis. Skiing and hiking are realistic for many. High-impact running

and jumping sports put wear on the implant, and most surgeons — Dr Broadhead included — advise against them as regular exercise on a replaced joint.

The follow-up

Every joint replacement patient is reviewed after surgery, usually around six weeks, with further reviews as needed. X-rays are repeated periodically over the years to watch the implant. If anything about the joint changes between reviews, do not wait for the next appointment — call.

SOURCES

- 1 OrthoInfo (AAOS) — Total Hip Replacement Exercise Guide; Activities After Total Knee Replacement — <https://www.orthoinfo.org/en/recovery/activities-after-total-knee-replacement/>
- 2 Practice rehabilitation protocols, [drmatthewbroadhead.com.au](https://www.drmatthewbroadhead.com.au) (hip and knee exercise guides) — <https://www.drmatthewbroadhead.com.au>