

Total Knee Replacement Discharge Instructions

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For patients being discharged to Rehab or SNF after their acute care stay

A) **DVT Prophylaxis:** There are essentially 2 choices, all patients should be on one.

□ Lovenox 30 mg sub Q B.I.D. for a total of 10 days from the date of surgery is sufficient according to the most recent literature. Some high-risk patients should be on Lovenox for 4 weeks. Patients on Lovenox should have weekly CBC to check their Hct. and platelet counts. The reason for this is that Lovenox can cause Thrombocytopenia, which can be very dangerous. An Hematocrit less than 30 or an abnormal Platelet count should be called to the doctor.

□ Coumadin-dose adjusted for an INR in the therapeutic range. The typical goal for prophylaxis is 2.0 INR. The attending doctor at the facility should adjust this dose, and coumadin when used should be given for 4 weeks from the date of surgery. For patients on CRC at NCH, you may use my coumadin sliding scale daily.

B) **Wound care:** Currently, our hip and knee replacement patients are having their wounds closed with a subcuticular stitch and Dermabond surgical glue. A Tegaderm dressing has been applied and can be left in place for approximately 2 weeks. If water gets under the dressing it can be replaced. It can be removed at 2 weeks and the incision can be left open to air. These patients have sutures on either end of their incision, and these knots can be simply cut and removed any time after 10 days. Do not attempt to pull on the stitch, just simply cut off the ends. The patient may shower with or without the Tegaderm.

C) **CPM machine:** The CPM is to be used on a regular schedule on a daily basis. Our current recommendation is to use the machine for two hours B.I.D or T.I.D. Using the machine excessively can actually stretch out our repair of the tendon and muscles. You should try to increase the flexion (bending) by 10 degrees each day. The goal for flexion is the maximum setting on the machine. The goal for extension (straightening) is 0 degrees. The period of usage for the CPM is 3 weeks or until active and passive range of motion are equal and > 100 degrees.

D) **Physical Therapy:** P.T. should be on a B.I.D. schedule using the existing Total Knee Replacement protocols. Weightbearing is as tolerated and there are no restrictions on active and passive ROM unless otherwise stated. Ice can be used on a p.r.n. basis. Aquatic exercises or whirlpool can be used as long as the incision is dry and clean with no drainage. Do not let the patients lie in bed with a towel roll or pillow placed under their knee. This will promote a flexion contracture, which we are trying to correct in most patients. They can place the pillow or towel under their ankle, with nothing under their knee.

E) **Venous Ultrasound:** Any calf or thigh tenderness or increased swelling should be investigated with a venous ultrasound and those results should be faxed to our office, positive or negative.

F) **TED Stockings:** Can be used to control typical and normal postoperative swelling. Patients with normal shaped or normal sized legs can use Thigh high hose, and patients with fat or atypical shaped legs do better with knee high hose. These should be removed at night, and are not needed for every patient.

G) **Follow Up Appointment:** 2 weeks after discharge from your facility.

H) **Prescriptions upon discharge:** At the discretion of the attending physician at the Rehab facility or SNF. Almost all TKR patients will be discharge on coumadin, which is recommended to be continued for one month post operatively. Pain meds should be as they were using at time of discharge. Oxycontin usage upon discharge from Rehab/SNF is discouraged.

Updated January 10, 2007 by H. Morton Bertram III, M.D. 239-592-0373