LATERAL RESURFACING
ELBOW REPLACEMENT

INFORMATION FOR PATIENTS

GATESHEAD
UPPER LIMB UNIT
This leaflet has been designed by the Orthopaedic unit to give you further information about Lateral Resurfacing Elbow Replacement, it is used in conjunction with the discussions you have had with your surgeon and information you have been given by him.

The Elbow Joint

The elbow consists of three bones; the humerus which is the upper arm bone, and the radius and ulna, which are the forearm bones.

The elbow joint works as two compartments, an inner one which acts as a hinge enabling you to bend and straighten your elbow, and an outer one which allows rotation to turn your palm up towards the ceiling.

Why do I need an elbow replacement?

The most common reason for replacing the elbow joint is arthritis, usually rheumatoid arthritis. It may also be recommended if you have osteoarthritis which makes your elbow stiff and painful, or if you have a severe fracture of the elbow. The main reason for doing the operation is to reduce pain in the elbow; bending the elbow to reach the mouth and turning the forearm usually show the greatest improvement. However, you should be aware that following the operation your elbow may still not straighten completely.

What is elbow joint replacement surgery?

Total Elbow Joint Replacement
Until recently the operation known as Total Elbow Joint Replacement was carried out on everyone requiring surgical treatment. The operation is designed to replace the joint surfaces to give a hinged
joint. The top of one of the forearm bones (the radius) is removed and both remaining sides of the joint are replaced with components fixed either with or without cement. The type of surgical cement used is identical to that used in dental surgery. The upper arm (humeral) and forearm (ulnar) components are made of a combination of metal and plastic.

Lateral Resurfacing Elbow Replacement
More recently the operation known as Lateral Resurfacing Elbow Replacement has been developed and introduced in our hospital. This operation has been designed for those people whose disease in the elbow involves mainly the outer compartment of the joint. The components are made from the same materials as those of the Total Elbow Joint Replacement and are fixed to the bones in the same way. In this operation the top of the radius is not removed, a new surface is applied instead, together with a new surface for the upper arm bone (humerus) with which it forms the outer compartment of the elbow.

The operation technique is the same whichever joint replacement is carried out. To get into the elbow joint the muscle on the back of the elbow (the triceps) is split, this is then re-stitched at the end of the operation.

**How do we choose which operation is the right one for each individual, and what are the advantages and disadvantages of each?**

If both the inner and outer components of the elbow have severe arthritis then a Total Elbow Replacement is the only option. The advantage of this type of procedure is that it has been performed for many years and the long term results are known. The disadvantage is that if the joint wears out then the relatively large components can be difficult to remove and replace and the results of further (revision) surgery are not as good as the original operation.

If only the outer compartment of the elbow joint has severe arthritis then a Lateral Resurfacing Elbow Replacement can be used. The advantage of this procedure is that this preserves the natural inner compartment of the elbow and movements are therefore likely to be more like a natural elbow joint (less like a hinge). As the components of a Lateral Elbow Resurfacing are much smaller than those of a Total Elbow Replacement, and these wear out, their removal is likely to be easier and a revision to Total Elbow Replacement more successful. The disadvantage is that as the Lateral Resurfacing Elbow is new, although the results up to now are good, the long term results are not yet known.
Are there any complications with elbow replacement?

Complications following elbow surgery are not uncommon (approx. 10 -15%), however most are just temporary and can be treated successfully. The risks of these complications occurring will vary from patient to patient so will be discussed on an individual basis.

- **Infection**: Superficial wound problems can be treated with antibiotics. Rarely a deep wound infection may require further surgery.
- **Nerve damage**: Temporary tingling or numbness in the little and ring fingers is quite common. Permanent nerve injury is rare.
- **Loosening**: The new elbow replacement may become loose with time, requiring further surgery.
- **Dislocation**: The components of the elbow replacement can dislocate (separate), requiring further surgery.
- **Broken bone**: Due to very thin and weak bone quality, a fracture of the elbow bones can occur during surgery or at any stage thereafter. This would be treated with a plaster cast or further surgery.
- **Stiffness**: The elbow can become stiffer following the operation which may require further surgery to improve the movement.

How long will I be in hospital?

The operation is usually carried out as an inpatient. The majority of patients are admitted to hospital on the day of their surgery. However it may be necessary to admit you the day prior to surgery. The anaesthetist will make this decision and inform you. The average length of stay following this surgery is two to three days.
What happens before the operation?

Prior to admission you may need to have a pre-operative assessment. This is an assessment of your health to make sure you are fully prepared for your admission, treatment and discharge. The pre-operative assessment nurses will help you with any worries or concerns that you have and will give you advice on any preparation needed for your surgery. Before the date of your admission please, read very closely, the instructions given to you. If you are undergoing a general anaesthetic you will be given specific instructions about when to stop eating and drinking, please follow these carefully as otherwise this may pose an anaesthetic risk and we may have to cancel your surgery. You should bath or shower before coming to hospital. On admission a member of the nursing staff will welcome you. The nurses will look after you and answer any questions you may have. You will be asked to change into a theatre gown.

The surgeon and anaesthetist will visit you and answer any questions that you have. You will be asked to sign a consent form. A nurse will go with you to the anaesthetic room and stay with you until you are asleep. A cuff will be put on your arm, some leads placed on your chest, and a clip attached to your finger. This will allow the anaesthetist to check your heart rate, blood pressure and oxygen levels during the operation. A needle will be put into the back of your hand to give you the drugs to send you to sleep.

What happens after the operation?

After your operation you will then be taken to the recovery area where you will be closely monitored by a recovery nurse until you are awake and comfortable. A nurse will check your blood pressure, pulse and the area where the operation has been done. You will have a clear oxygen mask in place and sometimes the oxygen will be continued on the ward. Once your initial recovery period is over you will be transferred to the ward. You will normally be able to have a drink shortly after the procedure and eat as soon as you feel hungry.

You can usually get out of bed an hour or so after you wake up and you should wait for the nurses to help you as you may feel a little dizzy at first. It is likely to be a bit painful where the operation has been carried out, but if you move carefully, the pain is not usually severe. The nurses will monitor your pain and give you painkillers, if necessary. It is quite normal for a small amount of blood to soak through the dressing and this can easily be changed. Sometimes the staff will need to press gently on the dressing for a while to prevent this happening again.

Recovery after surgery

This leaflet gives a guide to when you may be able to do things, however you must always be guided by your physiotherapist or surgeon. You will be seen by a physiotherapist on the ward after your operation and they will advise you on exercises for your wrist and hand. You will be fitted with a removable cast on the back of your arm to protect the new joint. You will be shown how to remove it for exercise. The exercise must be followed carefully to avoid damaging the
repaired structures.

An appointment will be made for you to be reviewed by a member of the upper limb team in clinic. You will also be monitored by a physiotherapist on discharge from hospital.

If you have not been given your physiotherapy appointment, please contact us. Tel 4452320 (see numbers on back of leaflet).

**When do the stitches come out?**

The stitches (or clips) will be removed at your GP surgery usually 10-14 days after your operation. You must keep the wound dry and covered until it is well healed. The nursing staff will advise you about this before your discharge from hospital.

**Pain**

Some degree of pain and discomfort is usual after surgery. Your GP/Pharmacist should be able to advise you on effective pain control. If you feel you are unable to manage your pain please discuss this with your GP, Surgeon or Physiotherapist.

**Wearing the cast**

As mentioned above, you will have a cast fitted to the back of your arm one to two days after surgery. Instructions regarding the use of the cast will be given to you by your physiotherapist.

If you find it difficult to sleep you can use pillows in front of you to rest your arm on.

**Washing**

You may remove the cast to wash once the wound is healed and the stitches have been removed. You will be shown how to position your arm while showering/bathing. You **must not** use your arm for washing or attempt to lift yourself out the shower or bath with the arm.

**Daily activities**

For the first four weeks all activities of daily living e.g. eating, dressing, cooking etc must be done using your un-operated arm.

At four weeks you will be allowed to slowly wean from the cast through the day. You **must not** lift anything or try to push your arm straight. Avoid pushing yourself out of a chair, pushing a door, polishing, reaching for a
At six weeks you will be able to leave the cast off altogether and gradually increase your activities. You should still avoid lifting and pushing with the arm. You should avoid twisting the elbow with the arm out to the side.

**Leisure activities**

Your physiotherapist and surgeon will advise you when it is safe to resume your leisure activities.

You are advised not to do any forceful pushing and pulling activities e.g. bowling, gardening etc. It is recommended that you should not lift heavy objects at all in the future.

**Returning to work**

If you have a heavy manual job you will be unable to return to work in the same capacity. We advise you to avoid lifting weights over approximately 10lbs in weight and avoid pushing/pulling activities.

If your job involves overhead activities we recommend you avoid these for three to six months. If you have a light job we recommend you have a minimum of eight weeks off work.

This should be discussed with your physiotherapist or surgeon.

**Driving**

You should be able to return to driving a power assisted car at approximately eight weeks. Driving will be more difficult if your left arm has been operated on due to using the gear stick and handbrake.

We advise that you should check with your insurance company before starting driving.

**Physiotherapy**

Rehabilitation is important if you are to get the most out of your elbow after the operation.

As already discussed you will have a removable splint fitted to your elbow 24 - 48hrs after your operation, which should only be removed for hygiene and exercise in the first four weeks.

Your physiotherapist will teach you gentle exercises for your elbow using your other hand for support. The exercises are initially very gentle to allow the muscle on the back of the arm to heal. It is important that you don’t try and push your arm straight, but use your other arm to lower it down.

You will be instructed how and when to progress your exercises by your physiotherapist. Please check
with your physiotherapist before recommencing any manual work or leisure activity.

If you are at all concerned about your elbow please contact us, see telephone numbers on the back of the booklet.

**Useful telephone numbers**

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<tr>
<td>During the hours of 8am -8pm contact the Day Surgery Unit, North East NHS Surgery Centre, Queen Elizabeth Hospital</td>
<td>0191 4453009</td>
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<tr>
<td>During the hours of 8pm -8am contact Level 1, North East NHS Surgery Centre, Queen Elizabeth Hospital</td>
<td>0191 4453005</td>
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<tr>
<td>During the hours of 0800 -1630 contact the Physiotherapy Department (please ask for a member of the upper limb team)</td>
<td>0191 4452320</td>
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<tr>
<td>Main switchboard</td>
<td>0191 4820000</td>
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**Useful Organisations**

**The Arthritis Research Campaign**
PO Box 177  
Chesterfield  
Derbyshire  
S41 7QT  
Tel: 0870 850 5000

[www.arc.org.uk](http://www.arc.org.uk)  
Funds research and produces a free range of leaflets and information booklets

**Arthritis Care**
18 Stephenson Way  
London  
NW1 2HD  
Tel: 0207 380 6500  
[www.arthritiscare.org.uk](http://www.arthritiscare.org.uk)  
Offers self help support and a range of leaflets on arthritis

**Patients Association**
PO Box 935  
Harrow  
Middlesex
Provides a helpline, information and advisory service. It also campaigns for a better health care service for patients.

Data Protection

Any personal information is kept confidential. There may be occasions where your information needs to be shared with other care professionals to ensure you receive the best care possible.

In order to assist us improve the services available your information may be used for clinical audit, research, teaching and anonymised for National NHS Reviews. Further information is available in the leaflet Disclosure of Confidential Information IL137, via Gateshead Health NHS Foundation Trust website or the PALS Service.

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