3) Postoperative recommendations:

The postoperative period requires a collaborative approach with effective communication between surgeon, nurse, physiotherapist and anaesthetist. Most of the recommendations below are readily achievable even in low resource settings.

1) Patients should be encouraged to eat and drink as soon as they feel ready.[40]
2) All patients should be mobilised at least once in the first 24 hours post-surgery.[3, 4, 14, 40]
3) If a urinary catheter was inserted during surgery, it should be removed as soon as is practically possible.[4]
4) Multimodal analgesia including paracetamol and NSAIDS where appropriate should be continued to reduce opioid consumption. The oral route is preferable.[3, 4, 24]
5) Postoperative nausea and vomiting prophylaxis should be continued.
6) Opioids can be considered for rescue analgesia e.g. oxycodone or fentanyl. Patient-controlled analgesic pumps are not recommended. [3, 4]
7) Mechanical thromboprophylaxis should be instituted as soon as possible, with the addition of pharmacological prophylaxis at a later stage, as per current local guidelines for venous thromboembolism prevention. [41, 42]
8) Non-pharmacological interventions for preventing delirium should be instituted. Examples include repeated orientation for patients, cognitive aids, early return of hearing aids and spectacles, and encouraging family visits. [50]

The effectiveness and success of the arthroplasty team will be dependent on successfully incorporating as many components as possible from well described arthroplasty and ERAS pathways. ERAS has been shown to improve outcomes in almost all major surgeries. [4]

Data collection to allow for objective assessment and continual audit is paramount to implementing an arthroplasty programme. The following parameters have been consistently shown to benefit such programmes.

1) Clinical outcomes e.g. length of stay, readmissions, major complications, adverse events
2) Non-clinical outcomes e.g. patient satisfaction scores
3) Overall cost of care to allow for effectiveness of treatment to be measured

More specifically, long term functional assessments like the Oxford Hip and Knee Scoring systems are also needed. [53, 54]

The measures above will allow for arthroplasty surgery in different scenarios to be compared effectively, and allow for this multimodal intervention to be dynamic, guided and modified by new evidence as it emerges.

Anaesthesiology has a significant role to play when patients present for THA/TKA surgery. The major focus for anaesthetists should be on providing modern anaesthesia techniques with optimal pain management until discharge from hospital, whilst facilitating as many of the components of holistic care that fall within their domain.

To achieve quality of care, we will need to focus on both the individual and population at large, so that the provision of health services achieves the desired clinical outcomes, consistent with current best practice.

From a patient perspective, we need to make sure that quality care is accessible to as many of our citizens as possible, is effective once they have engaged with health care structures and meets both the expectations of the clinicians and those receiving the treatment.

This guideline will hopefully play a part in achieving this.

SASA Arthroplasty Guideline Committee

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