CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

PATIENT INFORMATION

Dislocation after hip replacement

What you're feeling

When a hip replacement dislocates, the ball part of the new joint slips out of its socket. You will usually know it has happened. The leg may look shortened or turned oddly, and you cannot put weight on it or move it the way you normally would. It is painful and frightening, but it can be put back in place.

Some hips do not fully come out of joint. Instead they slip partway and slide back. This is called subluxation. You might feel a clunk, a sharp pain deep in the groin, and a sense that the hip is unstable or about to give way.

The pain sits deep in the groin or the buttock, and it can run down the front of the thigh toward the knee. It tends to flare when you bend the hip too far, twist on a planted foot, or lean forward from a low chair. Getting up from a toilet seat, lowering into a deep armchair, or bending to pick something off the floor can all set it off. Getting in and out of a car is often awkward because of the low seat and the twisting involved.

The hip is often at its worst at night when you roll over in bed, or first thing in the morning when you have been lying still for hours. Once you are up and moving gently, it usually settles.

Day to day, the things that become hard are the ones that need deep bending or crossing your legs: putting on socks and shoes, trimming toenails, sitting in low seats, or kneeling in the garden. You may find yourself reaching for a walking stick outdoors because you do not trust the hip on uneven ground.

If your hip has slipped out more than once, you may start avoiding movement altogether and planning every trip around where the nearest chairs and handrails are. That caution is common, and it is worth telling your surgeon about it.

What's actually happening

Your new hip joint is a ball sitting in a socket. In a normal hip, strong straps of tissue around the joint, along with the muscles over the hip, hold that ball firmly in place. During your operation, some of those straps are stretched or cut to reach the joint, and they need time and care to heal back up. Until they do, the ball can slip out of the socket if the leg is bent or twisted too far.

The socket side of the joint is a cup set into your pelvis, and the ball sits on the top of your thigh bone. The cup is lined with a smooth rim that helps hold the ball in, a bit like a gasket sealing a lid. When everything lines up

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well, the ball stays centred even under load. But if the cup and ball are angled in a way that leaves the ball less covered, or if the muscles around the hip are weak, the ball can ride up over the rim and pop out. That is the dislocation you felt, and it explains why certain movements, like deep bending or twisting on a planted foot, are the ones that set it off.

Some hips are more at risk than others. If your replacement was done after a broken hip, if you have a condition that affects your balance or posture such as Parkinson's disease, or if you have had spinal fusion surgery in your lower back, the joint has less natural protection. The same goes for hips where earlier injuries or operations have weakened the muscles on the outside of the hip. Your surgeon takes all of this into account when planning your operation, and there are implant choices and surgical techniques that make the joint more stable when the risk is higher.

What we can do about it

Dr Kieran Hirpara, a hip surgeon at Mater Private Hospital Rockhampton, starts with the least invasive options that suit your situation. Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. At that visit we take a history, examine you, and arrange imaging where it is needed.

The first step after a dislocation is putting the hip back in place. After that, we look at what makes your hip unstable and work out which options fit you. We usually try non-operative care first: changing how you move, and physiotherapy to strengthen the muscles that hold the ball in the socket. We give this a fair trial before we talk about surgery.

For pain while that is happening, simple pain medication and anti-inflammatories can help you stay comfortable and keep moving. We will talk you through what suits you.

If a hip keeps coming out despite all of this, surgery is considered. There are two broad paths. One is to revise the replacement, which means changing some or all of the parts to make the joint more stable. One option is a cup design with two moving surfaces, called a dual-mobility cup, which gives the ball extra hold. The other path applies when the first replacement was only a partial one after a broken hip: converting it to a full hip replacement. Both are bigger operations than the first one, and we will talk you through the elevated risks before you decide anything. This is a shared decision, made together with you.

Where the operation happens also matters. We work from a hospital that does this surgery regularly, and the evidence points to lower dislocation rates when both the surgeon and the hospital handle a higher volume of hip replacements.

If your first replacement was done through the back of the hip, an early, structured physiotherapy program lowers the chance of it happening again. And if surgery is on the table for you, we tailor the approach to your own hip, your own risks and your own needs, because there is no single approach that suits everyone.

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What to expect

Most hips that dislocate once do not keep doing it. The hip is put back in place, the tissues around it heal, and with care the joint settles. Many people never have a second episode. But some hips do come out again, and a hip that has slipped out more than once is more likely to keep doing so without further treatment.

How likely this is depends on your own hip. For most people having a first hip replacement, the risk of dislocation within 2 years is 3.5%. If your replacement was done after a broken hip, the risk is higher: about 1 in 20 patients dislocate within a year. As covered earlier, hips are also at more risk after spinal fusion surgery or with conditions such as Parkinson's disease.

If your hip does keep coming out, surgery to make the joint stable again usually works. When the parts of the replacement are changed to hold the ball more firmly, that stops further dislocation in 91% of people whose hip was unstable. That is the realistic picture: most hips are fixed by further surgery, but not all.

Leaving a hip unstable is not a good plan. A joint that keeps slipping damages the new parts and the bone around them, and it wears away the smooth cartilage left in the joint. Over time that leads to stiffness, pain and arthritis, and it makes any later surgery more difficult. The longer a hip stays out of place, the harder it is to get a good result from putting it back.

The honest summary is this. One dislocation, treated promptly and followed by sensible precautions and strengthening, usually settles and stays settled. Repeated dislocations rarely fix themselves. They need proper assessment and, often, further surgery. If you are avoiding movement, planning your day around chairs and handrails, or worried the hip will go again, tell your surgeon. That pattern is worth acting on early, before the hip or your confidence wears down further.

When to see someone

If your hip has slipped out of joint, it needs attention straight away. Go to an emergency department if you cannot put weight on the leg, if it looks shortened or turned oddly, or if the pain is severe and the hip will not move. The hip needs to be put back in place promptly, and the longer it stays out, the harder that becomes. Ask for an urgent specialist review if you feel a clunk and sharp groin pain but the hip slides back in by itself, or if the hip has come out more than once. Also tell your surgeon if you have new numbness, pins and needles or weakness moving your foot or ankle, because the nerve running down the back of the leg can be affected.

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