

Oxford Partial Knee Replacement

Remember when simple routine tasks were something you took for granted? If knee pain is changing your lifestyle, and only one compartment of the three compartments is affected. The new concept in joint replacement surgery is to only replace the worn out portion of the arthritic joint.

The Oxford® Partial Knee Replacement is the first implant that can accomplish this task with proven long term results of 95% at 15 years and beyond. For this reason the Oxford® makes a total knee joint replacement unnecessary in some cases. The common patient scenario is bone on bone osteoarthritis in the medial compartment (the inside part of the knee). This occurs due to degeneration or “wear and tear” of the articular cartilage, and degeneration or surgical removal of the meniscus. Once this situation develops, the individual usually develops pain and limitations. An Oxford is perfect for this situation.

After an Oxford has been placed, the bone on bone rubbing condition has been replaced by the Oxford with its meniscus replacement bearing. The implant actually sits between the bones and cruciate ligaments and the medial collateral ligament.

The Oxford® Unicompartmental Knee System offers these advantages:

- At 15 years following surgery, 95% of implants are still functioning well.
- More normal motion of the knee
- Only a portion of the knee is replaced, making this procedure available to a younger population
- Minimally invasive - a small incision is utilized
- Less pain due to a smaller operation
- Outpatient, or one night in hospital
- Quicker recovery - discontinue crutches as fast as one desires
- The anterior cruciate and posterior cruciate ligaments are always preserved.



In Hospital Care and Physical Therapy:

Early efforts at mobilizing the patient are made on the day of surgery. Usually a Continuous Passive Motion machine (CPM machine) is applied to the operative leg on the day of surgery to start early range of motion. The patient is helped up to a chair the evening of surgery. Extensive walking is avoided for 12 to 18 hours post-operatively till the effects of the nerve blocks wear off and muscular control of the leg has returned (a small price to pay for the comfort provided).



On the day following surgery, the surgical drain (if utilized) is removed. The post-op compressive dressing is changed to a light dressing on post-op day # 2. Immediate full weight bearing is allowed. Range of motion and strengthening exercises are begun. Ambulation is encouraged. Stair climbing is taught.

The goal of therapy is to reduce swelling and pain, normalize gait, restore strength, range of motion and balance.

Hospital Stay:

The hospital stay is brief. Many patients are usually discharged home the day after surgery. Very rarely is a two night hospital stay required to meet goals of independent care.

Showering Post-operatively:

It is safe to get the wound wet after the sutures/staples have been removed at the 1st post-op visit, until then showers are allowed with a waterproof dressing. If any drainage persists, the wound should be kept clean and dry with a sterile gauze dressing applied and changed as necessary and the incision cleaned with alcohol till it completely stops.

Physical Therapy after Hospital Discharge: Two options are available for post hospital therapy.

1. Home therapy – This is now the most commonly employed option. Most patients have insurance coverage for home therapy. The quality of home therapy is quite excellent. Duration varies, but is generally employed for 1 to 2 weeks.
2. Outpatient therapy - Outpatient therapy in a physical therapy department has the advantage of better equipment vs. what is available in home. More mobile patients often opt for outpatient care. Patients often migrate from home to outpatient therapy as they become more mobile.

Prevention of Blood Clots:

Some type of blood thinner is used in almost all cases to prevent the formation of blood clots. The most common option utilized is the oral administration of enteric coated aspirin (ECASA) 325 MG 1 tablet once a day for 1 month after surgery along with compressive stockings (TEDS).

If you are at high risk for blood clots, oral Coumadin (Warfarin) or fractionated Heparin (Fragmin) subcutaneous injections for 2 weeks will be utilized. If Coumadin is used twice weekly blood work is performed to ensure that the blood is not “too thin” and the dosing is correct to reduce the risk of blood clots. ECASA 325 mg twice daily is recommended for the next 2 weeks after the Coumadin or Fragmin is stopped.

Time on Walker or Crutches:

Full weight bearing is allowed immediately after surgery. Most patients can wean off the walker or crutches as their muscle function, swelling and soreness allows. Many patients have moved to the use of a cane by 5 to 7 days post-op.

Time on a Cane:

Once off the walker or crutches, the use of a cane in the opposite hand is helpful for another week. Most physically fit patients are off all ambulatory aids including a cane by 2 weeks post-op.

Time until Return to Driving:

Patients should not return to driving until cleared to do so post-op. In part this is due to liability issues if an accident should occur. It is generally safe to return to driving 2 to 4 weeks post-operatively (shorter for a left knee, longer for a right knee)



Time until Returning to Work:

Predicting a return to work date is difficult. Motivational issues play an important role. Great variability exists. In general, patients returning to a sedentary job tend to return to work 2 to 4 weeks post-op and those with more physically demanding jobs tend to return at 2 to 3 months post-op.

Time until Returning to Recreational Athletics:

Patients can begin to return to light recreational sports such as golf by 4 to 6 weeks post-op. More strenuous sports, such as tennis may require 12 weeks before a return is possible.