PREPARING FOR SURGERY · NO. 4

Anesthesia and pain control, explained.

Spinal or general, what a nerve block actually does, and an honest account of what the first week feels like.

THE ONE-MINUTE VERSION

If you only read one page, read this.

- Spinal and general anesthesia are both used routinely for joint replacement; the choice is made with your anesthesiologist, and neither is a lesser option.
- A nerve block numbs the knee without disabling the muscle you need for walking.
- Pain control is built from several small medications rather than one large one, which is why the plan looks like a list.
- The block wearing off, usually overnight, is the moment patients are least prepared for. Get ahead of it.
- Days two through four are typically the hardest. That is expected, not a setback.

DR. SEEM'S PERSPECTIVE

Nobody signs up for a joint replacement because they are excited about the anesthesia. But how your pain is managed in the first week shapes how you remember the whole operation, and it is the part patients are given the least information about. If you have a high tolerance, a history with opioids, or a bad experience under anesthesia before, tell us early. That conversation changes the plan, and it is never held against you.

Who decides, and when

Your anesthesia plan is made by an anesthesiologist, in conversation with you, on the day of surgery, informed by your medical history and the operation itself. Dr. Seem tells the anesthesia team what the procedure requires; they determine what is safest for your heart, lungs, airway, and spine.

You are not expected to arrive knowing what you want. But knowing what the options are makes that conversation a real one rather than a form to sign.

Spinal or general

Both are used routinely for joint replacement, both are safe, and neither is a lesser option. Which one you have depends on your health, your spine, the medications you take, the preference of your anesthesiologist, and your own preference. Some patients have a clear reason for one or the other. Many could reasonably have either.

	SPINAL WITH SEDATION	GENERAL ANESTHESIA
What it is	Numbing medication placed in the lower back, plus sedation so you sleep through the operation	Fully asleep, with your breathing managed by the anesthesia team
What you experience	You do not see, hear, or remember the operation. You wake with legs that feel heavy and numb, and sensation returns over the next several hours.	You do not see, hear, or remember the operation. Waking can feel groggier at first, and your legs work normally right away.
Things to know	The numbness occasionally lasts longer than planned, which can delay standing, walking, and going home. Some patients have temporary difficulty urinating. A headache afterward is uncommon and treatable.	A sore throat afterward is common. Nausea and grogginess are more likely in the first hours. Because the leg is working immediately, some patients find it easier to get up and move sooner.
When it is chosen for you	Often preferred when avoiding a breathing tube is desirable, and when your spine and medications allow it	Necessary when prior back surgery, spinal anatomy, or certain blood thinners rule out a spinal, and used whenever it is the better fit

You may hear strong opinions in either direction. The honest position is that the published differences between the two for joint replacement are modest, and that the right choice is the one made for your particular situation by the physician managing your anesthesia. If you have a preference, or a bad

experience in your history, say so early enough for it to be part of the plan.

> **THE MOST COMMON MISUNDERSTANDING**
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> A spinal does not mean being awake for your operation. You are sedated and asleep. People picture lying there listening to the surgery, and that is not what happens.

Nerve blocks

A nerve block is numbing medication placed near the nerves that carry sensation from the joint, usually with ultrasound guidance, before surgery begins. For knee replacement the common choice is a block that numbs sensation while deliberately sparing the quadriceps muscle, so the knee hurts less but the leg still works well enough to stand and walk safely the same day. Blocks that shut the muscle down produce a comfortable leg you cannot trust, which is how people fall.

Separately, Dr. Seem injects a mixture of long-acting local anesthetic around the joint during the operation itself. A good share of your comfort on the first day comes from that injection.

Why the plan is a list of small things

Modern pain control is deliberately built from several medications that work in different ways, at modest doses, rather than one large dose of one medication. Smaller amounts of several things control pain better, with fewer side effects, than a large amount of any one thing. Your plan will usually include:

- Acetaminophen, taken on a fixed schedule rather than as needed
- An anti-inflammatory, if your kidneys, stomach, and heart allow it
- A nerve block, plus the surgical injection described above
- A short course of opioid medication for the pain the rest does not cover
- Ice and elevation, which are not a formality and genuinely reduce swelling and pain
- Movement, which sounds like the opposite of pain control and is not

What the first week actually feels like

Day one is often better than people expect, because the block and the surgical injection are both still working. That sets up the most common surprise in the entire recovery:

THE TRANSITION NOBODY PREPARES FOR

Your block wears off somewhere between twelve and twenty-four hours after surgery, often in the middle of the first night. If you wait for the pain to arrive before taking anything, you spend hours catching up to it. Take your scheduled medication on schedule from the very beginning, including overnight, even while you still feel comfortable.

Days two through four are usually the hardest. This is expected. It is not a complication, it does not mean something went wrong, and it does not mean you are recovering badly. Swelling peaks, the last of the injected anesthetic fades, and you are moving more than you did on day one. Nearly everyone turns a corner during the second week.

Sleep is often the worst part of the first two weeks, and it is what patients mention most at the first follow-up. Broken sleep in this stretch is normal.

Opioids, plainly

Opioid medication has a real place in the first days after a joint replacement, and a short one. Most patients are off it, or nearly off it, within one to two weeks. Some need less than they were given. Almost nobody needs more than a few weeks.

- Start a stool softener the day of surgery, before you need one. Constipation from these medications is close to universal, and it is far easier to prevent than to fix.
- Do not drive while taking them, and do not add alcohol.
- Take the smallest amount that lets you sleep and do your exercises. Those two things are the goal. Being entirely pain-free is not a realistic target in week one.
- Store them where visitors, grandchildren, and household members cannot reach them, and dispose of what is left at a pharmacy take-back rather than leaving it in a cabinet.

IF THIS IS COMPLICATED FOR YOU, SAY SO EARLY

If you take opioids regularly now, have a high tolerance, are in recovery from a substance use disorder, or take buprenorphine or methadone, tell the surgical and anesthesia teams well before the day of surgery. There are good plans for every one of those situations, and they have to be made in advance. This information is used to control your pain properly, and for nothing else.

Newer non-opioid medications

In 2025 the FDA approved the first genuinely new class of pain medication in more than two decades. It is a tablet that blocks the pain signal out in the nerves of the body, before it ever reaches the brain. Because it does not act on the brain at all, it does not produce the sedation, the fog, or the dependence

that opioids can, and it is not a controlled substance.

That is a real advance, and it deserves an honest account of what is settled and what is not.

- **What the evidence shows.** It relieves moderate to severe short-term pain better than a placebo, and it was well tolerated in the studies that led to its approval.
- **What it has not yet shown.** In those same studies it did not outperform a standard combination of an opioid and acetaminophen. The trials were run after abdominal and foot operations, not after hip or knee replacement, so how well it works for the operation you are actually having is still an open question.
- **The practical part.** It costs considerably more than the medications it would replace, and insurance coverage varies a great deal from plan to plan.

> **DR. SEEM'S POSITION**
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> I use these medications sparingly for now, while the evidence catches up. That is not skepticism about the idea. A non-addictive medication that genuinely controls pain after joint replacement would be one of the best things to happen to this operation in years, and I want it to succeed. It is that I will not put a new medication at the center of your recovery until it has been shown to be safe and effective for the operation you are having. If avoiding opioids entirely matters a great deal to you, say so before surgery. It is a conversation worth having, and these newer options are part of it.

Common, minor, and worth expecting

- **Nausea.** Common, treatable, and actively prevented by your anesthesia team.
- **Trouble urinating** in the hours after a spinal, occasionally needing a temporary catheter. Briefly uncomfortable, and not dangerous.
- **Sore throat** after general anesthesia, from the breathing tube.
- **Itching** from opioid medication, which is a side effect rather than an allergy, though it is worth reporting either way.
- **A headache after a spinal** that is clearly worse sitting up and better lying flat. Uncommon, and very treatable. Call if it happens.

What makes pain control work better

- Take the scheduled medications on schedule, especially during the first four days.
- Ice and elevate genuinely often. Toes above the nose is the version people remember.
- Move a little, frequently, rather than a lot, occasionally.

- Do your exercises about forty-five minutes after a dose, not before it.
- Tell us when the plan is not working. A medication that is not controlling your pain is information, and there is almost always a better combination.

RELATED GUIDES IN THIS LIBRARY

- Medication Instructions Before Surgery
- The day of your surgery, hour by hour
- Recovery Milestones Guide

What happens next

If you decide to be seen, the consultation starts with Dr. Seem listening: your story, your goals, and what the joint is taking from you. Then an examination, and a review of your imaging together on the screen, so you can see what we see. You'll leave with an honest recommendation and every reasonable option explained, including the option of waiting. Nothing is decided without you.

To schedule: call (540) 667-8975: Winchester Orthopaedic Associates, 128 Medical Circle, Winchester, VA 22601.

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