LIFE WITH A REPLACEMENT · NO. 1

How long it lasts, and what you can do with it.

Realistic survivorship numbers, the activities that are encouraged, the few that are not, and what actually shortens an implant's life.

THE ONE-MINUTE VERSION

If you only read one page, read this.

- The old “ten to fifteen years” figure is out of date; large registries now show roughly nine in ten knee replacements still in place at fifteen years.
- The strongest predictor of needing a second operation is how young you were at the first one.
- Almost every activity patients ask about is permitted. Repetitive high-impact running is the main one that gets a real conversation.
- Kneeling is uncomfortable for about half of knee replacement patients and harms nothing.
- Follow-up runs at four weeks, four months and one year, then as needed; a joint that is behaving does not need routine surveillance.

DR. SEEM’S PERSPECTIVE

People ask me to promise them twenty-five years. I can tell them what the registries show for implants put in during the 1990s, and I can tell them modern implants are almost certainly better, but I cannot promise a number for a device that has not been in a person that long yet. What I can tell them is that the goal is a joint you stop thinking about, and that if you ever do have to think about it, my door is open that week.

The number people quote, and the better number

Almost everyone arrives having heard that a joint replacement lasts ten to fifteen years. That figure is decades out of date, and it causes real harm: it convinces people in their fifties and sixties to suffer for years waiting for an arbitrary birthday.

Large national registry studies, pooling data on tens of thousands of patients followed for decades, give a much better picture. Roughly nine in ten knee replacements are still in place at fifteen years, and about eight in ten at twenty-five years. Hip replacements run close behind, with about nine in ten at fifteen years, and somewhere between six and seven in ten still serving at twenty-five years depending on which data set you use.

> **THE HONEST CAVEAT**
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> Those patients were operated on in the 1990s and early 2000s, with the implants and techniques of that era. They represent the best long-term evidence that exists, and they almost certainly understate how today's implants will perform. But no one can honestly promise you a twenty-five-year number for a device that has not yet been inside a human being for twenty-five years. Anyone who does is guessing.

What actually determines your number

- **Your age at surgery.** This is the strongest single predictor. A joint replaced at fifty faces more decades and more steps than one replaced at seventy-five. Younger patients have measurably higher rates of eventual revision, and that is a reason to plan for it, not a reason to wait in pain.
- **Bodyweight.** More load, over more years, is more wear.
- **Infection.** Uncommon, and the reason for dental and skin care described below.
- **How well the implant was positioned and balanced.** Which is the part that belongs to your surgeon, and the reason for everything in the technology guides.
- **Repetitive high impact,** which is the only activity category with a real argument behind it.

Notably absent from that list: normal, vigorous, daily use. Walking a great deal does not wear out a modern replacement. Being active is associated with better outcomes, not worse ones.

What you can do with it

ENCOURAGED	WORTH A CONVERSATION	GENERALLY DISCOURAGED
Walking and hiking	Downhill skiing	Distance running
Pickleball	Singles tennis	Contact sports
Cycling	Running for fitness	Jumping sports
Swimming	Ice skating	High fall risk
Golf	Horseback riding	
Doubles tennis	Heavy manual labor	
Elliptical		
Rowing		
Dancing		
Bowling		
Weight training		
Gardening		

The middle column is not a list of prohibitions. It is a list of things that depend on the joint replaced, your bone quality, your skill in the activity, and how much it matters to you. An experienced skier who has skied for forty years is a different conversation from someone taking it up at sixty-eight. Pickleball deserves a mention of its own, because it is the activity patients ask about most. It is low impact, it is good for you, and it is encouraged. The thing worth watching is not wear on the implant but the fall: most pickleball injuries come from a sudden lunge or a step backwards, so warm up properly and play at a level that matches your footing.

> *"I would rather you use the joint and need it looked at in twenty years than protect it carefully and not use it at all. You did not do this to own an implant. You did it to get your life back."*

Practical questions people are too polite to ask

Can I kneel on a knee replacement?

You are allowed to. Roughly half of knee replacement patients find kneeling uncomfortable anyway, usually because of skin and scar sensitivity rather than anything to do with the implant. It causes no damage. A cushion helps. Whether it is comfortable is largely out of anyone's control, and it is worth knowing in advance if your work or your faith involves kneeling.

Are there permanent restrictions after a hip replacement?

It depends on the approach used. Anterior hip replacement generally requires few or no long-term positional restrictions. The traditional posterior precautions, avoiding deep bending and crossing the legs, apply mainly in the early weeks and mainly to that approach. Your specific instructions come from

Dr. Seem based on how your hip was done.

Will I set off airport security?

Less often than people expect, and it depends on the machine. The millimeter-wave body scanners now standard at most airports alarm for roughly a third of joint replacement patients. The older walk-through metal detectors alarm closer to half the time, and handheld wands fall in between. Knees tend to set them off somewhat more often than hips. Published figures vary from study to study, so treat those as rough rather than exact.

In practice it matters very little. Mention that you have a joint replacement, and if something does alarm, expect a short secondary screening of the area. An implant card is not proof of anything, is not required, and will not spare you the screening, so there is no need to carry one.

Can I have an MRI?

Yes. Joint replacements are MRI-safe. The metal creates distortion in images taken near the implant, which the radiologist accounts for.

Protecting it from infection

An artificial joint has no blood supply of its own, which means bacteria that reach it are harder for your body to clear. This is rare, and worth a few permanent habits:

- Treat infections anywhere in the body promptly, including urinary, skin, and dental infections. A tooth abscess is not a small thing once you have an implant.
- Keep up with routine dental care rather than avoiding it.
- Take breaks in the skin near the joint seriously, especially in diabetics.
- Call about a replaced joint that becomes newly painful, warm, or swollen without an injury, particularly during or after an illness.

> **ANTIBIOTICS BEFORE DENTAL WORK**
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> Dr. Seem's recommendation is simple. **For the first year after your joint replacement, take an antibiotic before dental work. After that first year, it is not needed.** Tell your dentist you have a joint replacement either way, and if your dental office wants that confirmed, call us and we will put it in writing. You may hear something different from a friend or an older handout; national guidance on this has shifted over the years, so go by what your own surgeon tells you.

How Dr. Seem follows you afterward

You will be seen at about four weeks, again at four months, and again at one year. After that, there is no fixed schedule. You come back when you need to.

That surprises people who expect to be called in every couple of years for an X-ray, so it is worth explaining. A joint replacement that is working well at a year, with no pain and no trouble, is statistically likely to keep working well. Routine imaging of a joint that is not causing symptoms rarely changes anything, and it has not been shown to produce better outcomes. What it reliably produces is appointments, imaging, and worry that were not needed.

So the plan after the first year is simple and deliberate: live your life, and get in touch if the joint gives you a reason to.

COME BACK ANY TIME, FOR ANY OF THIS

New or worsening pain in the replaced joint. A change in how it feels, sounds, or moves. Swelling or warmth without an injury. A limp that was not there before. Difficulty bearing weight. A fall. Any concern at all, however small it sounds. There is no waiting period and no need for a reason that sounds serious enough. Call the office.

THESE DESERVE A CALL THE SAME DAY

Fever with a hot, swollen, painful joint. A wound or sore over the replaced joint that is not healing. Sudden inability to bear weight after a fall. Infection anywhere in the body along with new pain in the replacement.

KEEP YOUR RECORDS

Keep a copy of your operative report and know the make and model of your implant. If you ever need care somewhere else, or years from now, that single piece of paper saves an enormous amount of guesswork.

RELATED GUIDES IN THIS LIBRARY

- Why joint replacements fail, and what can be done
- Recovery Milestones Guide
- Anterior or posterior hip replacement?

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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