MAKING THE DECISION · NO. 6

Treating your arthritis without surgery.

What genuinely helps before you are ready for a replacement, what is oversold, and how to tell when a treatment has stopped working.

THE ONE-MINUTE VERSION

If you only read one page, read this.

- Most people who see a joint replacement surgeon are not ready for a replacement, and there is real work to do in the years before one.
- Strength, load, low-impact motion, and the right medication carry more weight than any injection.
- Cortisone is genuinely useful and repeatable; the “gel” shots and cash-pay stem cell offers are not what the marketing claims.
- If a replacement is being planned, say so before accepting a cortisone injection from anyone; the timing matters.
- The signal that non-surgical care has run out is not a worse X-ray; it is a smaller life.

DR. SEEM’S PERSPECTIVE

I see people who have been told there is nothing left to try, and most of the time that is not true. The years before a replacement are not dead time. They are years you get to live, and how you spend them changes both how long you can wait and how well you do when the operation finally makes sense.

Start here

Most people who come to see a joint replacement surgeon are not ready for a joint replacement, and that is good news rather than bad. Arthritis is a slow disease. There is usually a long stretch of life between the first concerning X-ray and the day an operation becomes the right answer, and how you spend that stretch genuinely matters.

This guide is about that stretch: what actually works, what is marketed to you that does not, and how to recognize the point at which non-surgical care has done everything it can.

> *"An operation I don't do can't hurt you. My job in the years before surgery is to keep your world from shrinking."*

The four things that carry the most weight

Everything else in this guide is a supporting actor. These four are where the results come from, and none of them is a procedure.

01 **Strength around the joint.** Weak muscles transfer load straight into a worn joint surface. Strong ones absorb it. Quadriceps strength in particular tracks with how well people with knee arthritis function, and it is trainable at any age.

02 **Load.** Bodyweight is the one variable that changes the force through the joint with every single step you take.

03 **Motion, of the right kind.** Arthritic joints stiffen when they are rested and complain when they are pounded. Low-impact motion, done often, is the middle path: walking, cycling, swimming, an elliptical.

04 **The right medication, used correctly.** Most people are either undertreating with the wrong medication or taking a reasonable medication in a way that cannot work.

Physical therapy: what it can and cannot do

Therapy will not regrow cartilage, and any program that promises to is selling something. What it does is build the muscle that protects a worn joint, restore motion that has quietly been lost, and correct the limp that is now hurting your other hip.

Supervised therapy works better than a photocopied handout, mostly because people actually do it. But a home program you perform four times a week beats a supervised program you attend twice and abandon. The best exercise is the one that fits your life.

If you finished therapy years ago and felt better, that is not a reason to skip a second course. Strength is perishable.

Weight, honestly

Studies estimate that each pound of bodyweight is felt at the knee as roughly four pounds of force during walking, and more on stairs. The arithmetic runs in both directions: a ten-pound loss arrives at the knee as something closer to forty.

This is the hardest paragraph in this guide to write, because the advice is circular. Arthritis makes movement painful, pain makes activity harder, and reduced activity makes weight loss harder still. Being told to lose weight by someone who is not living inside that loop is not useful, and it is not a moral judgment on you.

What is worth saying plainly: weight loss is one of the few interventions that reliably reduces arthritis pain, and the medications now available for it have changed what is realistic for many people. That is a conversation for your primary care physician. If you are taking one of those medications and surgery is being planned, tell the surgical and anesthesia teams, because they affect how the stomach empties and therefore how fasting is handled.

Medications

Acetaminophen

Modest but real, very safe within its limits, and best taken on a schedule rather than chased after the pain arrives. Respect the daily ceiling, count what is hidden inside combination products, and be cautious if you drink regularly or have liver disease.

Topical anti-inflammatories

Often never offered, and worth asking about. Diclofenac gel is available over the counter and is applied directly over the joint, which puts less medication into your bloodstream than swallowing the same anti-inflammatory. It helps some people with knee arthritis and not others, and it is a reasonable thing to try before moving to pills. It is much less useful for a hip, which sits deep beneath muscle.

Oral anti-inflammatories

Effective for many people, and the reason some patients function well for years. They also carry real risks: stomach bleeding, kidney strain, higher blood pressure, and cardiovascular risk that rises with dose and duration. Whether they are safe for you is a question for the physician who manages your kidneys, stomach, and heart, not one to answer from a pharmacy shelf.

What not to use

Opioids are not an appropriate long-term treatment for arthritis pain. They do not work well for it, tolerance builds, and being on them before surgery makes pain after surgery considerably harder to control. If you are on them now, that is a problem to solve together, and not a reason to avoid being seen.

Supplements

Glucosamine, chondroitin, turmeric, and collagen have weak evidence and low risk. If one of them helps you and the cost does not bother you, there is no objection here. Just tell us what you take, because several supplements affect bleeding and matter before an operation.

Injections: an honest comparison

INJECTION	WHAT IT IS	HONEST ASSESSMENT
Corticosteroid	A strong anti-inflammatory placed directly in the joint	Genuinely useful. Relief usually starts within days and lasts anywhere from a few weeks to several months. It can be repeated, generally no more often than about every three months. Diabetics should expect blood sugar to rise for several days afterward.
Hyaluronic acid, the “gel” shot	A lubricating molecule injected as a series or a single dose	The national orthopaedic guidelines do not recommend it routinely for knee arthritis, because across good studies it performs close to placebo. Some individual patients report real relief, coverage varies widely, and harm is low. Reasonable to try if it is covered and you understand the odds. There is no evidence supporting it in the hip.
Platelet-rich plasma, or PRP	Concentrated platelets spun from your own blood	Evidence is mixed and slowly improving, but not yet conclusive. It is almost never covered by insurance, and costs run from several hundred to a few thousand dollars out of pocket. Not unreasonable to consider, as long as you go in with clear eyes about what is actually known.
“Stem cell” and amniotic injections	Marketed as regenerative therapy	Be skeptical. Most commercial preparations contain few or no living stem cells, none are FDA-approved for arthritis, the pricing is aggressive, and it is almost always paid out of pocket. This is the corner of the field where patients are most often taken advantage of.

IMPORTANT IF SURGERY MAY BE COMING

A cortisone injection given within roughly three months before a joint replacement has been associated with a higher risk of infection around the new implant. If a replacement is being planned, or even discussed, say so before you accept an injection from anyone, and tell us about any injection you have had recently. This one detail can change the timing of your operation.

Braces, canes, and shoes

- An unloader brace can help when arthritis is confined to one side of the knee. It is bulky, and people tend to either use it constantly or abandon it in a closet.
- A cane belongs in the hand **opposite** the painful joint. Almost everyone does this backwards at first. Used correctly it takes a meaningful amount of load off the joint, and it is not a symbol of defeat.
- Cushioned shoes with decent support help more than most specialty footwear. Elaborate custom orthotics rarely earn their price for arthritis.

What to be skeptical of

- **Arthroscopic "clean-out" for arthritis.** Several high-quality trials have shown it does not help an arthritic knee. It remains a reasonable operation for specific mechanical problems, but not for arthritis itself.
- **Anything promising to regrow cartilage** in an arthritic adult joint.
- **Copper sleeves, magnets, and infomercial devices.** They are harmless, and that is the strongest thing that can be said for them.

How to tell non-surgical care has run out

It is not a number on an X-ray. The X-ray was already abnormal when we started. The honest signals are these:

- Your world is getting smaller. You have stopped doing things you value, and the list keeps growing.
- The joint wakes you at night, or aches at rest rather than only with use.
- Injections that used to buy you months now buy you weeks.
- You are climbing the medication ladder just to stay where you are.
- You have stopped treating the joint as a problem to solve and started organizing your life around it.

THE POINT OF ALL THIS

Non-surgical treatment is not what you do while waiting to be old enough for surgery. It is real treatment, it works for a long time in most people, and it leaves you stronger for the operation if that day arrives. Come back when the list above starts describing you.

RELATED GUIDES IN THIS LIBRARY

- Do I actually need a joint replacement yet?
- What your X-ray says, and what it can't
- Partial or total knee 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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