

TABLE E-1 Study Details

	“Restricted” Patients <u>with</u> Additional Restrictions	“Unrestricted” Patients <u>without</u> Additional Restrictions	P value
Number of hips (patients)	152 (131) 110 Unilateral 21 Bilateral	151 (134) 117 Unilateral 17 Bilateral	-- 0.37 0.62
Gender (patients)	66 male 65 female	73 male 61 female	0.59 0.59
Age (range)	58.6 (14-88)	57.3 (29-85)	0.39
Body mass index	29.3 (15.9-50.2)	28.7 (17.6-45.7)	0.34
Diagnosis* ( <i>no. of hips</i> )	OA (126) ON (20) DDH (4) RA (2)	OA (127) ON (15) DDH (5) RA (4)	0.80 0.43 0.97 0.70
Acetabular liner type	0° (143) 10° (9)	0° (142) 10° (9)	0.82 0.82
Femoral head size	22 mm (0) 28 mm (108) 32 mm (43) 36 mm (1)	22 mm (1) 28 mm (117) 32 mm (30) 36 mm (3)	0.99 0.25 0.11 0.61
Femoral neck length	-4 mm (35) +0 mm (84) +4 mm (31) +8 mm (2)	-4 mm (24) +0 mm (85) +4 mm (40) +8 mm (2)	0.15 0.95 0.26 0.62
Femoral stem offset	Standard (89) Lateral (63)	Standard (100) Lateral (51)	0.21 0.21
Follow-up (range) ( <i>mo</i> )	10.7 (6-17.8)	10.8 (6-17.2)	0.52
Dislocations	1/152 (0.7%)	0/151 (0.0%)	0.997
Length of hospital stay (range) ( <i>day</i> )	3.5 (2-5)	3.5 (2-8)	0.88
Rehabilitation stay needed ( <i>no. of hips</i> )	125 (82.2%)	100 (66.2%)	0.002
Total costs for equipment	\$96,500	\$31,500	<0.001

\*OA = osteoarthritis, ON = osteonecrosis, DDH = developmental dysplasia of the hip, and RA = rheumatoid arthritis.

## Follow-up Questionnaire(1)

### Hip Precautions Study 6-week Follow-up Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_ Group: Restricted Unrestricted

Please answer the following questions as accurately as you can. Your honest answers will be very helpful to us in evaluating the results of this study and in treating future hip replacement patients.

Thank you, Drs. Rothman, Hozack, Sharkey, Purtill, and Peak

#### Leg Position Precautions:

How often were you able to avoid the following positions in the first 6 weeks after surgery?

#### Position to Avoid

#### Percentage of Time Avoided

Bending over at waist past 90°/right angle	0%	25%	50%	75%	90%	100%
Sitting with knees higher than hips (hip flexion > 90°)	0%	25%	50%	75%	90%	100%
Crossing legs above or below knee (leg adduction)	0%	25%	50%	75%	90%	100%
Excessive twisting of foot relative to thigh (internal/external rotation >45°)	0%	25%	50%	75%	90%	100%

#### Usage of Additional Equipment:

Please circle whether or not you used the following equipment at different stages of your recovery in the first 6 weeks after surgery.

Equipment	Used in:			Approximate Date (or # of weeks postop )		Stopped Using
	Hospital	Rehab	Home			
Elevated hip chair	Yes No	Yes No	Yes No	_____ / _____	_____	#weeks postop / Still Use
Elevated toilet seat	Yes No	Yes No	Yes No	_____ / _____	_____	#weeks postop / Still Use
Pillows between legs in bed	Yes No	Yes No	Yes No	_____ / _____	_____	#weeks postop / Still Use
Pillows between legs for Side-sleeping	Yes No	Yes No	Yes No	_____ / _____	_____	#weeks postop / Still Use
Walker	Yes No	Yes No	Yes No	_____ / _____	_____	#weeks postop / Still Use
Crutches	Yes No	Yes No	Yes No	_____ / _____	_____	#weeks postop / Still Use
Cane	Yes No	Yes No	Yes No	_____ / _____	_____	#weeks postop / Still Use

#### Activity-Related Questions (in the first 6 weeks after surgery):

1. What percentage of time did you sleep on your: Back \_\_\_\_\_% or Side \_\_\_\_\_% (total = 100%)
  2. For back-sleeping, did you find this cumbersome or uncomfortable? No Yes N/A
  3. For side-sleeping, which side did you sleep on? Surgical side / Opposite side / Both. Approximate date you began side sleeping: \_\_\_\_\_ or \_\_\_\_\_ # weeks after surgery
  4. Have you been a passenger in a car yet? No / Do not use cars / Yes. If yes, when did you ride in a car for the first time? For trip home from rehab / Today for doctor visit / or Approximate date: \_\_\_\_\_ or \_\_\_\_\_ # weeks after surgery. Approximate total # of times as a passenger in a car since surgery: \_\_\_\_\_
  5. Have you driven a car yet? No / Do not drive / Yes. If yes, when did you drive in a car for the first time? Today for doctor visit / or Approximate date: \_\_\_\_\_ or \_\_\_\_\_ # weeks after surgery. Approximate total # of times you have driven a car since surgery: \_\_\_\_\_
  6. Have you returned to work yet? No / Retired or Homemaker / Yes. If yes, approximate date that you returned to work: \_\_\_\_\_ or \_\_\_\_\_ # of weeks after surgery.
  7. Has your hip dislocated since you left the hospital? No / Yes. If yes, please give date: \_\_\_\_\_
- Please write any additional comments or suggestions on the back of this paper. Thank you!

## Follow-up Questionnaire(2)

### Hip Precautions Study **6-Month** Follow-up Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_ Group: Restricted Unrestricted

Please answer the following questions as accurately as you can. Your honest answers will be very helpful to us in evaluating the results of this study and in treating future hip replacement patients.

Thank you, Drs. Rothman, Hozack, Sharkey, Purtill, and Peak.

#### Leg Position Precautions (between 6 weeks and 6 months after surgery):

At your 6 week visit, you were told that you could resume your normal daily activities and that the leg position precautions were no longer as critical to your recovery. How often do you now avoid the following positions at 6 months after surgery?

Position to Avoid	Percentage of Time Avoided					
Bending over at waist past 90°/right angle	0%	25%	50%	75%	90%	100%
Sitting with knees higher than hips (hip flexion > 90°)	0%	25%	50%	75%	90%	100%
Crossing legs above or below knee (leg adduction)	0%	25%	50%	75%	90%	100%
Excessive twisting of hip/foot relative to thigh (internal/external rotation >45°)	0%	25%	50%	75%	90%	100%

#### Usage of Additional Equipment (between 6 weeks and 6 months after surgery):

Please mark when you stopped using the following equipment since your 6 week visit after surgery.

Equipment	Before 6 wk visit (reported in 6 wk Survey)	Right after 6 week visit	Number of months after surgery stopped using
Elevated hip chair	<input type="checkbox"/>	<input type="checkbox"/>	____ #months postop / Still Use
Elevated toilet seat	<input type="checkbox"/>	<input type="checkbox"/>	____ #months postop / Still Use
Pillows between legs for Side-sleeping	<input type="checkbox"/>	<input type="checkbox"/>	____ #months postop / Still Use
Walker	<input type="checkbox"/>	<input type="checkbox"/>	____ #months postop / Still Use
Crutches	<input type="checkbox"/>	<input type="checkbox"/>	____ #months postop / Still Use
Cane	<input type="checkbox"/>	<input type="checkbox"/>	____ #months postop / Still Use

#### Activity-Related Questions (between 6 weeks and 6 months after surgery):

- |   | Before 6 wk visit (reported in 6 wk Survey) | Right after 6 week visit | # of months after surgery |
|---|---|--------------------------|---------------------------|
| 1. What percentage of time do you <u>now</u> sleep on your:<br>Back _____% or Side _____% (total = 100%)<br>How does this compare to <u>before</u> surgery?<br>Same amount for each / More time on Back / More time on Side   |   |                          |                           |
| 2. When did you begin side-sleeping? <input type="checkbox"/> N/A   | <input type="checkbox"/>                    | <input type="checkbox"/> | ____ #months postop       |
| 3. Have you been a passenger in a car yet? No / Do not use cars / Yes.  |   |                          |                           |
| 4. If yes, when did you begin riding in a car on a <u>regular</u> basis? <input type="checkbox"/>   | <input type="checkbox"/>                    | <input type="checkbox"/> | ____ #months postop       |
| 5. Have you driven a car yet? No / Do not drive / Yes.  |   |                          |                           |
| 6. If yes, when did you resume driving a car on a <u>regular</u> basis? <input type="checkbox"/>  | <input type="checkbox"/>                    | <input type="checkbox"/> | ____ #months postop       |
| 7. Have you returned to work/school yet? No / Retired / Homemaker / Disabled / Yes.   |   |                          |                           |
| 8. If yes, when did you return to work? <input type="checkbox"/>  | <input type="checkbox"/>                    | <input type="checkbox"/> | ____ #months postop       |
| 9. As compared with <u>before</u> surgery, what percentage of your usual daily activities (household/work/school/hobbies/sports) are you <u>now</u> able to perform? <25% 50% 75% 90% 100% or Other: _____% More than before surgery  |   |                          |                           |
| 10. For <u>Restricted</u> group patients: if you chose not to follow all activity restrictions in the first 6 weeks after surgery, please state why: <input type="checkbox"/> knowledge that other study (Unrestricted) patients were not following them / <input type="checkbox"/> planned to recover at my own pace anyway / Other: _____   |   |                          |                           |
| 11. For <u>Unrestricted</u> group patients: do you feel that having your doctor's permission to have fewer activity restrictions made your recovery: easier / harder / no different / other: _____  |   |                          |                           |
| 12. For patients who had a <u>hip replacement on the other side in the past</u> : <input type="checkbox"/> N/A. Month/year of previous total hip replacement: ____/____. Was your recovery this time: easier / harder / about the same? Do you attribute this to: only one side hurting this time / fewer activity restrictions / being able to place full weight on leg this time / did not follow all restrictions last time / other: _____ |   |                          |                           |
| 13. Has your hip dislocated since your 6 week visit? No / Yes. If yes, please give date: _____  |   |                          |                           |

Please write any additional comments or suggestions on the back of this paper. Thank you!