Primary Total Knee Arthroplasty — Decision Aid

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> This is an honest summary of what is known about primary total knee arthroplasty, laid out so you can decide well — together with your surgeon, on your own terms.

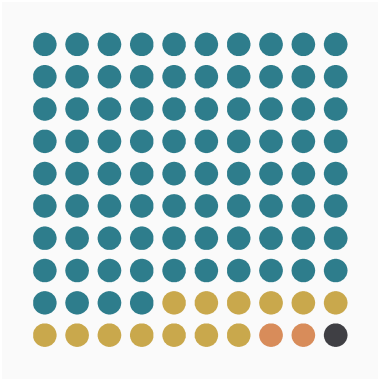
MOST PEOPLE DO WELL — BUT NOT EVERYONE

Most people do well — about 80 out of 100 are back to comfortable function in a year. About 6 out of 100 are not. Three risk profiles below — read across to see how the picture shifts.

LOW-RISK PATIENT PROFILE

Younger, lower BMI, no major comorbidities (ASA 1-2).

+4 comfortable -2 dissatisfied -1 complication vs typical

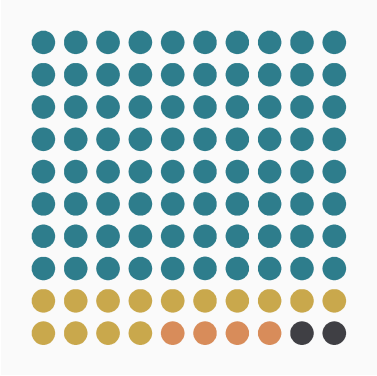


- **84** out of 100 — Back to comfortable function
- **13** out of 100 — Satisfied with some residual symptoms
- **2** out of 100 — Dissatisfied with the result
- **1** out of 100 — Had a serious complication

TYPICAL-RISK PATIENT PROFILE

Average arthroplasty candidate; this is the default panel shown.

reference panel

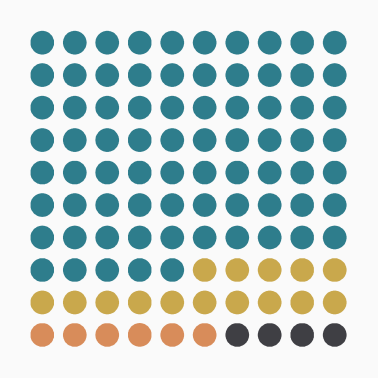


- **80** out of 100 — Back to comfortable function
- **14** out of 100 — Satisfied with some residual symptoms
- **4** out of 100 — Dissatisfied with the result
- **2** out of 100 — Had a serious complication

ELEVATED-RISK PATIENT PROFILE

Age ≥75 OR BMI ≥35 OR diabetes OR ASA ≥3.

-5 comfortable +2 dissatisfied +2 complication vs typical



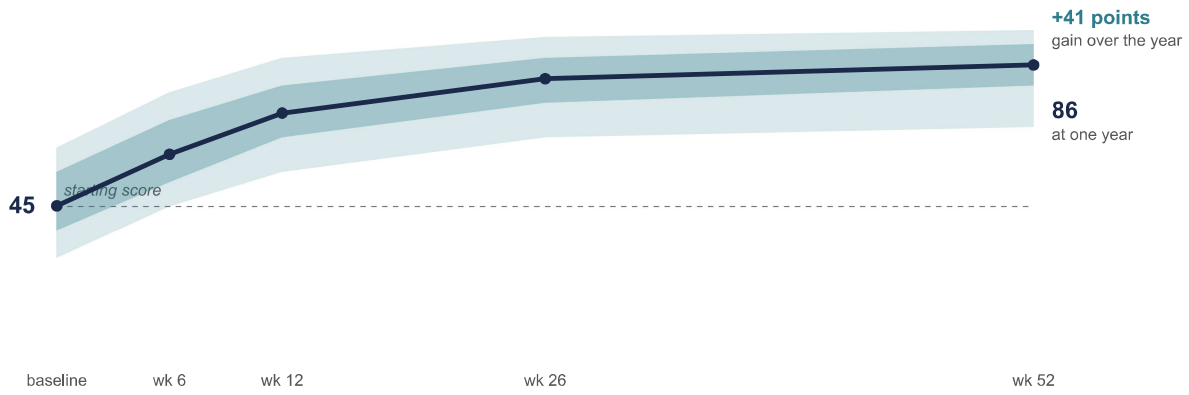
- **75** out of 100 — Back to comfortable function
- **15** out of 100 — Satisfied with some residual symptoms
- **6** out of 100 — Dissatisfied with the result
- **4** out of 100 — Had a serious complication

Sources: AJRR annual report; Bourne RB et al. — see citations.csv for per-value provenance.

> **About these numbers.** The array shows what happens on average to 100 people. You will not experience 80% of anything — you will end up at exactly one dot in the array. The average tells you the odds, not your story. And some dots are paths you cannot easily come back from (deep infection, chronic pain, revision surgery): once a path like that opens up for one person, the "average" does not lift them out of it. The room loses 5%; one person loses 100% or wins 200% — never 5%. *(Mathematicians call this **ergodicity**. Suggested reading: Taleb, Skin in the Game; Peters, Ergodicity Economics; West, Scale.)*

YOUR COMEBACK IS MOSTLY IN THE FIRST SIX WEEKS — AND KEEPS GOING FOR A YEAR

Most of the comeback comes in the first six weeks — but improvement keeps arriving steadily for the rest of the year. (KOOS Jr score: higher is better; dashed line is where you start.)



Dark line: the typical patient's score over time. Light bands: where most people fall (inner band = middle 50%, outer band = middle 80%).

Sources: Lyman S et al. — see citations.csv for per-value provenance.

THE RISKS WORTH UNDERSTANDING BEFORE YOU DECIDE

Most complications are small. A few are serious. Here are the ones worth understanding before you decide. Each row's small grid shows the rate visually.

FREQUENCY	RATE	WHAT IT IS
●●●●●	**5 of 100**	Need for second surgery within 10 years
●●●	**3 of 100**	Stiffness needing manipulation
●●	**1.5 of 100**	Blood clot (DVT/PE)
●	**1 of 100**	Deep infection

Sources: AJRR annual report; Anderson DR et al. — see citations.csv for per-value provenance.

SURGERY IS ONE PATH. HERE ARE THE OTHERS.

Surgery is one of several reasonable paths. Where you fit depends on you, your goals, and your health.

PATH	BEST FIT FOR SOMEONE WHO...
Watchful waiting + activity modification	early disease, infrequent pain
Physical therapy + bracing	moderate disease, willing to do daily exercises
NSAIDs / acetaminophen	intermittent flares, no contraindications
Intra-articular injection (steroid / HA)	intermittent flares; <3 injections/year
Weight loss program (if BMI ≥30)	BMI ≥30; reduces pain and improves surgery outcomes
Total knee replacement	daily pain limiting walking, sleep, or function despite the above

THREE THINGS TO DO NEXT

1. **Write down your three biggest questions** before your next visit. The questions on the patient handout are a starting point; the most important ones are yours.
2. **Bring a partner, family member, or trusted friend** to that visit. Two sets of ears hear more than one — and decisions like this are easier to live with when someone else heard the same conversation.
3. **Decide what "success" would look like for you** — in your own words, not the surgeon's. Then share that with your surgeon. Aligning on what would count as a good outcome is the single best thing you can do to avoid being the patient who has a technically perfect surgery and still wishes they'd waited.

Two short, validated tools are in the full handout to help you prepare: the **SURE test** (4 yes/no questions, before your visit) and **CollaboRATE** (3 questions, after your visit). The handout also includes a plain-language checklist of what good informed consent should look like before you sign anything.

This handout summarizes what is known from research about people who have had this procedure. Your individual result depends on your health, your surgery, and your recovery. Discuss any questions with your surgeon.