

Knee Replacement with Dr. Hurt: What Makes My Approach Different?

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Less is more. Less variation from your knee's normal anatomy, less cutting of tissue, less swelling, and less bleeding all add up to less pain — and a better experience and final result.

My Approach

I perform roughly 30 joint replacements a month — and climbing — the majority of them knee replacements. Traditional knee-replacement recovery is often described as painful, with heavy swelling and grueling physical therapy. I do it differently. My whole approach rests on three things working together: a **minimally invasive technique** that works around your muscles instead of cutting them, **robotic (MAKO) technology** that lets me plan and execute with great precision, and a **kinematic philosophy** that restores your knee's own natural anatomy rather than forcing it into one generic position. On top of that, I control swelling aggressively from the very first day and layer several non-narcotic pain treatments together — so most patients need much less opioid medication, sometimes none, and recover faster. Everything you'll read below is a piece of that plan. **Your part in all of this — especially the icing, elevation, and gentle movement — is just as important as mine.**

What a Knee Replacement Actually Is

Before the details, here are the basics — and they're essentially the same for everyone. A knee replacement is really a **resurfacing**. I remove the worn-out surfaces and cap the ends of the bones: a **metal cap on the end of the thighbone (femur)** and a **metal tray on the top of the shinbone (tibia)**, with a medical-grade **plastic spacer (polyethylene)** in between that lets the joint glide smoothly. **Most of the time I also resurface the kneecap (patella)** with a small plastic button — though not always. I use the **Stryker Triathlon** knee. Where surgeons differ is in the **details**: how the implants are positioned, how the ligaments are handled, how the knee is opened, and how bleeding and swelling are controlled afterward. That's what the rest of this guide is about.



The components: femoral cap (top) and tibial tray with plastic spacer (bottom). Patella component not shown.



Front-view X-ray of a finished knee replacement.



Side-view X-ray of the same knee.

About your kneecap: We basically never remove your kneecap. We either leave it intact, or shave off just the back half of it and resurface that with a small polyethylene (plastic) dome. There are pros and cons either way — resurfacing can reduce the chance of ongoing kneecap pain for many patients, while leaving it alone preserves your own bone — so it's a judgment I make for your specific knee.

Before Your Surgery

Once we decide together to proceed with surgery, our surgery scheduler, **Nadine**, will usually call you within **2–3 business days** to set your surgery date. If you need to reach her, call our office and ask for surgery scheduling. Before your surgery day, a few things happen:

- **A CT scan** of your knee — this is what the robot uses to build your personalized plan. Nadine will schedule it for you.
- **Pre-operative medical clearance** when indicated, to make sure you're in good shape for surgery.
- **A pre-op visit about 7–10 days before surgery.** We'll confirm everything is lined up, prescribe your physical therapy and home health, make sure you have all your medications, and answer any remaining questions. You'll also receive your pain-medication prescriptions at this visit, so you have them in hand before you arrive at the surgery center.

Your Day of Surgery

Here's what a typical day looks like, so there are no surprises:

- You'll get a **nerve block** and, when possible, a **short-acting spinal** instead of general anesthesia.
- With a spinal you are **not intubated** — you breathe on your own and are simply sedated and asleep. It's a gentler experience with less grogginess, nausea, and throat irritation afterward.
- Most patients are **drinking and eating within about 30 minutes** of finishing.
- Once the spinal wears off, we get you up and moving. When you can safely walk and use the restroom, you go **home the same day** — recovering in your own bed, not a hospital room.

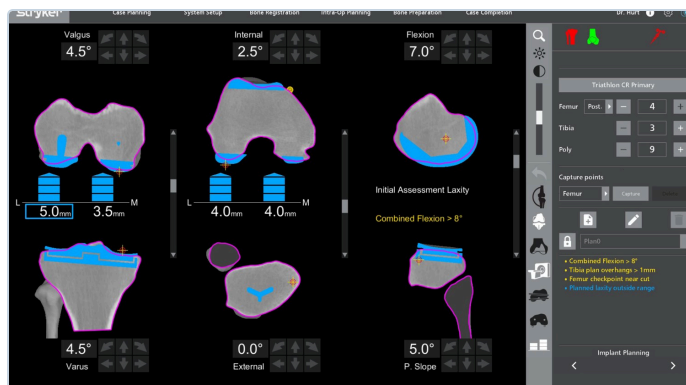
During Your Surgery

What I do	Why it helps	Learn more
Less-invasive "muscle-sparing" (subvastus) approach, when your anatomy allows	This is a form of minimally invasive surgery in the truest sense: instead of cutting through the big quadriceps tendon, I work around it — through the natural planes between muscles and nerves rather than cutting them. Sparing muscle and nerve means less trauma, less pain, and less to repair and heal later. In the studies this lower pain isn't just the first week — it has been shown across the first several weeks, and even out to the first two to three months. See the difference in the pictures below — the muscle-cutting approach on the left, the muscle-sparing approach I favor on the right.	<i>Liu 2018; Geng 2022 (RCTs)</i>
Robotic-assisted (MAKO) planning — built around your knee	The robot gives me an unusually detailed picture of your knee — I can view it in three dimensions and in three separate cross-sections, and make adjustments as fine as half a millimeter (0.5 mm). I still design and perform your surgery; the robot is a powerful measuring and guidance tool that lets me customize the fit for your individual anatomy.	<i>Stryker MAKO</i>
Kinematic alignment — restoring your natural knee	Rather than forcing every knee into one generic position, I restore your knee's own natural shape and motion. In my hands this produces better outcomes and knees that feel more natural — something supported by peer-reviewed data and confirmed by my own results. It usually also means less cutting and releasing of tissue. See the pictures below that demonstrate this.	<i>McEwen 2020</i>
Seeing more with the computer → cutting less, with invisible safety boundaries	Because the computer helps me see the knee, I don't rely only on direct line of sight, so I cut and pull on tissue less. The system also holds invisible boundaries my saw cannot cross into sensitive structures — a second safety check working alongside my own judgment during the procedure.	<i>Stryker MAKO</i>
Meticulous bleeding control	I'm vigilant about stopping bleeding, using a specialized cauterizing device (the Werewolf). Less bleeding means less bruising and swelling. In a small number of patients I'll also place a temporary drain to keep blood from collecting in the joint. If a drain is placed, it comes out within two days.	<i>Werewolf FASTSEAL (Smith+Nephew)</i>
Long-acting numbing medicine plus a periarticular injection (ZYNRELEF + cocktail)	At the end of the case I place a long-acting numbing medication (ZYNRELEF) — a viscous, honey-like substance that coats the inner aspect of the knee and slowly releases over three to five days; it's been a game changer in my practice. Along with it we do what's called a periarticular injection : we inject the tissues at the back of the knee and all around it with a cocktail of numbing medication, an anti-inflammatory, a steroid, and epinephrine. The numbing medication helps your short-term comfort; the anti-inflammatory and steroid reduce inflammation, swelling, and pain; and the epinephrine reduces bleeding.	<i>ZYNRELEF PI; PAI reviews 2025</i>
A medicine that reduces bleeding (tranexamic acid)	Less bleeding means less bruising and swelling.	<i>Huang 2014</i>
A dilute betadine rinse before closing	Just before closing, we rinse the joint with a dilute betadine (povidone-iodine) solution as an added antiseptic step — a low-cost measure supported by large clinical studies for reducing infection risk.	<i>Shohat 2022</i>

The Technology Behind Your Surgery

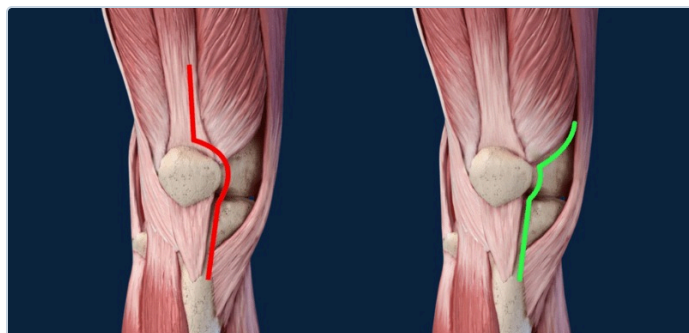


The Stryker MAKO robotic-arm system.

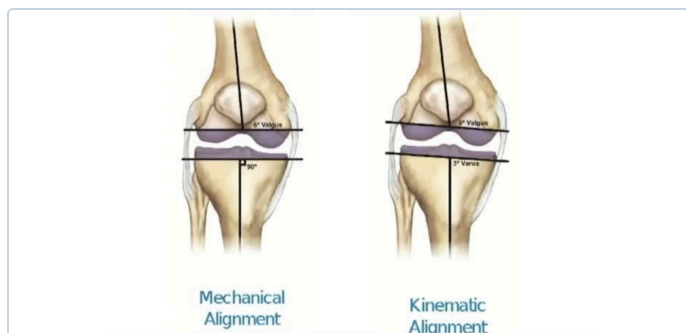


A live view of the detailed 3-D plan I use to design and check every cut for your knee.

The robot doesn't perform your surgery — **I do**. What it gives me is an unusually complete picture of your knee and the ability to carry out my plan exactly. I build the plan; the robot helps me measure and execute it, down to fractions of a millimeter.



Left: the traditional approach cuts through the muscle. Right: the muscle-sparing (subvastus) approach works around it.



Left: older "one-size" mechanical alignment. Right: kinematic alignment, which follows your knee's own natural angles — usually meaning less tissue cut or released.

Safety, Efficiency & Infection Prevention

Infection after knee replacement is uncommon — reported at roughly 1 in 100 nationally. My own rate runs **below 1%**, through a deliberate, layered approach, not luck:

What I do	Why it helps	Learn more
Antibiotics + rigorous sterile technique	The proven foundation of infection prevention.	Standard of care
Surgical helmet systems in the OR	An added barrier between the surgical team and your joint.	Sterile setup
Surgery in a dedicated surgery center, not a hospital	A focused, elective-only environment means less exposure to the resistant germs that circulate in busy hospitals.	ASC outcomes
Getting you home the same day	Recovering at home rather than in a hospital reduces your exposure to hospital-acquired infections.	Outpatient TKA
Efficient surgery — about 30 minutes before we begin closing	My average operating time is around 30 minutes before we start closing the case — a reflection of an experienced, well-drilled team. Shorter operative time is linked in large studies to lower infection risk and better recovery.	Cheng 2024 (427k pts)

A note on honesty: Some of these (the surgery-center setting, same-day discharge) mainly reduce your exposure to hospital germs and speed recovery; the strongest direct evidence for lower infection is around sterile technique, antibiotics, and shorter surgical time. I do all of them because they stack up in your favor.

Before Surgery: Two More Things That Protect You

Your part: come to surgery infection-free

Before surgery, you must have **no open wounds and no active infections anywhere in your body** — and especially none on the surgical leg or anywhere near where the incision will be. If you fall and scrape your knee, or develop a skin infection, boil, or similar problem in that area before your surgery date, **we will have to postpone the surgery** to let it fully heal first. It's not worth risking an infection in your new joint.

Dental work & your new knee

It's best to get any **needed dental work** — **cavities, cleanings, extractions** — **done before your surgery**, so you don't need dental procedures in the first six months afterward. Here's why: a fresh knee replacement is a little like **freshly tilled ground** — **you don't want to scatter seed on it**. Dental work releases bacteria into your bloodstream, and those bacteria are more likely to settle on a recently replaced joint than an established one.

For about the **first two years** after your knee replacement, Dr. Hurt recommends taking an antibiotic before dental procedures as a precaution: **amoxicillin 2 g by mouth, about one hour before** the procedure (for penicillin-allergic patients, azithromycin is used instead). If your dentist prefers not to prescribe it, **call our office** — **we're happy to**.

About Your Pain Medicine

Let's be realistic: this is a knee replacement, not removing a mole. For most patients we can't erase *all* pain — but we can dramatically reduce it. If you do need pain medicine, that is **not a failure**, and we're glad to help — please tell us early so we can stay **ahead** of the pain rather than chasing it. Our goal throughout is to get you off these medicines as quickly as reasonable, because they carry side effects (see below). Generally, you'll be given your pain-medication prescriptions at your pre-op visit, so you have them in hand before you ever arrive at the surgery center — one less thing to worry about later.

It helps to understand that pain medicines come in different classes:

Medicine	What it is
Celebrex (celecoxib)	An anti-inflammatory , in the same family as ibuprofen and meloxicam. We use it because it treats both inflammation and pain in a non-narcotic way.
Tylenol (acetaminophen)	A non-narcotic pain reliever, but not an anti-inflammatory. Important: Tylenol is usually already included in the combination pain pills we prescribe — so don't add extra Tylenol unless we specifically tell you to , to avoid overdosing on it.
Hydrocodone	Our workhorse narcotic; enough for most people. Some studies suggest 20–25% of people don't convert it well into its active form — so if it doesn't seem to be helping you, tell us and we'll adjust.
Oxycodone	Works much like hydrocodone but through a different pathway, and is generally more potent for controlling pain.
Tramadol	A narcotic that works on different receptors — it can be added alongside oxycodone for a little extra relief when we direct it.
Gabapentin	Not a pain medicine as such — a nerve-modulating medication we sometimes use.
Journavx (suzetrigine)	A newer non-opioid pain medicine (FDA-approved 2025) that blocks pain signals in the nerves before they reach the brain. Some patients really like it. It can be expensive .

The bottom line: We never want you in pain, and if you need these medicines we will give them to you. But our whole plan is built to make you **less reliant** on them — and to get you off them as soon as reasonable, which means a clearer head, fewer side effects (constipation, nausea, vomiting, itching), and a safer recovery.

What to Expect After Surgery

Your follow-up timeline

First, we'll do a **telemedicine visit at about 2 weeks** — a chance to check your progress, answer questions, and talk through anything on your mind (including the kneecap decision if it applies to you). If anything comes up sooner, or you'd rather be seen in person, you can always **come in earlier**. After that, I'll see you back at **6 weeks**. By then, about **60% of my patients no longer need clinic visits** — they're feeling good and the trajectory is up and to the right. Another **20–25%** I'll see up to **3 months**, and about **5%** up to **6 months**, before we both feel comfortable saying you're there.

Remember: **full recovery takes a whole year**. A knee that's still warm and a little swollen at 3 months is **completely normal**, not a sign anything is wrong. The photo shows the same patient's two knees — one at 6 weeks after replacement, the other at 6 months — so you can compare side by side how the swelling settles and the incision fades over that time.



The same patient's two knee replacements side by side — one 6 weeks old, the other 6 months old. The younger knee shows more redness, more swelling, and (if you could feel it) more warmth. All of this is normal and settles with time. Used with permission.

Returning to work

On average, **desk / office work is about 3 weeks**. A job where you're **on your feet 8 hours a day is more like 6–8 weeks** — standing, stairs, and lifting all drive swelling and can slow your motion, so let's plan your return together.

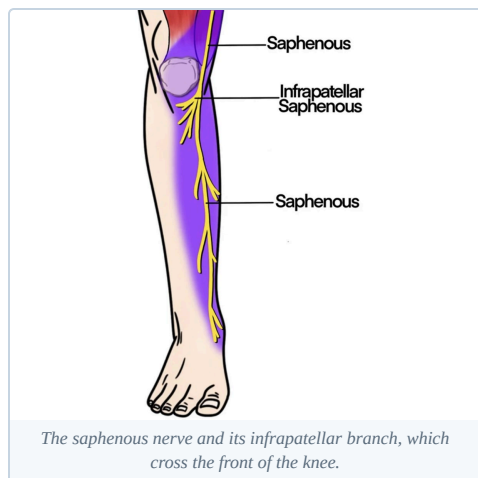
Activities you can expect to return to

This surgery is designed to let you **walk without pain**. Many patients go on to **play pickleball or doubles tennis**, and **skiing is possible for most** knee replacements. Higher-impact activities — **jumping, running, or singles tennis** — are harder on a replaced knee and difficult for most patients.

Three normal things that are NOT complications

Kneeling discomfort. It's very common to have some pain kneeling on a replaced knee. That's simply a product of the prosthesis being there — not a sign anything is wrong.

Clicking or a clicking sensation. It's very common — and normal — to feel (and sometimes hear) a click in a replaced knee. Metal and plastic can almost always be felt moving against each other; most of the time it's just a sensation, not a sound. Your new knee is designed with a small gap between the surfaces — a normal knee has roughly 1–5 mm of space between its two surfaces — and that clearance is what lets the joint move smoothly. If I fit it tightly enough to never click, it wouldn't bend and move the way a knee should. So the clicking is simply the feel of a well-functioning joint. It will feel foreign at first, because even a natural bone-on-bone knee doesn't create that sensation — but it is not a complication.



An area of numbness on the outer side of the knee. To reach your knee I make a vertical incision, and that incision predictably crosses a small nerve branch (the infrapatellar branch of the saphenous nerve). The result is a patch of numbness on the outer side of the knee. This is a **predictable, expected result of the incision — a sequela, not a complication**. It's nothing to worry about, and for most people it fades or becomes unnoticeable over time.

Your range of motion

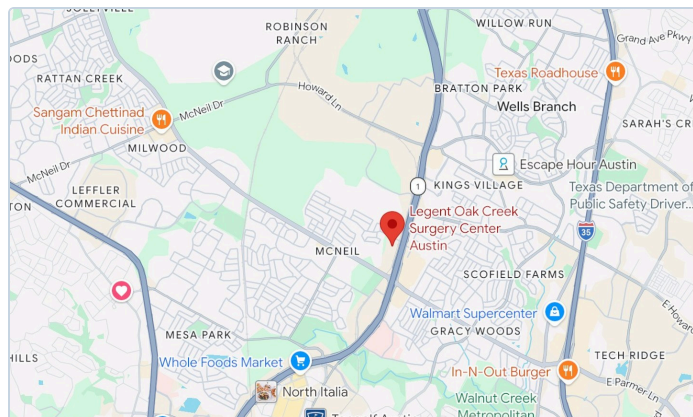
The average range of motion after a knee replacement is about **0–120°**. Some patients get more, some less. What goes into it: your **range of motion before surgery**, your **body type** (more muscular or larger legs can make motion slower to return), everything we do to control swelling and pain, and — importantly — **your compliance with therapy and willingness to work through discomfort**. You have about **3 months** to achieve your motion, though the majority of it should come in the **first 6 weeks**.

Physical Therapy

For most patients I arrange **home health therapy for the first two weeks**, then **transition to outpatient therapy** after that. If you'd prefer to go straight to outpatient from the start, that's allowed too — it's really a convenience decision, and we'll do whatever works best for your situation. **Home health typically comes 2–3 times a week**, and once you move to outpatient, **physical therapy also runs about 2–3 times a week until you no longer need it**. Some patients need only a few weeks; others use it up to about three months. It just depends on you.

Where Your Surgery Happens — Oak Creek Surgery Center

Your surgery is at the **Oak Creek Surgery Center**, which opened in **July 2025**. It sits just off **North MoPac (Loop 1)**, north of the Domain — at **3107 Oak Creek Dr, Suite 120, Austin, TX 78727**. It's a brand-new, elective-only facility built for exactly this kind of procedure.



Oak Creek Surgery Center, just off N MoPac / Loop 1.



The building that houses the surgery center.



Our waiting area.



Private pre-op bays.



Dr. Hurt in one of our operating rooms.

Your First Two Weeks at Home

Swelling peaks around **days 6–8**, so we get ahead of it immediately. This is the single biggest thing *you* control — please follow it closely.

Do this	How often	Learn more
Ice your knee	40 minutes of every hour while awake, for the first 10–14 days.	Wickline 2023
Elevate your leg — foot and knee above your heart	40 minutes of every hour, first 10–14 days. The goal is to get your foot and knee higher than your heart so gravity pulls the fluid out of your ankle and knee, down into your thigh and body. Lie back to do it — it barely works sitting up. "Toes above your nose" is the easy way to remember it. Pair it with your icing.	Wickline 2023
Wear your compression wrap	Foot to mid-thigh, as instructed.	Wickline 2023
Gentle range-of-motion exercises	A few minutes each hour: heel slides, straightening, ankle pumps, a few steps. Goals: full straightening (extension) by 2 weeks , and bending to 90° or more by 2 weeks .	Wickline 2023
Don't overdo walking	Aim for a ceiling of ~750 steps/day week 1, ~1,200/day week 2. Too much walking early increases swelling.	Wickline 2023
Take your anti-inflammatory (Celebrex)	As prescribed — this works on swelling, not just pain.	Huang 2008 (RCT)
Take your tranexamic acid	For about 2 weeks — it reduces bleeding and inflammation.	Wickline 2023
Medrol dose pack (around week 2)	A short steroid taper if prescribed. Held for diabetics and patients with glaucoma.	J Arthroplasty 2023 (RCT)
Eat low-salt, anti-inflammatory foods	Less salt means less fluid retention and swelling.	Wickline 2023

Ice safety: Keep each icing session to the recommended time, and never ice directly on bare skin over a numb area — always use the pad or a layer of cloth. If we've given you an ice machine, it makes this schedule far easier to keep — and keeping the schedule is what actually works.

Weeks Three Through Six

As swelling settles, we ease off the intensive schedule and build your strength and motion.

Do this	How often	Learn more
Continue ice & elevation	At least 40 minutes, 3 times a day — more if you're still swollen. Keep the foot and knee above your heart (lying back), so gravity does the work.	Wickline 2023
Range-of-motion work	A few minutes, about 6 times a day. Aim to reach your best in-surgery motion by week 4.	Wickline 2023
Gradually increase walking	Roughly 2,000 steps/day week 3, building to ~4,500 by week 6. Let pain and swelling be your guide.	Wickline 2023
Be careful returning to work before 6 weeks	Standing, stairs, and lifting all increase swelling and can slow your motion. Let's plan your return together.	Wickline 2023

When to Call Us

Please contact the office if you notice any of the following:

- Fever, or increasing redness, warmth, or drainage from your incision
- Calf pain, or swelling that suddenly worsens rather than improving
- Pain that isn't controlled by your prescribed plan
- Falling behind on your motion milestones — full straightening (extension) not achieved by 2 weeks, less than 90° of bend by 2 weeks, or not reaching 120° by 4 weeks
- Numbness or tingling that doesn't resolve (distinct from the expected patch on the outer knee)
- Any concern at all — I would always rather hear from you

Our door is always open — call us at (512) 856-1000. There is always a member of Dr. Hurt's team on call — Dr. Hurt himself or one of the two orthopedic PAs who work with him, both of whom have over 15 years of experience specifically in orthopedics. If you need us during your recovery, come see us. We always make room in our clinic schedule to see post-operative patients — if you feel like you need to be seen, show up, and we will fit you in that day or the next. You've entrusted us with your care, and we take that seriously.

A Book I Recommend

Many of the swelling-control ideas here are beautifully explained for patients in Dr. Andrew Wickline's *Less Swelling, Less Pain* (knee edition). Patients tell me the day-by-day guide takes the fear out of recovery. It's optional, but a worthwhile read: [lessswellinglesspain.com](https://www.lessswellinglesspain.com)

Where This Guidance Comes From

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