BEFORE YOU DECIDE

A Surgeon's *Complete* Guide to Hip & Knee Replacement.

An honest, specific conversation about when joint replacement helps, when it does not, and how to recognize the difference.

SECTION ONE OF THREE

The Essentials

01 HOW JOINTS FAIL

02 SIGNS THAT MATTER

03 NON-SURGICAL

04 YOUR OPTIONS

05 CANDIDACY

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SECTION ONE — THE ESSENTIALS

What's inside this section.

The Essentials covers the five conversations I have with almost every patient considering hip or knee replacement. Read it in order, or jump to the chapter that applies to your joint.

00 A Note from Dr. Calendine
WELCOME LETTER · WHY THIS GUIDE EXISTS
Welcome

01 How Healthy Joints Work — and Why They Fail
CARTILAGE · THE FOUR CAUSES · WHAT CHANGES EVERYTHING
Chapter 01

02 Signs You May Need Hip or Knee Replacement
HIP & KNEE SYMPTOMS · IMAGING · THE QUESTIONS I ASK
Chapter 02

03 Non-Surgical Options: What to Try First
THERAPY · WEIGHT · MEDICATIONS · BRACING · INJECTIONS
Chapter 03

04 A Brief Overview of Your Options
TOTAL VS. PARTIAL · APPROACHES · ROBOTIC · RECOVERY
Chapter 04

05 Are You a Candidate? How the Decision Gets Made
THE THREE FACTORS · HEALTH · TIMING · MINDSET · CONSULTATION
Chapter 05

5	~7,800	3
CHAPTERS IN THIS SECTION	WORDS · ROUGHLY 35 MIN READING	SECTIONS IN THE COMPLETE GUIDE

WELCOME LETTER

A note from Dr. Calendine.

Dear reader,

If you're reading this, you're probably dealing with something that has been changing your life in ways you didn't expect — and didn't ask for.

Maybe it's the stairs you now negotiate one at a time. The sleep you can't get through without waking up. The golf game you've quietly stopped planning for. The pickleball court you've stopped showing up to. The grandchildren you're watching run instead of chasing. Pain has a way of slowly renegotiating the terms of your life, and most people endure that process far longer than they should before asking whether something can be done about it.

I wrote this guide because the most important conversation I have is not in a conference room or lecture hall. It is across an exam table, with a patient trying to understand what comes next. That conversation deserves honesty. It deserves specificity. And it deserves enough time to do it right.

This is that conversation — written clearly, without shortcuts.

In nearly twenty years in practice, I've performed well over 10,000 hip and knee replacement procedures — adding more than 700 each year. I've trained surgeons on robotic technique across the United States and around the world. And I've sat across the exam table from thousands of patients who came in either too early — hoping surgery would solve something it couldn't — or far too late, having spent years in unnecessary pain because no one had given them a clear picture of what was actually possible.

WELCOME · CONTINUED — A NOTE FROM DR. CALENDINE

My goal is not to talk you into surgery. It is to help you understand when it helps, when it does not, and how to recognize the difference. Joint replacement is one of the most effective elective procedures in all of medicine — but only for the right patient, at the right time, performed by a surgeon with the training and volume to do it well. My goal is to give you the foundation to know whether that describes your situation.

By the time you finish this guide, you'll understand how your joint works and why it fails. You'll know what symptoms and imaging findings actually indicate that surgery is the right next step. You'll understand what conservative treatment can and cannot do. You'll know the difference between surgical approaches and why those differences matter. And you'll be equipped to have a far more informed conversation with whatever surgeon you choose to see — whether that surgeon is me or someone else.

Read it in order or jump to the section that applies to your joint. Share it with the people who will be in your corner through this process.

You deserve real answers. That's what this is for.

I'm glad you're here.

— Cory Calendine, MD

BOARD-CERTIFIED ORTHOPAEDIC SURGEON · HIP & KNEE REPLACEMENT · BONE AND JOINT INSTITUTE OF TENNESSEE · FRANKLIN, TN

01

CHAPTER ONE

How healthy joints work — and why they fail.

A healthy joint is silent. It moves without effort, absorbs force without complaint, and asks nothing of your attention. To understand why joints fail, you need a clear picture of what a healthy one actually does.

FOCUS	YOU'LL LEARN	READING TIME
Anatomy, cartilage, and why it cannot heal	Four main causes of joint failure	About 7 minutes

CHAPTER 01 HOW JOINTS FAIL

Most people never think about their hips or knees until something goes wrong. That's exactly how it should be. You climb stairs, get out of a car, walk through a parking lot — and your joints simply do their job while your mind is somewhere else. When that changes, everything changes. The patients who make the best decisions are the ones who understand what's happening inside that joint, not just that it hurts.

§ 1.1 Two different joints. One shared failure point.

Your hip and your knee are built differently because they do different jobs. The **hip is a ball-and-socket joint** — the rounded head of your thigh bone fits into a deep, cup-shaped socket in your pelvis. That deep socket is part of what makes the hip so reliable and lets you swing your leg forward, backward, and out to the side. It's a stable, mobile joint that handles enormous loads with remarkable consistency.

The **knee is a hinge joint**. It connects your thigh bone to your shin bone, with the kneecap riding along the front. Unlike the hip, the knee depends heavily on the ligaments and muscles around it for stability — and it's more vulnerable to misalignment, injury, and wear. Different joints, different designs. But both depend on the same thing: a layer of cartilage that caps the ends of the bones.

§ 1.2 The cartilage that makes it all possible.

Articular cartilage is what makes a healthy joint work. It's smooth, dense, and slightly compressible. Its job is to do two things almost nothing else in nature can do at once: **absorb impact and let the joint surfaces glide without resistance**. A healthy joint moves with less friction than ice on ice. When you walk, your knee handles forces equal to three to five times your body weight with every step — thousands of times a day, year after year, as long as it stays healthy.

The joint is enclosed in a capsule that produces synovial fluid — its own lubricating and nourishing system. That fluid keeps the cartilage hydrated and delivers the nutrients it needs, because cartilage has no direct blood supply of its own. You never think about any of it. Until the cartilage is gone.

> *Cartilage does not heal. No blood supply means no repair mechanism. Once cartilage is lost, it is lost.*
>
> THE ONE FACT THAT CHANGES EVERYTHING

CHAPTER 01 · CONTINUED — THE FOUR CAUSES

Almost every patient says the same thing: **"I wish I had understood this sooner."** Everything else in this guide makes more sense once you understand that one fact.

§ 1.3 Why cartilage fails — the four main causes.

OSTEOARTHRITIS MOST COMMON	By far the most common reason patients come to see me. A degenerative process in which cartilage breaks down gradually over years. Bone begins to contact bone, causing pain, swelling, stiffness, and loss of motion. Influenced by genetics, body weight, prior injury, and alignment. **It can be managed. It cannot be reversed.**
INFLAMMATORY ARTHRITIS IMMUNE-MEDIATED	Includes rheumatoid, psoriatic, and lupus-related arthritis. Your immune system attacks the joint lining. Over time that inflammation degrades cartilage and bone, causes deformity, and can affect multiple joints at once.
POST-TRAUMATIC AFTER INJURY	Develops after a significant joint injury — a fracture, major ligament tear, or dislocation. Even when the injury heals properly, the altered mechanics can accelerate cartilage wear. I see patients in their thirties and forties with severe degeneration that traces directly back to an injury in their twenties.
AVASCULAR NECROSIS LOSS OF BLOOD SUPPLY	Happens when the blood supply to a section of bone is cut off and the tissue dies. Most commonly affects the ball of the hip joint. Causes include corticosteroid use, excessive alcohol, certain blood disorders, or trauma — sometimes we never find a clear cause.

> **WHAT I WANT YOU TO TAKE FROM THIS**
>
> Joint replacement is a solution to a structural problem. When cartilage is gone, no medication, injection, or exercise program changes that. The question is never whether you're old enough — it's whether your joint has deteriorated to the point where the benefits of surgery outweigh the risks **for you, specifically, at this point in your life**.

CONTINUE TO CHAPTER 02
Signs You May Need Hip or Knee Replacement →

02

CHAPTER TWO

Signs you may need hip or knee replacement.

There is no single test that tells you it is time. No blood value, no imaging finding, no pain score that crosses a line and makes the decision for us. The decision is always made in context.

FOCUS
Patterns of symptoms in the hip and knee

YOU'LL LEARN
What imaging shows — and what it doesn't

READING TIME
About 8 minutes

CHAPTER 02 SIGNS THAT MATTER

After thousands of these conversations, the same combinations of symptoms show up again and again in patients who are genuinely ready for this discussion. Read the hip section, the knee section, or both — and pay attention not just to which symptoms you recognize, but to how many, and how long they've been present.

§ 2.1 HIP Hip replacement: symptoms that matter.

The most telling symptom of hip arthritis is not pain on the outside of the hip. It's **pain in the groin** — the front of the hip, right at the crease where your leg meets your torso. Deep, aching pain in that area — the kind that catches you when you stand up from a chair, take a step going up stairs, or have been walking for more than a few minutes. Patients frequently tell me they thought it was a pulled muscle, a hernia, or something unrelated. It's not. Groin pain is where the hip lives.

- **Stiffness that makes everyday tasks difficult.** Putting on shoes and socks. Getting in and out of a low car. Crossing your legs. Rotation is usually the first motion to become painful and limited.
- **A limp that developed gradually.** Most patients don't notice it themselves at first — someone close to them points it out.
- **Pain that radiates into the thigh, buttock, or outer hip** — a deep ache that's difficult to localize precisely. That quality is itself a clue.
- **Pain at rest or at night.** One of the clearest signals the joint has progressed beyond the point where reducing load provides relief.
- **Increasing reliance on a cane, walking stick, or someone's arm.** If you've started reaching for support you didn't used to need, your hip is telling you something important.

CHAPTER 02 · CONTINUED
KNEE · IMAGING · QUESTIONS

§ 2.2 KNEE

Knee replacement: symptoms that matter.

Where arthritis develops in your knee often relates to how your leg is aligned. Most people carry more load through the inner side — the medial compartment — and that's where arthritis most often begins. **Bow-legged alignment** concentrates that load on the medial side even further. Others carry more load through the outer side — often associated with **knock-kneed alignment**. Alignment affects how arthritis progresses and how we plan the correction at surgery.

- **Stiffness worst in the morning or after sitting.** More than fifteen or twenty minutes to ease, and it never quite resolves the way it used to.
- **Difficulty on stairs.** Going down is usually harder than going up — the quadriceps works against gravity on the descent.
- **Pain that wakes you up or prevents sleep.** The joint is inflamed beyond what rest alone can calm.
- **Swelling that persists without specific injury.** In advanced arthritis it becomes a near-constant presence.
- **A knee that buckles, gives way, or feels unstable.** Muscles and ligaments can no longer compensate reliably.
- **Visible deformity.** Bow-legged or knock-kneed alignment that has worsened over time.
- **Loss of range of motion.** When the knee no longer fully straightens or fully bends, simple things become hard.

CHAPTER 02 · CONTINUED — IMAGING & QUESTIONS

§ 2.3 The role of imaging — and the questions I ask.

Symptoms tell us what you're experiencing. X-rays tell us what's actually happening inside the joint. The primary thing we look for is **joint space** — the visible gap between the bones that represents your cartilage. In advanced arthritis it disappears entirely. When we say "bone-on-bone," that's what we mean.

We take **weight-bearing X-rays** — you're standing when the images are taken, with your full body weight loading the joint. A lying-down X-ray lets the joint gap open slightly and can make cartilage loss look less severe than it actually is. X-rays and pain do not always match; both matter.

> *Quality of life is the deciding factor. Not just pain levels, not just X-ray grades — but whether you are living the life you want to live, or whether your joint has started making that decision for you.*

If several of these describe your experience, a formal orthopaedic evaluation is appropriate:

- Have you given up activities important to you because of joint pain?
- Does pain prevent you from sleeping through the night?
- Are you calculating distances now — choosing parking spots, skipping outings?
- Are you avoiding social situations, travel, or family time because of the joint?
- Has pain worsened progressively over the past year despite treatment?
- Are you regularly relying on pain medication just to get through a normal day?

ONE MORE THING ABOUT TIMING

You don't have to wait until you can barely walk. You don't have to earn joint replacement by suffering long enough. The right time is when your joint has failed to the point where surgery offers a meaningful, lasting improvement in your quality of life — and when your overall health supports it. **That's the standard. Not how long you've endured it.**

03

CHAPTER THREE

Non-surgical options: what to try first.

Joint replacement is not the first step — and it should not be. Surgery only enters the conversation when conservative measures have been given a real opportunity to work — and haven't.

FOCUS	YOU'LL LEARN	READING TIME
What each conservative treatment actually does	When each option helps — and stops	About 9 minutes

CHAPTER 03 NON-SURGICAL OPTIONS

Nothing reverses cartilage loss. No medication. No injection. No therapy. What these treatments do is manage symptoms, help you function better, and in many cases buy real time before surgery becomes necessary. For some patients that's years — for others months. Understanding what each option can and cannot do is the only way to make good decisions about your care.

§ 3.1 LIFESTYLE Activity, therapy, and weight.

ACTIVITY MODIFICATION	Cutting back on high-impact activities — running, jumping, heavy lifting — and switching to lower-impact alternatives like swimming, cycling, walking on softer surfaces, and water aerobics. Keeps you fit and maintains muscle strength while taking most of the hard impact off your hip or knee. **This isn't giving up — it's being smart.**
PHYSICAL THERAPY	For the knee, the focus is the **quadriceps** — the joint's primary shock absorber. For the hip, the **hip abductors** on the outer hip and buttock play the same protective role. PT works best earlier in the disease when muscle weakness is part of the problem. The strength you build now is never wasted — the stronger your muscles going into surgery, the faster and more completely you come out of it.
WEIGHT MANAGEMENT	For every 5 pounds you lose, your knee absorbs roughly **20 fewer pounds** of force with every step. The hip carries similarly multiplied loads. Losing weight doesn't just help a little — it helps a lot, more than most patients expect. It won't reverse arthritis, but it can take the edge off your symptoms and meaningfully improve the outcome if you eventually need surgery.

CHAPTER 03 · CONTINUED — MEDICATIONS

§ 3.2 PHARMACOLOGY

Medications that actually help.

NSAIDS
FIRST-LINE

Usually the best first choice because arthritis is an inflammatory condition and NSAIDs attack both pain *and* inflammation. Over-the-counter: ibuprofen (Advil®, Motrin®), naproxen (Aleve®). Prescription: meloxicam (Mobic®), celecoxib (Celebrex®). **Long-term use carries real risks — stomach, heart, kidney.** Talk to your doctor before starting any NSAID, especially with a history of ulcers, heart disease, high blood pressure, or kidney problems.

ACETAMINOPHEN
TYLENOL®

A pain reliever, not an anti-inflammatory. Takes the edge off discomfort but doesn't address the inflammation driving your arthritis. An important option for patients who can't take NSAIDs — those with certain heart, GI, or kidney concerns. Generally safe at the right dose, but not risk-free, particularly with liver disease or regular alcohol use.

TOPICAL NSAIDS
DICLOFENAC GEL

Voltaren® Arthritis Pain gel delivers anti-inflammatory medication directly through the skin into the joint. Very little enters the bloodstream, so stomach, heart, and kidney risks are much lower than with oral NSAIDs. Safe, accessible, and a reasonable first thing to try — especially for knee arthritis.

CBD
A CAVEAT

Early data suggests potential benefit for pain and inflammation — and I don't dismiss it. But CBD **is not regulated by the FDA**. Product quality, concentration, and purity vary widely. If you try it, choose a reputable, established company that does its own rigorous independent testing. It is not a replacement for treatments with stronger evidence.

CHAPTER 03 · CONTINUED — BRACING & INJECTIONS

§ 3.3 PROCEDURES

Bracing and injections.

UNLOADER BRACING	Shifts load away from the damaged side of the knee to the healthier side. For patients whose arthritis is on one side rather than throughout, they can provide real relief. Reality check: bulky, warm, and require consistent use. Rarely worth the trouble for whole-knee severe arthritis.
CORTISONE INJECTIONS	Powerful anti-inflammatory delivered directly into the joint. Most patients notice improvement within days; relief can last weeks to months. Work best earlier in the disease when inflammation drives symptoms — less reliable once it's bone-on-bone. **Can be repeated, but not without limit** — more than two or three times a year in the same joint can accelerate cartilage wear.
HYALURONIC ACID "GEL SHOTS"	HA is a natural component of healthy synovial fluid. Up to **80% of patients** get meaningful relief for up to six months. Unlike cortisone, works gradually — can take 6–8 weeks for full benefit. Available as a single injection or a series of three to five. Newer biofermentation-produced options eliminate any concern for patients with avian allergies.
PLATELET-RICH PLASMA PRP	Uses your own blood — concentrated platelets and their anti-inflammatory and repair chemicals injected back into the joint. Growing research, particularly for earlier-stage arthritis. Not yet standard first-line treatment, rarely covered by insurance — but a reasonable conversation for patients exploring options before surgery.
STEM CELL INJECTIONS I DO NOT RECOMMEND	**There is no credible human evidence that they restore cartilage or provide lasting relief. None.** Being actively marketed — often at significant cost, almost never covered by insurance. I would give you this advice even if they were free. The cost makes the advice more important, not less.

> *When you've genuinely tried and it's no longer enough, that's not failure. That's information. It tells us the structural problem in your joint has moved beyond what symptom management can fix.*

04

CHAPTER FOUR

What surgery actually is.

There is a lot of confusing language around joint replacement. Total versus partial. Anterior versus posterior. Robotic versus traditional. This chapter is your plain-English map.

FOCUS
Approaches, robotics, and implant longevity

YOU'LL LEARN
What the differences actually mean for you

READING TIME
About 8 minutes

CHAPTER 04 YOUR OPTIONS

§ 4.1 Total vs. partial replacement.

In a **total joint replacement**, the surgeon removes the damaged surfaces on both sides of the joint and replaces them with artificial parts precisely fitted to your anatomy. For the knee: the bottom of the thigh bone, top of the shin bone, and typically the back of the kneecap. For the hip: the ball and the socket. An entirely new joint surface on both sides.

In a **partial replacement**, only the most damaged portion is replaced and healthier portions are left alone. In the knee this is most often the inner side. In the hip — a hemiarthroplasty — it is used in specific situations, most commonly certain hip fractures in older patients rather than for arthritis. The majority of patients I see have arthritis involving more than one area by the time they need surgery, which is why total replacement is more commonly the right answer.

§ 4.2 HIP Anterior vs. posterior approach.

The **posterior approach** has been the most widely used technique for decades. Accesses the hip from the back and side. Excellent visibility, works for virtually any patient regardless of size or anatomy, and produces outstanding results in experienced hands.

The **anterior approach** accesses the hip from the front, working between the muscles rather than detaching them. Because the muscles are not cut, recovery can be faster in the early weeks — patients often spend less time with a cane and report less pain initially. It is technically more demanding. **The best approach is the one your surgeon does most, does best, and has the results to back up.**

§ 4.3 KNEE Standard vs. subvastus approach.

The **standard (medial parapatellar) approach** involves an incision through or alongside the quadriceps tendon. The most widely used technique, with excellent results in experienced hands. The **subvastus approach** goes beneath the vastus medialis, leaving the entire quadriceps tendon intact. This is the approach I use for the majority of my knee replacement patients. When the tendon is never touched, patients typically regain quad strength faster and have a smoother early recovery.

CHAPTER 04 · CONTINUED
ROBOTICS · RECOVERY

§ 4.4 ROBOTICS The Mako® system, explained plainly.

Before surgery, a **CT scan is taken** of your hip or knee and used to build a three-dimensional model of your specific joint — bone geometry, anatomy, alignment. I plan the surgery in detail before entering the operating room. Implant size, position, and alignment are mapped out in advance based on your individual anatomy — not intraoperative estimates.

In the operating room, the robotic arm assists me in executing that plan with a high degree of precision. **It does not operate on its own. It does not make decisions.** I am in complete control at every moment. What it does change: better implant positioning, more accurate alignment, a joint more likely to feel balanced and natural after surgery. Research supports that robotic-assisted joint replacement reduces the rate of implant malalignment — a leading cause of early implant failure and patient dissatisfaction.

~1%	80%	1 night
PER YEAR MODERN IMPLANT WEAR	OF PATIENTS AT 20 YEARS STILL GOING STRONG	OR SAME DAY — TODAY'S TYPICAL STAY

§ 4.5 Longevity and outpatient recovery.

Modern implants wear slowly — roughly **1% per year**. That means at 20 years, about 20% of patients may have needed an additional procedure; the other 80% are going just like the day we put them in. Those numbers come from older implant designs — newer ones are expected to last longer.

Most joint replacement patients today go home the **same day or after one night**. For appropriately selected patients, early mobilization at home produces better outcomes than extended hospital stays.

> **WHAT THIS MEANS AS YOU EVALUATE OPTIONS**
>
> Technology is a tool. Approach names are labels. What shapes your outcome more than any of these things is the surgeon performing your procedure — **their training, their volume, their judgment, and their commitment to getting it right for you specifically**.

Disclosure: Dr. Calendine is a paid consultant to Stryker® for the Mako® robotic-arm platform.

05

CHAPTER FIVE

Are you a candidate? How the decision gets made.

Everything in this guide has been building toward this. It's not a checklist. It's a judgment — one that weighs your symptoms, imaging, health, life, and goals together. No two patients are the same.

FOCUS
The framework behind a candidacy decision

YOU'LL LEARN
What to bring to your consultation

READING TIME
About 8 minutes

CHAPTER 05 CANDIDACY

§ 5.1 There is no age requirement.

There is no minimum age for joint replacement surgery. There is no maximum age either. I have performed hip and knee replacement on patients in their **thirties and on patients in their nineties**. What determined their candidacy was not how old they were — it was whether their joint had failed, whether their health supported surgery, and whether the likely benefit was worth the known risk. Younger patients who have surgery earlier in life may need a revision procedure down the road — a real consideration to weigh, not a reason to endure years of unnecessary pain waiting for a birthday that changes nothing clinically.

§ 5.2 The three things that determine candidacy.

1. QUALITY OF LIFE
WHAT MATTERS MOST

The primary driver of this decision — not pain scores, not steps before it hurts. The real question: has your joint reached the point where it is **taking things from you that matter?** Sleep. Mobility. Independence. Time with the people you love. Activities that define who you are. When the answer is yes — and has been yes despite genuine conservative treatment — that is a powerful signal.

2. IMAGING
THE STRUCTURE

X-rays give us the structural picture. **Significant joint space narrowing, bone-on-bone contact, deformity, bone loss** — these findings tell us the joint has deteriorated beyond what non-surgical means can restore. The imaging needs to match the symptoms. Mild findings with severe pain may need further evaluation; severe findings with manageable symptoms may not be ready yet — or may be closer than you realize.

3. A FAIR CHANCE
FOR CONSERVATIVE CARE

Physical therapy **completed**, not abandoned after two sessions. Medications used consistently. Injections given time to work. We need to know the conservative path has been genuinely followed before concluding that surgery is the right next step. Not because you have to earn surgery — but because some patients find meaningful relief through those measures, and it's always worth knowing whether you're one of them.

CHAPTER 05 · CONTINUED
HEALTH · MINDSET · CONSULTATION

§ 5.3 Health factors that affect candidacy.

- **Cardiovascular health.** Heart and lungs need to handle the demands of surgery and anesthesia — evaluated with your cardiologist or primary care physician.
- **Diabetes.** Uncontrolled blood sugar increases infection risk and impairs healing. Optimizing glucose before surgery is one of the most impactful things within your control.
- **Body weight.** Elevated weight increases wound complications, infection risk, and anesthesia demands.
- **Smoking.** Impairs healing and increases infection risk. Stopping before surgery — and through recovery — is one of the most important things you can do.
- **Dental health.** Bacteria from dental infections can travel through the bloodstream and cause serious infection in a new joint.
- **Bone health.** Osteoporosis affects how implants anchor — not a disqualifier, but information that influences surgical planning.

§ 5.4 Mindset, expectations, and what to bring.

The right time is when symptoms and imaging are pointing clearly in the same direction — and when your overall health is in the best shape we can get it. Patients who go in with realistic expectations consistently report higher satisfaction and better outcomes. Joint replacement relieves pain, restores function, and gives back quality of life arthritis had taken away. It does not make a 65-year-old joint feel 25 — come in with clear eyes and a genuine commitment to the work of recovery.

- **Your imaging.** Recent weight-bearing X-rays of the affected joint.
- **A clear picture of your symptoms** — where it hurts, and what it's preventing you from doing.
- **A list of treatments you've tried** and how they worked.
- **Current medications** and the doctors you see, with phone numbers.
- **Questions, written down.** Bring someone with you — a second set of ears makes a real difference.

THIS COMPLETES SECTION ONE — THE ESSENTIALS

The right decision becomes clear when you understand the *problem*.

If this clarified the decision, the next step is understanding the details. That is what Section Two and Section Three are for. And if you're ready to talk, scheduling a consultation is not a commitment to surgery — it's a conversation.

SECTION TWO

The Complete Guide to Hip Replacement

SECTION THREE

The Complete Guide to Knee Replacement

Schedule a Consultation

FRANKLIN · MIDDLE TENNESSEE

PRACTICE

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