

**Andrew Zogby, MD**

Orthopaedic Surgeon, Sports Medicine Specialist

332 Santa Fe Drive, Suite 110

Encinitas, CA 92024

azogby@coreorthopaedic.com

(760) 943-6700

**Post Operative Physical Therapy Guidelines- Hip Arthroscopy**

A. Patient to be seen 1-3x/wk for 12-16 wks.

B. This protocol is written for the treating physical therapist and is not to substitute as a home exercise program for patients.

C. The post operative rehabilitation is just as important as the surgery itself

1. Please take a hands on approach to the patient’s care utilizing manual therapy techniques to prevent and minimize postoperative scarring and

tightness

2. Please emphasize form and control when instructing patients in exercise to prevent compensation and soft tissue irritation from compensatory patterns

3. The protocol serves as a guideline to patient care for the first 12-16 weeks

of rehab.

4. Patients may progress through the protocol at different rates, please

always use clinical decision making to guide patient care

D. DO NOT PUSH THROUGH PAIN

Post Operative Range of motion restrictions for hip arthroscopy

A. Flexion limited to 90 degrees x 2 wks

B. Abduction limited to 30 degrees x 2 wks

C. Internal rotation at 90 degrees flexion limited to 20 degrees x 3wks

D. External rotation at 90 degrees of flexion limited to 30 degrees x 3 wks

E. Prone internal rotation and log roll IR- no limits

F. Prone external rotation limited to 20 degrees x 3 wks

G. Prone hip extension limited to 0 degrees x 3 wks

Weight Bearing Schedule

A. Partial Weight Bearing with crutches or walker

**Labral repair, with/without Osteoplasty (bone resection) – 2-3 weeks partial weightbearing (20lbs or less)**

**Brace Use- brace to start at 2 weeks post op as you start to wean off crutches and increase weight bearing**

A. Brace positioned over the lateral aspect of the thigh

B. Brace must be worn at all times when the patient is up/weight bearing

**I. Initial Phase (weeks 1-6)**

Goals:

-Provide patient with education on initial joint protection to avoid joint and surrounding soft tissue irritation

-Begin initial passive range of motion within post operative restrictions

-Initiate muscle activation and isometrics to prevent atrophy

-Progress range of motion promoting active range of motion and stretching

-Emphasize proximal control of hip and pelvis with initial strengthening

-Initiate return to weight bearing and crutch weaning

-Normalize gait pattern and gradually increase weight bearing times for function

A. Day of surgery

1. Isometric glut sets, calf pumps

2. Ice therapy

B. Weeks 2-6 -- advancements to be done as a progression

1. Normalize gait – eliminate limp!!

2. Continue to increase range of motion with gradual sustained end-range stretches (still as pain tolerates).

3. Postoperative exercises

a. Isometrics!!! Quad, gluts, hamstring, adductors/abductors!

b. Active assisted range of motion in all planes (do not push through painful endpoints)

c. Hip mobilization – straight plane distraction, inferior glides, posterior Glides. (see below)

d. Closed chain bridging, weight shifts, balancing drills

e. Open chain standing abduction, adduction, flex/ext without Resistance

4. Cardio program as below

Precautions for Phase 1 - Hip Arthroscopy Rehabilitation

-Avoid hip flexor tendonitis

-Avoid irritation of the TFL, gluteus medius, ITB, and trochanteric bursa

-Avoid anterior capsular pain and pinching with range of motion

-Prevent low back pain and SIJ irritation from compensatory patterns

-Manage scarring around portal sites and at the anterior and lateral hip

-Do not push through pain with strengthening or range of motion

**II. Intermediate Phase (weeks 6-12)**

Goals:

-Return the patient to community ambulation and stair climbing without pain using a normal reciprocal gait pattern

-Continue to utilize manual techniques to promote normal muscle firing patterns and prevent soft tissue irritation

-Progress strengthening exercises from double to single leg

-Promote advanced strengthening and neuromuscular re-education focusing on distal control for complex movement patterns

-Progress the patient to phase 3 rehabilitation with appropriate control and strength for sport specific activities

A. Postoperative weeks 6-12

1. Begin progressive resistive exercises as tolerated.

a. Closed chain single leg bridging

b. Open chain above knee resistive Theraband or pulley exercise in flexion, extension, adduction, abduction and hamstring curls as tolerated

c. Bike as tolerated

d. Pool exercises

2. Cardio program as below

Precautions for Phase 2 – Hip Arthroscopy Rehabilitation

-Continue to avoid soft tissue irritation and flare ups that delay progression

-Be aware of increasing activity and strengthening simultaneously to prevent compensation due to fatigue

-Promote normal movement patterns and prevent compensations with higher level strengthening

-Do not push through pain

**III. Advanced Phase (weeks 12+)**

Goals: Increase functional strength and endurance

A. Gradual progression of activities

1. Functional activities

2. Sport-specific activities

3. Return to sporting activity (with clearance from physician and Physical Therapist and MD) -- Full return to competitive and/or higher impact sports will occur between 4 and 6 months post-operatively, depending on the sport and your progress with rehab.

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Cardiovascular Program (Weeks 1-12)

A. Start Week 2 - Stationary Bike (no resistance) x 20 minutes, 1-2/day x 4 weeks

1. Increase duration on bike by 5 minutes/wk beginning at week 3

B. Aquatic PT Program

1. Can begin aquatic PT program week 4 (incisions must be well healed)

C. Elliptical trainer - Can begin week 6 post-op

1. Start with 10 minutes, increase 5 minutes/wk for next 6 weeks

D. Combination program- Begin alternating stationary bike and elliptical at week 8

1. Start with 20 minutes total time progressing as tolerated.

E. Treadmill walking program may begin week 12

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Addendum – Distraction Mobilization Techniques

In athletes with painful hip disorders, distraction mobilization techniques can be very effective both preoperatively and postoperatively. Distraction reduces the compressive forces across the articular surfaces. This counterforce often provides significant relief to an inflamed and irritated joint. Over time, these counter-reactive forces promote a cartilage-healing environment in the hip which is an excellent adjunct to the traditional hip range-of-motion and strengthening exercises. The following is a brief review of the three distraction mobilization techniques for the hip:

1. Straight-plane distraction: The patient is in the supine position. The therapist grasps the lower leg above the ankle and applies a manual traction force. It may be necessary for an assistant to provide countertraction by stabilizing the torso. The traction vector can be applied with the hip in various degrees of flexion and abduction. Best results are accomplished if progressive and sustained distraction for 10-15 seconds is performed. The patient should be frequently reminded to remain relaxed so that joint distraction can be accomplished. 5 repetitions are recommended.

2. Inferior Glide distraction: The patient is supine with the hip and knee flexed 90 degrees. The therapist rests the patient’s lower leg on the therapist’s shoulder. A manual distraction force is applied to the proximal anterior thigh. This is best performed by interlocking both hands and then applying pressure, distracting in a distal direction. 5 repetitions are recommended.

3. Posterior Glide distraction: The patient is supine with the hip and knee flexed 90 degrees. The applied force is directed downward on the knee such that posterior translation of the femoral head is accomplished. The therapist should be positioned directly over the knee such that the therapist’s body weight can be used to gently apply the posteriorly directed force. 5 repetitions are recommended. (Note: This exercise should not be performed in patients with posterior instability.)