Orthopaedic Specialty Institute
Medical Group of Orange County

DR. ROBERT GRUMET, MD
280 S. MAIN ST. SUITE 200
ORANGE, CA 92868
PHONE: 714-937-2113
FAX: 714-634-4569

PATIENT NAME:_____

DATE OF SURGERY: _____

Post Operative Hip Arthroscopy Rehabilitation Protocol
Labral Repair with or without FAI Component

Initial Joint Protection Guidelines (Post Op Weeks 1-4)

- Patient Education
  - Assistance from a family member/care taker needed for transitioning positions for the 1st week after surgery.
  - Lay on stomach for 2-3 hours per day to decrease tightness in the front of the hip
    - *Note: patient with low back pain may have to modify position*
  - **Labral Repairs Only:**
    - Avoid actively lifting, flexing, and/or rotating hip (thigh) for first 2-3 weeks
    - Do not sit in a chair or with hip bent to 90 degrees for greater than 30 minutes for the first 2 weeks after surgery to avoid tightness in the front of the hip
- Weight Bearing Restrictions
  - Foot flat weight bearing (FFWB) x 10 days if NO microfracture (MFx)
    - FFWB x 6-8 weeks if with MFx
  - Physical Therapy (PT) to provide education on FFWB with 20lbs of pressure
- Post Operative Range of Motion (ROM) Restrictions for Hip Arthroscopy
  - Flexion → limited to 90 degrees x 2 weeks *(Note: limitation for Labral Repairs Only)*
  - Abduction → limited to 30 degrees x 2 weeks
  - Internal Rotation (IR) at 90 degrees of flexion → limited to 20 degrees x 3 weeks
  - External Rotation (ER) at 90 degrees of flexion → limited to 30 degrees x 3 weeks
  - Prone IR and log roll IR → no limits
  - Prone ER → limited to 20 degrees x 3 weeks
  - Prone Hip Extension → limited to 0 degrees x 3 weeks

Post Operative Physical Therapy Guidelines

General

- Patient is to be seen 2x per week for 12-16 weeks
- This protocol serves as a guideline to patient care for the first 12-16 weeks of rehab
  - *NOTE: This protocol is written for the treating PT and is NOT to substitute as a home exercise program for patients*
- Post operative rehabilitation is just as important as the surgery itself
  - Please take a hands on approach to the patient's care utilizing manual therapy techniques to prevent and minimize post op scarring and tightness
  - Please emphasize form and control when instructing patients in exercise to prevent compensation and soft tissue irritation from compensatory patterns
  - Patients may progress through the protocol at different rates, please always use clinical decision making to guide patient care.
- DO NOT PUSH THROUGH PAIN
- Please contact our office with any questions regarding post op protocol at **714-937-2113.**

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Phase I: Weeks 1-6

Rehabilitation Goals

- Provide patient with education on initial joint protection to avoid joint and surrounding soft tissue irritation
- Begin initial PROM within post op restrictions
- Initiate muscle activation and isometrics to prevent atrophy
- Progress ROM to promote AROM and stretching
- Emphasize proximal control of hip and pelvis with initial strengthening
- Initiate return to WB and crutch weaning
- Normalize gait pattern and gradually increase WB times for function

Precautions

- Avoid hip flexor tendinitis
- Avoid irritation of TFL, gluteus medius, ITB, and trochanteric bursa
- Avoid anterior capsular pain and pinching with ROM
- Prevent LBP and SI joint irritation from compensatory patterns
- Manage scarring around portal sites and at anterior and lateral hip
- Do not push through pain without strengthening or ROM

PROM

- Circumduction
- Neutral Circumduction
- Supine Hip Flexion
- Supine Abduction
- Supine ER
- Supine IR
- Sidelying Flexion
- Prone IR
- Prone ER
- Prone Extension
- Prone on Elbows/ Press Ups
- Quadraped Rocking
- Half Kneeling Pelvic Tilt

Manual Therapy

- Scar Tissue x 5minutes
    - Incision portals → begin POD 2 to week 3
- Soft Tissue Mobilization x 20-30minutes
    - Begin POD 4 to weeks 10-12
    - Begin with superficial techniques to target superficial fascia initially
    - Progress depth of soft tissue mobilization using techniques such as deep tissue massage, effleurage, pettrissage, strumming, perpendicular deformation, and release techniques
    - *NOTE: the use of mobilization with active and passive movement is very effective with this patient population (ART, functional mobilization, etc).*
    - Structures to focus on:
        - Anterior → Hip Flexors, TFL, Rectus Femoris, Inguinal Ligament, Sartorius

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- Lateral → ITB, Gluteus Medius (all fibers, especially anterior), Iliac crest,/ASIS, Quadratus Lumborum
  - Medial → Adductor Group, Medial hamstrings, Pelvic floor
  - Posterior → Piriformis, Proximal Hamstrings
    - Glutes (medius, minimus, maximus)
    - Deep Hip ER (gemellus, quadratus femoris, obturator internus)
    - Sacral Sulcus/PSIS/SI joint
    - Erector Spinae
    - Quadratus Lumborum

- Joint Mobilization
  - Begin post op weeks 3-12
  - Begin with gentle oscillations for pain grade I-II
  - Caudal glide during flexion may begin week 3 and assist with minimizing pinching during ROM
  - Begin posterior/inferior glides at week 4 to degree posterior capsule tightness
    - May use belt mobilization in supine and sidelying
  - Do not stress anterior capsule for 6 weeks post op with joint mobilizations

Phase II: Weeks 6-12

Rehabilitation 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 patient to phase III rehab with appropriate control and strength for sport specific activities

Precautions

- Continue to avoid soft tissue irritation and flare ups that delay progression
- Promote normal movement patterns and prevent compensations with high level strengthening
- Be aware of increasing activity and strengthening simultaneously to prevent compensation due to fatigue
- Do not push through pain

Manual Therapy

- Continue to utilize manual therapy including soft tissue and joint mobilizations to treat patient specific ROM limitations and joint tightness
  - *Note: especially for pinching in anterior hip*
- Address any lumbar or pelvis dysfunction utilizing manual therapy when indicated

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Muscle Activation, Neuromuscular Re-Education, and Strengthening (BOTH PHASE I & II)

- Isometrics → POD 1-7
  - Gluteal Sets
  - Quad Sets
  - TA isometrics w/ diaphragmatic breathing
- Post Op Weeks 2-12
  - **Supine Progression**
    - Supine hook lying hip IR and ER
    - Pelvic Clocks (12-6; 9-3; diagonals)
    - Supine lower trunk rotations
    - TA isometric with bent knee fall outs
    - TA isometric with marching
    - Supine FABER slides with TA isometric
    - Bridging Series
      - Double Leg Bridging → Bridge with Adduction Isometric → Bridge with Abduction → Bridge with Single Knee Kicks → Single Leg Bridge
  - **Sidelying Progressions**
    - Sidelying pelvic A/P elevation and depression
    - Sidelying Clams
    - Sidelying Reverse Clams
  - **Side Plank Progression**
    - Half Side Plank Taps
    - Half Side Plank Holds
    - Modified Side Plank Holds → top knee extended; bottom leg still flexed at 90
    - Full Side Planks
  - **Prone Progressions**
    - Prone Alternate Knee Flexion w/ TA Isometric
    - Prone Hip IR and ER
    - Prone Hip Extension w/ Extended Knee
    - Prone Hip Extension w/ Flexed Knee
    - Prone Alternate Arm & Leg Extensions
    - Prone Hip Extension on Exercise Ball
    - Prone Alternate Arm & Leg Extension on Exercise Ball
  - **Prone Plank Progression**
    - Modified Prone Plank
    - Half Prone Plank (Pillar Bridge)
    - Full Prone Plank
    - Full or Half Prone Plank on BOSU Ball
    - Full or Half Prone Plank with Lateral Slides

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- **Quadraped Progressions**
  - Quadraped Anterior/Posterior Pelvic Tilts
  - Quadraped Arm Lifts
  - Quadraped Hip Extensions
  - Quadraped Alternate Upper & Lower Extremity Lifts
- **½ Kneeling Progression**
  - ½ Kneeling Pelvic Clocks
  - ½ Kneeling Weight Shifts
  - ½ Kneeling Upper Shoulder Girdle Strengthening
  - ½ Kneeling Trunk Rotations
- **Gait Progression**
  - Standing Side to Side Weight Shifts
  - Standing Anterior & Posterior Weight Shifts
  - Backwards Walking
  - Side Stepping
  - Side Stepping w/ Resistance Band
  - Retro Walking w/ Resistance Band
- **Closed Chain Squat Progression**
  - Exercise Ball Wall Sits
  - One-Third Knee Bends → flexing knees to 30 degrees
  - Double Leg Squats
  - Double Leg Squats w/ Weight Shift
  - Balance Squats
  - Single Leg One-Third Knee Bends
  - Sing Leg Squats
  - Balance Squats w/ Rotation
- **Slide Board Exercises**
  - Lateral Slides
  - Lateral Lunge Slides
  - Hip Split Slides
  - Reverse Lunge Slides
- **Lunge Progressions**
  - Split Lunge
  - Forward Lunge
  - Lateral Lunge
  - Reverse Lunge
  - Lunge w/ Trunk Rotations
- **Balance Progressions**
  - Single Leg Balance
    - Standing Single Leg Hip Hiking w/ Ball

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- Standing Single Leg Balance w/ Opposite Hip Isometric Abduction
- Standing Single Leg Balance w/ Opposite Hip Isometric IR
- Standing Gluteus Medius
  Isometric w/ Foam Roller
  in Running Position

<u>Cardiovascular Program (BOTH PHASE I & II)</u>

- Stationary Bike
  - NO RESISTANCE x 20minutes, 1-2 times per day x 4 weeks
  - Increase duration on bike by 5 minutes per week beginning at week 2
- Aquatic Program
  - May begin at week 3 *(incisions must be well healed)*
- Elliptical Trainer
  - May begin at week 6
  - Start w/ 10 minutes and increase 5 minutes per week for the next 6 weeks
- Combination Program (alternative stationary bike & elliptical)
  - Begin at week 8 for 20 minutes total time, progressing as tolerated
- Treadmill Walking
  - May begin at week 12
- Running
  - Usually at 3-4 months → *based on Physician's discretion*