

Hip Arthroscopy Rehabilitation Protocol



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This protocol is a generic outline of the postoperative management for patients undergoing hip arthroscopy. Depending on the exact diagnosis and the procedures performed, the surgeon may recommend variations of the therapy program. The therapist is encouraged to make recommendations as issues arise and should not hesitate to contact the surgeon to discuss the progress of these patients.

It is important to understand that rehabilitation after hip arthroscopy is very different than the traditional therapy that has been employed for open hip surgeries, e.g. total joint replacement or fracture stabilization. Traditionally physical therapy after open hip surgery employed the principles of gait training, oftentimes with weightbearing restrictions and hip precautions. The emphasis was largely on regaining the ability to perform activities of daily living.

The goals of patients undergoing hip arthroscopy are strikingly different. Oftentimes the patients undergoing hip arthroscopy procedures are quite athletic and the goal is to return them to sports as quickly as possible. Early weightbearing and range of motion exercises are emphasized. Progressive strengthening programs are started almost immediately and cross training activities are encouraged early in the rehabilitation process.

Ideally, a therapist-patient relationship will have already been formed as many of the patients undergoing hip arthroscopy will have undergone a “prehab” program (See Prehab Handout). Many of the same exercises used preoperatively will be employed in the postoperative period, but in a slower and more progressive manner. The better conditioned the patient is preoperatively will largely determine the rate at which the patient improves postoperatively.

The first step of the postoperative program will begin just like any other protocol with the initial assessment and identification of the patient’s goals and expectations. The importance of the therapist’s assessment cannot be overemphasized. We consider the physical therapy assessment just as important as the medical assessment. The amount of time spent with the therapist by far exceeds the amount of time spent with the physician and thus important details will often be recognized that are not picked up by the surgeon. An ongoing dialogue with the physician is encouraged and changes in the protocol can be adjusted as necessary depending on this interaction.

The goals of the patient should be clearly established and should be reviewed and adjusted regularly. Unrealistic goals should be identified early and more realistic goals can be established. Again, the diagnosis, the surgery performed and the preoperative activity level of the patient will largely determine the ultimate goals – always remembering that the primary focus is to return these people back to sports and training regimens as expeditiously and safely as possible. Oftentimes in the elite athletes this will require “holding back the reins” at times as these patients tend to try to progress too rapidly and can actually inhibit their rehabilitative potential. Again, this protocol is a general outline and can be accelerated or decelerated depending on each individual situation. If any questions arise please contact Dr. Michael Gerhardt at (310) 829-2663.

I. Initial Phase

Goals: Decrease soreness and swelling, gently increase range of motion to tolerance, inhibit further muscle atrophy

A. Day of surgery

1. Isometric glut sets, calf pumps
2. Cold therapy

B. Postoperative days 1-7

1. Dressing change on postop day #1
2. Partial Weight Bearing with crutches or walker
 - a. Labral debridement – 5-7 days only
 - b. Osteoplasty (bone resection) – 2 weeks
 - c. Microfracture – 4 weeks
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.
 - d. Closed chain bridging, weight shifts, balancing drills
 - e. Open chain standing abduction, adduction, flex/ext without resistance

II. Intermediate Phase

Goals: Regain and improve strength, regain normal joint kinematics

A. Postoperative weeks 2 – 3

1. Normalize gait – eliminate limp!!
2. Continue to increase range of motion with gradual sustained end-range stretches (still as pain tolerates).
3. 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

III. Advanced Phase

Goals: Increase functional strength and endurance

A. Postoperative weeks 4-6

1. Continue flexibility exercises
2. Continue progressive resistive strengthening exercises
 - a. Closed chain exercises as tolerated: multiplane strength exercises, hamstring curls, knee extensions

B. Gradual progression of activities

1. Functional activities
2. Sport-specific activities

3. Return to sporting activity (with clearance from physician and physical therapist)

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.)