ROCKFORD ORTHOPEDIC

Hip Arthroscopic Labral Repair Protocol
(with or without FAI Component)

Initial Joint Protection Guidelines: 1-4 weeks post-op

Joint Protection Patient Education:

- Avoid active lifting or flexing and rotating the hip for 2-3 weeks
- Assistance to move the involved LE is required for all transfers for 1 week
- Do not sit with hip flexed to 90 deg for greater than 30 min for 2 weeks
- Lay on stomach for 2-3 hours/day to decrease hip tightness anteriorly (patients with LBP may modify position)

Weight bearing restrictions:

- FFWB x 2 weeks if no MFx (Microfracture), x 8 weeks with MFx
- PT educate patient on FFWB with 20 lbs pressure

Brace:

- ROM set at 0 deg extension and 60 deg flexion for walking
- Wear brace for sleeping, no change in ROM

Post Operative ROM restrictions: ROM are guidelines, painfree range only

- Flexion limited to 90 and Abd limited to 30 deg x 2 weeks
- In 90 deg. flexion supine: IR limited to 20 deg and ER to 30 deg x 3 weeks
- Prone IR – no limits. Prone ER limited to 20 deg x 3 weeks
- Prone hip extension to 0 deg x 3 weeks

Post Operative Therapy guidelines:

- Patient seen 1-3x/week x 12-16 weeks
- Rehabilitation key to prevent stiffness and post-op scarring
- Form and control are key to prevent compensatory patterns and soft tissue irritation
- Patient may progress at different rates, please use clinical decision making to guide patient care
- Time frames may be modified depending on patient's preoperative fitness level

Phase I (1-5 days post op)

- Wound care: Observe for signs of infection.
- Modalities: PRN for pain and inflammation (Cryotherapy, IFC)
- Patient education, WB and Brace: See above
- Manual therapy interventions: Beginning superficial day 1 for edema control and scar mobilization. Monitor adductors mm group for rapid development of mm tone.
- Joint mobilizations: none at this phase
- ROM: PROM Performed by therapist within protocol and patient tolerance week 1.
    - Bike may replace time in CPM – see above guidelines

- PROM *within above listed ROM limits* including:
    - Circumduction: Hip flex 70/knee 90, move thigh in small CW/CCW circular motions. Avoid rotation of the hip into IR/ER.
    - Neutral Circumduction: knee ext, abd patient leg to 20 deg, small circles CW/CCW.
    - Supine hip flexion to max of 90 degrees until p/o 2 weeks. Avoid anterior hip pinching. No caudal glides until 3 weeks post-op
    - Supine abduction: direct abd to max of 30 deg, neutral rotation
    - Supine ER: Hip flex 70/knee 90, slowly ER to max of 30 deg
    - Supine IR: Hip flex 70/knee 90, slowly IR to max of 20 degrees avoiding any pinching in the groin or back of hip

- Prone IR: knee flex 90, IR slowly as tolerated
- Prone ER: knee flex 90, gently stretch to max of 20 (avoiding ant hip pain)
- Prone ext: knee flex 90, slowly extend hip to 0 deg maximum
- Prone on elbows or press ups: slow extension of lumbar spine beginning by propping on elbows and progressing to press ups as tolerated

- AROM: none first week, gradually introduce in Phase II p/o week 2-3 painfree only avoiding tendonitis

- Strengthening: Isometrics beginning post op day 1-day 7
  - Gluet sets, quad sets and TrA Isometrics supine or prone
  - Ankle AROM
  - Upright stationary bike with high seat for AROM (no recumbent bike)

Phase II (5 days to 6 weeks)	Phase III (6 weeks to 12 weeks)
Rehab Goals by completion of phase: • Progress ROM to 75% of uninvolved • SLR Abd gluet med x 10 reps at 4/5 w/o compensation • Progress to FWB without assistive device • Proximal stability, proper mm firing patterns	**Rehab Goals by completion of phase:** • Symmetrical ROM • Strength hip flexion 70% and all other hip motions 80% of uninvolved • Normal gait without Trendelenburg Sign
Precautions: • Avoid hip flexor tendonitis • Avoid anterior capsular pain and pinching with ROM. Do no push through pain for strengthening or ROM.	**Precautions:** • Continue to avoid soft tissue flare ups that delay progress • Promote normal movement patterns to avoid compensation with higher level activities • Do no push through pain

Phase II (5 days -6 weeks post op)

- Wound care: Continue Phase I
- Modalities: Continue Phase I
- Weight bearing: If no MFx may begin to progress WB within painfree levels
- Brace: Worn until s/p 6 weeks. MD may D/C earlier. May remove brace during therapy.
- Crutches: Begin to wean from crutches as WB restriction is lifted. Avoid rapid DC of crutches to avoid tendonitis of the hip flexor musculature.
- Manual therapy interventions: continue to progress soft tissue mobilization to prevent stiffness anterior hip
- Joint Mobilizations: at 3 weeks, may begin only if clear deficit is present. Do not want to decrease passive stability of the hip in not limited:
  - Gentle oscillations grade 1-2 for pain
  - Caudal glide during flexion to decrease pinching during ROM
  - Posterior/inferior glides at week 4
  - Do not stress anterior capsule for 6 weeks with joint mobilizations
- ROM: Continue with limited ROM as noted in guidelines until appropriate 2 or 3 weeks post op. Gradually progress A/PROM after this time working towards goal of 75% of uninvolved LE by end of Phase II. *Avoid anterior hip joint pinch or pain*. PROM may be progressed to also include:
  - Kneeling on stool and active IR/ER initially within ROM limits

- Quadruped rocking: Hands/knees position, pelvis level, slowly rock forwards/backwards from hands to knees. Once ROM restrictions lifted, patient may begin to rock back bringing seat to heels
- Half kneeling pelvic tilts: Kneeling on involved leg, slowly perform posterior pelvic tilt to stretch the anterior hip

• Strengthening: Gradual progression of strengthening throughout phase within painfree motion: *Below are guidelines only, various strengthening activities may be included.*

	Phase II(5 days to 6 weeks)	**Phase III(6 weeks to 12 weeks)**
Supine Progressions	• Hooklying hip IR/ER maintaining level pelvis • Pelvic clock (12-6, 3-9 and diagonals) • Supine lower trunk rotations • TrA isometric with bent knee fall outs and isometrics with marching • Supine FABER slides with TrA isometric-involved heel starts in FABERS position at medial malleoli and slide up to knee level	• Supine progression of TrA stabilization with UE/LE ext
Bridging Progressions	• Double leg bridge, bridge with add isometric w/pillow or ball, bridge with abduction with Theraband or Pilates ring	• bridge with single knee kicks and single bridge
Sidelying Progresions	• Sidelying clams with neutral spine and pelvis. Reverse clams. • Add Theraband for resistance or Pilates ring for isometric.	• Half side plank taps-Hips 0 ext, knees flex • Half side plank holds-same, hold 30 sec to 3 min • Modified side plank holds- top leg ext • Full side planks-LE ext
Prone Progressions	• Prone alternate knee flexion with TA isom • Prone hip midrange IR/ER with level pelvis • Prone hip ext with knee ext/flex • Prone alternate UE/LE extension	• Prone hip ext on exercise ball • Prone alternate UE/LE on exercise ball
Prone Plank Progressions	• Modified prone plank- knees bent	• Full prone plank-elbows and feet • Full /half plank on BOSU or with lateral slides
Quadruped Progressions	• Quadruped anterior/posterior pelvic tilts • Quadruped arm and leg raises with neutral pelvis/spine	• Quadruped alternate arm and leg raises-add resistance
Half Kneeling Progressions	Kneeling on involved: • ½ kneeling pelvic clocks • ½ kneeling weight shifts-neutral spine, shift forward for gentle stretch anterior hip within hip ext limit x week 3	• ½ kneeling upper shoulder girdle strengthening while maintaining neutral spine/hip positioning • ½ kneeling trunk rotations-clasp hands and rotate trunk

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Gait Progressions	• Standing side to side weight shifting • Standing anterior/posterior weight shifting- stagger stance	• Retro walking • Side stepping with or without band • Retro walking with resistance band
Squat/Lunge Progressions	• Exercise ball wall sits with ball behind low back • Partial squat with feet shoulder width apart and slight toe in position. Squat to 30 degrees at knees • Forward, lateral and reverse lunges - lunge towards involved • Split squat in limited range of motion	• Double leg squats/wall slides- to 70 deg flex • Double leg squat with weight shift • Sidestep w/band • Bulgarian split squats • Single leg squats- 30 deg progress to 70 • Split squats or lunges with rotation of trunk- bilat UE rotation. Add medicine ball/band. • Speedskaters
Balance Progressions	• Single leg balance with level pelvis	• Hip hiking- can add ball roll up wall with opp LE • Single leg stand, isom abd opp LE press into wall • flex to 20 deg
Slide Board Progressions	• none	• Unilateral Lat slides • Lateral lunges • Lateral Slides • Reverse lunges
Cardiovascular Program	• Stationary Bike w/o resistance x 20 min. Increase duration by 5 min/week @ week 2	• Elliptical may begin s/p 6 weeks • No TM ambulation until 12 weeks p/o

Phase IV: (12 weeks – 16 weeks)

ROM: Symmetrical ROM.

Strengthening: Gradually progress strength challenges and agility activities painfree level only. Normalize LE strength with all activities without compensation or Trendelenburg sign. Begin low level agility activities progressing towards higher level challenges.

Plyometrics: prior to initiating plyometrics patient should be able to complete a single leg press 1.5x body weight.

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Treadmill: May begin with walking on treadmill gradually progressing to running avoiding symptom flare or tendonitis. Guideline for return to running:

Running: prior to returning to running patient should be able to complete the "10 Rep Triple" which includes: 1. 10 single leg squats w/o kinetic collapse, 2. 10 front step downs w/o kinetic collapse, and 3. 10 sidelying Abd SLR against resistance grade minimum of 4/5 all reps.