ROCKFORD ORTHOPEDIC
CRYSTAL LAKE ORTHOPEDICS
A DIVISION OF ROCKFORD ORTHOPEDIC ASSOCIATES, LTD.

Geoffrey S. Van Thiel, MD/MBA
www.VanThielMD.com
gvanthiel@rockfordortho.com

Hip Arthroscopy
Labral Repair/Debridement with Femoroplasty

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 low back pain may modify position)

Weight bearing restrictions:

- FFWB x 2 weeks if no MFx (Microfracture), x 6 weeks with MFx
- PT educate patient on FFWB with 20 lbs pressure

Brace (if prescribed by Dr. Van Thiel) is used for 2 weeks:

- 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 0 deg and ER to 30 deg x 3 weeks
- Prone IR – to neutral. 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
    - Bike is an excellent tool with a raised seat to decrease hip flexion
    - 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
    - ROM: 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	**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

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 at 2 weeks. 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 in phase II and III.

	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	• 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
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
Quadruped Progressions	• Quadruped anterior/posterior pelvic tilts • Quadruped arm and leg raises with neutral pelvis/spine	• Quadruped alternate arm and leg raises- add
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

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
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
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

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.
- 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
        3. 10 sidelying Abd SLR against resistance grade minimum of 4/5 all reps