ARTHROSCOPIC HIP SURGERY WITH LABRAL REPAIR/RECONSTRUCTION

The intent of this protocol is to provide guidelines for your patient's therapy progression. It is not intended to serve as a recipe for treatment. We request that the PT/PTA should use appropriate clinical decision making skills when progressing a patient forward.

Please email **nstone@gracehealthsystem.com** to obtain the operative report from our office prior to the first post operative visit. Also please contact Dr Verdugo if there are any questions about the protocol or your patient's condition.

Please keep in mind common problems may arise following hip arthroscopy: hip flexor tendinitis, adductor tendinitis, sciatica/piriformis syndrome, ilial upslips and rotation, LB pain for QL hypertonicity, and segmental vertebral rotational lesions. If you encounter any of these problems please evaluate, assess and treat as you feel appropriate, maintaining Dr Verdugo's precautions and guidelines at all times. Gradual progression is essential to avoid flare-ups. If flare-ups occur, back off with therapeutic exercises until it subsides.

Please reference the exercise progression sheet for timelines and use the following precautions during your treatment. Thank you for progressing all patient's appropriately and please fax all progress notes to Dr Verdugo's office. **Successful treatment requires a team approach, and the PT/PTA is a critical part of the team!!**

Please use Appropriate Clinical Judgment During ALL Treatment Progressions.

Initial Pre-op Assessment

Physical Therapy Protocol

- Assess bilateral hips
- ROM - Flexion, extension, TR, ER, Abd, Add
- Gait - look for Trendelenburg gait
- Impingement test - flexion/adduction/IR often reproduces pain
- Ober Test
- Strength - abduction, flexion, extension

Phase 1: Weeks 1-2

Immediate Rehabilitation

Goals

- Protection of the repaired tissue
- Prevent muscular inhibition and gait abnormalities
- Diminish pain and inflammation

Precautions

- **For labral repair, non weight bearing status – start progressive weight bearing at 3 weeks for labral repair. Be full weight bearing at 4 weeks.
- **For a labral reconstruction, non-weight bearing for 4 weeks – start progressive weight bearing between 4 and 6 weeks. Be full weight bearing at 6 weeks.
- Do not push through the pain or pinching, gentle stretching will gain more ROM
- Gentle PROM only, NO PASSIVE STRETCHING
- Avoid Capsular Mobilizations
- Avoid any isolated contraction of iliopsosas

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Initial Exercises

- AAROM: within range limitation, pain free
- ROM Guidelines (pain free)
- Flexion: 90* x 3 weeks
- Ext: 0* x 3 weeks
- Abd: 25-30* x 3 weeks
- IR: 90* hip flexion: 0* x 3 weeks; neutral (prone): within comfort zone
- ER: 90* hip flexion: 30* x 3 weeks; neutral (prone): 20* x 3 weeks
- ***After 3 weeks, gradually progress ROM as tolerated, within pain free zone
- STM (scar, anterior, lateral, medial and posterior aspects of hip, lumbar paraspinals, quad/hamstring)
- Stationary bike with no resistance
- Isometric (quad setting, gluteal setting, TA isometrics with diaphragmatic breathing)
- Prone lying - AVOID in instability patient**s**

Phase 2: Weeks 3-8

Intermediate Rehabilitation

Criteria for Progression to Phase 2

- FULL WEIGHT BEARING MUST BE ACHIEVED PRIOR TO PROGRESSING TO PHASE 2
- Non weight bearing exercise progression may be allowed if patient is not progressed by MD to full weight bearing (Please see last page for microfracture modifications)

Goals

- Protection of repaired tissue
- Restore full hip ROM- (ROM must come before strengthening)

Goals

- Progressive strengthening of Hip, Pelvis and LE's
- Emphasize gluteus medius strengthening (non weight bearing)

Precautions

- No forced (aggressive) stretching for any muscles
- No joint/capsular mobilization- to avoid stress on repaired tissue
- Avoid inflammation of hip flexor, adductor, abductor and piriformis

Intermediate Exercises

- Gentle strengthening; ROM must come before strengthening
- Stationary bike no resistance, add resistance at 5-6 weeks
- Hooklying progression: pelvic clock, TA w bent knee small range ER, marching, add isometric w kegel ball, isometric abduction with ring
- Prone progression: IR/ER AROM, prone on elbows with glute setting-press ups, hip extension, alternating arm/leg raise
- Sidelying progression: clams 30* hip flexion to 60* hip flexion, hip abduction straight leg raise, side plank on elbow
- Bridge progression
- Pelvic floor strengthening
- Elliptical/stair stepper: 6-8 weeks
- Step and squat progression
- Slide board: hip abduction/adduction, extension, IR/ER. NO forced abductions. Stop short of pain barriers
- Continue to avoid any isolated contraction of iliopsoas

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Phase 3: Weeks 9-12

Advanced Rehabilitation

Criteria for Progression to Phase 3

- Full ROM
- Pain free normal gait pattern
- Hip flexor strength of 4/5
- Hip abd, add, ext and IR/ER strength of 4+/5

Goals

- Full restoration of muscular strength and endurance
- Full restoration of patient's cardiovascular endurance
- **Emphasize gluteus medius strengthening in weight bearing**

Precautions

- No contact activities
- No forced (aggressive) stretching
- No joint mobilizations- to avoid stress on repaired tissue

Exercises

- No treadmill walking until 12weeks
- 4 pt lumbar/core stabilization progression
- Anterior/side plank progression
- Crab/monster walk
- Lunges all directions
- Single leg squat
- **Continue progression of exercises in Phase II**

Phase 4: >12 Weeks

Sport Specific Training

Criteria for Progression to Sport Specific Training

- Hip flexor strength 4+/5
- Hip add, abd, ext, IR/ER 5/5
- Cardiovascular endurance to pre-injury level
- Demonstrates proper squat form and pelvic stability with initial agility drills, stable single leg squats
- Return to sport activities as tolerated without pain, consistent with MD orders

Exercises

- Customize strengthening and flexibility program based on patient's sport and or work activities
- Z cuts, W cuts and Cariocas
- Agility drills
- Jogging
- Gradual return to sport

Modifications for Specific Procedures

- See operative report for specifics and consider he following therapeutic techniques
- **Iliopsoas Release**
  - Begin gentle stretch beginning with prone lying (phase 1)
  - Gentle active release of iliopsoas (phase 2)
- **Microfracture**
  - 20lbs FWB with crutches x 8 weeks
  - Can progress from Phase 1 to non weight bearing strengthening portions of Phase 2
  - Begin full weight bearing at 8 weeks

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Capsular Plication for Hip Laxity

- Avoid combined Extension and ER for 6 weeks
- Focus rehab on gradual strength progression
- No joint mobilization for 6 weeks
- Gradually progress AAROM under patient's control within comfort

Piriformis Release

- POD #1 begin stretch piriformis (flexion, adductions and ER) without causing anterior hip pain and sciatic nerve flossing (Phase 1)
- Gentle active release of piriformis (Phase 2)