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ORTHOPAEDIC & SPINE  
CENTER OF THE ROCKIES

SPECIALISTS IN THE  
MEDICINE OF *motion*



## Joshua Snyder, MD

Hip Arthroscopy  
& Sports Medicine Surgery

Please take a moment to look over the following instructions regarding your surgery. We know that surgery can be a very stressful experience for you and your family and that you may be nervous. This is normal, and we will make every effort possible to make your experience the best it can be! We are dedicated to achieving the best possible outcome for you. This takes a team effort between you, us, and many other healthcare professionals.

The following packet will hopefully be informative and decrease your stress prior to surgery! There are many other great resources about your condition, hip arthroscopy, and sports medicine surgery. We encourage you to learn more about Dr. Snyder, your condition, and access links to helpful websites and videos at [www.OrthoHealth.com](http://www.OrthoHealth.com).

We strive for nothing less than excellence in our quest to help you be the best version of you. We look forward to seeing you on the day of surgery!





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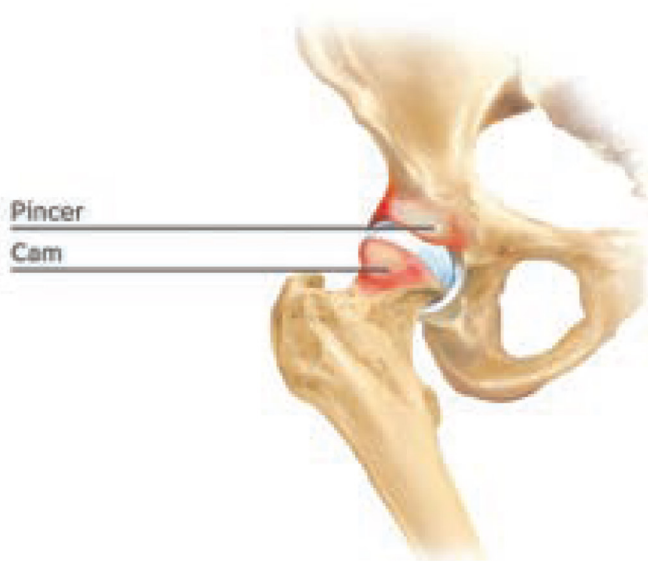
## FEMOROACETABULAR IMPINGEMENT (FAI) / LABRAL TEAR

A common source of hip pain is due to variability of the anatomic bony shape of the hip socket (acetabulum) and the ball on top of the femur (thigh) bone. Due to this variability there is less room for the hip joint to move and causes the two bones to rub together during certain hip motion, especially flexion and rotation of the hip.

Femoroacetabular impingement (FAI) typically falls into two categories. Pincer impingement is when the socket is too deep with an over covered femoral head or ball. Cam impingement is when the femoral head (ball) is not perfectly round or spherical. Most of the time FAI is mixed with some x-ray evidence of both Cam and pincer impingement.

During hip motion involving sports or even with daily activities FAI can cause damage to the cartilage in the joint. The hip joint has articular cartilage that lines the inside of the acetabulum and covers the top of the femoral head. There is also cartilage attached to the edge of the acetabulum called the labrum that acts like a gasket or a seal for the hip socket. Labrum tears are often seen with femoroacetabular impingement, FAI. Pain is usually felt in the front of the hip with flexing the hip during activity and often when sitting, driving or getting out of a seated position. Popping sensations may be felt and can sometimes refer pain to the back as well. Non-operative treatment such as physical therapy, activity modification, use of NSAIDs and sometimes injections will normally be utilized first for treatment. This type of treatment can improve the pain associated with FAI and labral tears but may not allow the labrum to heal fully due to the structural abnormality of the bone.

When conservative treatment does not alleviate the pain from labrum tears, hip impingement surgery is often indicated. The labrum can be repaired and the impingement or shape abnormality can be corrected arthroscopically through a small camera on a telescope. This is recommended when pain is not controlled with physical therapy and activity modification. Repair is usually an outpatient procedure under spinal anesthesia (cont.)



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or sometimes general anesthesia. During surgery the impingement lesions or bony shape problems on the acetabulum and femur are shaved to restore normal anatomy and the labrum is then sutured back down to the socket using small anchors drilled into the prepared bone.

These anchors will hold down the labrum so that it can heal. These anchors will stay in the hip forever. Occasionally the labrum is too damaged to repair, therefore a new labrum is reconstructed using a cadaver graft. Rarely the labrum and cartilage is too damaged to fix and the torn tissue is removed to alleviate pain but this is not as durable as fixing the cartilage. Removal is only done as a last option. Patients that have their labrum removed still normally experience excellent pain control but the damage will progress and other surgeries, such as a hip replacement may be necessary in the future.

Recovery after surgery typically takes 4-6 months. Immediately following surgery a brace will be applied to your hip to help protect the repair. You will also need crutches or a walker starting the day of surgery. The brace is typically on for 2 weeks and the crutches are used for 2-6 weeks. Lower body exercises are prohibited except when done with a physical therapist. Ice machines that decrease swelling and compress the operative hip are offered and utilized with some patients. A knee motion device is necessary to move

the hip and decrease stiffness. The motion device is usually discontinued once physical therapy has begun. During the first 3 months I recommend avoiding most lower body activities especially pivoting and twisting on the hip, repetitive flexion of the hip joint and lifting more than 20 pounds. I do allow

patients over the first 3 months to walk up to a mile, ride a stationary bike without resistance and swim without kicking. At approximately 3 months an elliptical may be used, patients can also increase how long they can walk, swim with kicking the legs and ride a bike with resistance. At 4 months, more impact activities are begun such as jogging, deeper hip flexion and pivoting or twisting. Recovery is mostly seen

within 4-6 months back to full activity but some will be delayed up to 8-12 months. The success rate for surgery is 90-95% with most people getting a full recovery and returning to full activity.

Complications are rare with the most common risks resolving shortly after surgery. A list of complications of surgery will also be provided. Driving after surgery is allowed when narcotic pain medications are not needed.

Driving is allowed in right hips once crutch use is discontinued. Sedentary or office work is acceptable usually within a week as long as pain is tolerable and frequent breaks are recommended. More physical jobs require up to 4-6 months of time off or work restrictions.



Top: Hip brace  
Bottom: Continuous passive motion device (CPM)



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## Expectations After Surgery is Scheduled.

### Shortly Before Surgery:

- Revisit with Dr. Snyder or his Medical Assistant, Carrie Crawford, to discuss surgery, sign consent for surgery, and obtain prescriptions for after surgery.
- Be fitted for hip abduction brace.
- Receive information and rental of a Continuous Passive Motion device (CPM) to decrease stiffness in the hip postoperatively as well as rental of crutches or walker and an ice machine.
- Discuss with brace company use of Gameready ice machine that circulates cold water around the hip and compresses the hip area.
- Usually, the day before surgery you will receive a call from the office or surgery center on when to arrive for surgery.

### Day of Surgery:

- Nothing to eat or drink past midnight (or pre-determined time)
- Meet with anesthesiologist and discuss types of anesthesia, spinal anesthesia along with sedation is usually recommended.
- Surgery performed.
- Crutches are not needed at the surgery center, but will be needed when you get home.

### 0-6 Weeks Post-Op:

- Post-op instructions and restrictions will be given at time of surgery.
- First post-op visit at approximately 2 weeks to remove sutures, discuss findings and to obtain physical therapy script.
- Physical therapy begins around 2 weeks.
- Recheck at 6 weeks in clinic.

## After Crutches have been Discontinued, Restrictions Include:

- No walking greater than one mile at a time and should not walk through pain.
- You may ride a stationary bike for 15 minutes 2x a day with no resistance. It is also recommended to keep the seat slightly higher.
- Pool therapy is allowed but no swimming and kicking the legs as this may cause hip flexor tendonitis. Keep incisions covered when submerged in water if scabs are not healed.
- No running, jumping, squatting or lifting greater than 20 pounds from the floor up.
- Upper body exercises are allowed.

**6-12 weeks Post-Op:** Continue with Physical Therapy and above restrictions; additional exercises will be added per physical therapy protocol. Some patients will notice increased pain around this time and additional exercises will be demonstrated at the 6 week visit to treat this pain.

**12 weeks Post-Op:** At the 3 month, visit progress will be evaluated and some activities may be restarted including elliptical and biking with resistance.

Typical retrun to activity as tolerated is 4-6 months.

## Frequently Asked Questions:

### When can I drive?

If you had right sided surgery you cannot drive until you are off the crutches and off narcotics. For left sided surgery, you may drive once you have discontinued the use of narcotic pain medications as long as your car has an automatic transmission & you feel safe driving.

### Can I go up and down stairs?

Yes, some patients with lots of stairs in their house



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(cont.) should setup space on the main level until off crutches. If this is not possible use a railing and one crutch to assist with stairs or you may also go up and down the stairs in a seated position.

### **When to wear the brace and how long do I need it?**

The brace goes on while in the operating room and is easiest to be worn over clothes. You can take the brace off for showers, to use the ice machine and the CPM/motion device. It must be worn when you sleep but some patients are more comfortable sleeping with the brace off while in the continuous passive motion device (it does not need to be on). You may also take off the brace if you are awake, in a seated position and are careful not to flex your hip past 90 degrees or move your leg outwards. It is OK to be out of the brace a couple times a day for 15 minutes when seated.

### **When can I go back to work?**

Return to work depends on the type of work you do. Sedentary desk jobs may return when the pain is tolerable and after stopping pain medications. Typically this is about 2 weeks. More frequent breaks and time to stretch out the hip is necessary throughout the day and most patients will start a half day for a few days and then proceed to full days after a week.

More physical jobs require job restrictions to return to work earlier. These consist of no running, jumping, squatting or lifting more than 20 pounds. You also should avoid ladders and climbing. If these restrictions are feasible, return to work in about 2 weeks or once the crutches have been discontinued is appropriate. If having restrictions is not feasible, returning to full duty may take up to 4-6 months.

### **How long do I need to use crutches?**

Crutch use is determined by the amount of injury found during

surgery. Normally, crutches are used from 2-6 weeks. The usual weight bearing amount with the crutches is toe touch weight bearing which means the toes can be placed on the ground for balance but you cannot place full weight on the foot or weight on the heel.

### **When do I start the CPM/ motion device?**

This should be started the day after surgery. You can remove the brace to use the CPM. Approximately 4 hours of CPM use throughout the day is recommended. Spread the use throughout the day as you feel appropriate, 30 minute sessions are usually easiest. Once physical therapy is started, the CPM is no longer needed.

### **Can I lie on my belly?**

“Tummy time” is actually recommended to decrease the risk of hip flexor tendonitis. Lying on your belly for 15 minutes a few times of day is beneficial. For stomach sleepers, I recommend having your feet hanging off the end of the bed.

### **When can I shower after surgery?**

Showering is ok the day after surgery. The initial bandage is waterproof and you may remove the brace to shower. It is recommended to place a shower stool in the shower. The incisions should not get wet until the sutures are removed therefore place waterproof bandages over the incisions when you shower. These may be removed after the shower and less adhesive/sticky bandages reapplied to decrease skin irritation.

### **Do I need an elevated commode?**

Taller patients will sometimes need an elevated commode during the first 2 weeks when the brace is on as the brace may make it difficult to sit. Most patients are ok without the elevated commode and simply lean back on the toilet instead. Once the brace is off, sitting on the toilet is easier.