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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.

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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HIP ARTHROSCOPY LABRAL REPAIR/RECONSTRUCTION

Physical Therapy Protocol:

The intent of this protocol is to provide guidelines for therapy progression. It is not intended to serve as a recipe for treatment. We request that the PT/PTA/ATC use appropriate clinical decision making skills when progressing a patient. The exercises listed are not all inclusive, you can modify exercises as long as you maintain the appropriate precautions. Please obtain documentation of the exact procedure that was performed from the office if it is not already provided.

Keep in mind common problems that may arise following hip arthroscopy: Hip flexor tendonitis, adductor tendonitis, sciatica/piriformis syndrome, ilial upslips and rotations, low back pain from QL, hyper tonicity and segmental vertebral rotational lesions. If you encounter any of these problems, please evaluate, assess and treat as you see fit, maintaining precautions and guidelines at all times. Gradual progression is essential to avoid flare-ups. If a flare up occurs, back off with therapeutic exercises until it subsides

Please reference the exercise progression sheet and timelines and use the following precautions during your treatments. Please contact Dr. Snyder at any time with questions or with any input that may improve the therapy protocol.

General Guidelines / Precautions

Immediately After Surgery:

- Weight bearing: Flat foot weight bearing for 2-6 weeks, use 2 crutches (length will be documented on PT script)
- ROM: NO Active or passive hip flexion past 90°, external rotation, extension passed 0°, abduction to 45°
- Do not push through pain or pinching, gentle stretching will gain more ROM
- Use CPM (continuous passive motion device) 4 hours per day flexion to 70 degrees (use until PT is started)
- Manage scarring around portal sites once incisions are healed
- Avoid capsular mobilizations
- Avoid isolated contraction of the iliopsoas

Phase 1: Protection Phase

(post-op weeks 0-4 with microfracture weeks 0-6)

Goals:

- Reduce swelling and pain.
- Protect repaired tissue.
- Restore mobility within limitations.
- Prevent muscular inhibition and gait abnormalities, promote proprioception.

Weeks 0-4

- CPM 4 hours/day (until PT has started); remove brace while in CPM. Alternatively use upright bike no resistance for 20 minutes up to one hour/day.
- Ice 4-6 times per day for 20-30 minutes with ice packs over a towel or with game ready device. Ice in the prone position to begin gentle hip flexor stretching.

ROM Restrictions and Exercises

- NO active or passive external rotation.
- PROM: Hip flexion to 90° and extension to 0° x 4 weeks then increase gradually.
- AAROM / AROM 2x daily for 10 minutes.
 - Circumduction with hip flexed less than 30° 3 minutes each direction.
 - Abduction to 30°.
 - Internal rotation log rolls.
 - Circumduction at 70° by PT only.
- Up right bicycle: No resistance and must be pain free. Start with ½ circles and progress to full rotations.
- Initiate Thomas stretch at week 3 start with extension to 0° and increase gradually after 4 weeks.

- Gentle soft tissue mobilization of scar and hip flexor.
- Week 4 PWB posterior capsular stretches.
- Aquatic therapy to begin when sutures are out and scabs are gone.
 - Circumduction, skaters and 1/3 squats.
 - Week 4 Forward and backward gait with full hip extension and upright trunk .

Strength

- Hip isometrics
 - (Begin at 2 weeks): extension and adduction.
 - (Begin at 4 weeks): hip flexion.
- Quad sets, Gluteus sets, hamstring sets and lower abdominal/ transverse abdominus activation with diaphragmatic breathing.
- Standing skaters (abduction internal rotation).
- Hamstring curls with swiss ball avoid adductor compensation week 3.
- Modalities for pain control and swelling.
- Proprioception and neuromuscular re-education:
 - Prone IR/ER stabilization (Modify if having low back pain, Avoid in instability patients).
 - Quadruped lumbopelvic stabilization.
 - ½ kneeling prior to full weight bearing (after 4 weeks or 6 weeks with microfracture).
 - Standing forward flexion.
- Wean from crutches 2 or 6 weeks depending on if microfracture was done.
 - Begin with tall kneeling and standing weight shifting exercises.
 - Joint mobilization very gently:
 - Week 3 oscillations, caudal glide with passive hip flexion begin .
 - Week 4 post/inferior glides to decrease posterior tightness .
 - Address pelvic and lumbar alignment.

Phase II: Begin Strengthening:

(post-op weeks 6-10 or post-op weeks 8-12 with microfracture)

Criteria for advancement to Phase II

- Full weight bearing and normal gait.
- Pain free PROM 80% compared to contralateral limb.
- Maintain tall kneeling position without anterior hip pain.
- Do not progress with trendelenberg gait, unequal hip extension at terminal stance or if cannot actively advance the leg during swing phase pain free.

Precautions:

- No forced stretching.
- Gentle joint capsular mobilizations .
- Avoid inflammation of hip flexors, abd/adductors and piriformis.

Goals:

- Full active and passive ROM.
- Rotary stability including side and front planks without compensation or pain.
- Restore normal gait pattern.
- Increase leg strength .
 - Single knee bend 70° without compensations.

Strength, Proprioception, and Neuromuscular

Re-Education:

- Closed chain single and double leg strength and stability (reverse lunge with glider).
- 1 mile walk.
- Ascending/descending stairs
- Single leg bridge.

- Hooklying progression: pelvic clock all planes, TA w/ bent knee small range ER, marching add isometric w/ ketel ball and isometric abduction w/ ring.
- Prone progression: IR/ER AROM, prone on elbows with gluteus setting press-ups, hip extension alternating arm leg raise.
- Side lying progression: clams 30° hip flexion to 60° hip flexion, hip abduction straight leg raise, side plank on elbow.
- Slide board progression: hip abduction/adduction, extension, IR/ER. (no forced abduction).
- Double knee bends without compensation.
- Bike gradually; start resistance at Week 12 gradually increase resistance.
- Elliptical trainer week 10-12 for 20 minutes only to ensure no increased hip pain.
- Swimming without leg kick Week 8 and with kicking week 12 (flutter/breaststroke kick).
- NO aquatic PT in resistance current until week 16.

Phase III: Advanced Strengthening:

(weeks 10-12)

Criteria for advancement to Phase III:

- Full active and passive ROM.
- Ascending/descending stairs with involved leg without pain or compensation.
- Gait without deviations or pain after 1 mile .
- 1 minute double knee bends without compensations.
- Single leg knee bends to 70° without compensation.
- Rotary stability and agility to hold plank.

Goals:

- Restore multi-directional stability and agility.
- Restore ability to absorb impact (plyometric strength).
- Full active hip extension.
- Emphasize gluteus medius strengthening in weight bearing.

Precautions:

- No contact activities.
- No forced aggressive stretching.

Proprioception/ Agility:

- Progress single leg strengthening including bosu proprioceptive training and added time to single leg bends.
- Reinforce posterior chain strength and endurance.
- Initiate light agility including lateral agility.
- Anterior/ side plank progression.
- Crab/ Monster walk.
- Lunges all directions.
- No running or kicking until 16 weeks and able to demonstrate pain free standing and repetitive hip flexion.

Phase IV: Return to Sport:

>12 weeks

Criteria for advancement to Phase IV:

- Hip flexor strength 4+/5.
- Hip abd/adduction IR/ER 5-/5.
- Demonstrates proper squat form and pelvic stability with initial agility drills.
- Bilateral stable 1 minute single leg stance with alternate hip flexion/extension.
- Single leg stance for 3 minutes.

Exercises:

- Customized strengthening and flexibility program based on sport or work activities.
- Z cuts, W cuts cariocas.
- Agility drills .
- Jogging.
- Gradual return to sport.
- Perform sports specific strength training and drills until patient begins team training.
- Closed chain pilates is recommended for hip maintenance and late gluteus strength.

Other Considerations:

Iliopsoas Release:

- Gentle psoas stretch beginning with prone lying in Phase I.
- Gentle active release (AROM and manual stretch) of psoas in Phase II.

Piriformis Release:

- Begin stretch piriformis (flexion abduction ER) without causing anterior hip pain and sciatic nerve flossing in Phase I.
- Gentle active release of the piriformis in Phase II.