



Hip Arthroscopy with Labral Repair, Femoroplasty, Chondroplasty, Acetabuloplasty

Post-operative protocol

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Phase I – Maximum protection

Weeks 0 to 3

- 50% weight bearing for 3 weeks
- CPM 4 to 6 hours per day or as tolerated
- Lie on stomach 2 or more hours per day
- Abduction brace: 0° to 90° for 3 weeks

Range of motion restrictions for 3 weeks

- Flexion 0° to 90° for 2 weeks and progressing to 120° by week 3
- Extension 0°
- External rotation 0°
- Internal rotation - work for full range at 0° to 90°
- Abduction 0° to 45°

Exercise progression (POD 1 to 7)

- Stationary bike with no resistance: immediately as tolerated
- Glute, quadriceps, hamstring isometrics, abduction, adduction (2x per day): immediately as tolerated
- Hip PROM (2x/day) flexion, abduction, and IR supine at 90° and prone at 0°
- Hip circumduction

Exercise progression (POD 8 to 14)

- Hip IR/ER isometrics (2x/day)
- Initiate basic core: pelvic tilting, TVA and breathing re-education
- Beginning POD 14: quadruped rocking

Exercise progression (POD 15 to 21)

- Standing abduction/adduction - full weight bearing on uninvolved side only

Criteria for progression to Phase 2:

- Mobility within limitations
- Early restoration of neuromuscular control
- Normal patellar mobility



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Phase II – Progressive stretching and early strengthening

Week 3 to 6

- May begin deep water pool walking at 3 weeks if incisions closed, flutter/ dolphin kick at 6 weeks

Goals

- Wean off crutches (over 7 to 10 days)
- Normal gait
- Normal single limb stance
- Full range of motion
- Improve lower extremity muscle activation, strength and endurance

Manual therapy:

- Scar mobilization
- STM to quad, ITB, hip flexors, glutes, hip adductors/abductors/rotators
- Continue work on range of motion (FABER, flexion, abduction, IR, ER)

Exercise progression (as tolerated)

- Bridging double and single
- Supine dead bug series
- Sidelying hip abduction
- Quadruped hip extension series
- Standing open and closed chain multi-plane hip
- Standing internal/external rotation strengthening (use stool)
- Step-up progression
- Squat progression
- Heel raises
- Stationary biking
- Stretching: quadriceps, piriformis and hamstrings

Criteria for progression to Phase 3:

- Hip abduction strength 4/5
- Flexion, ER and IR range of motion within normal limits
- 50% FABER range of motion compared to uninvolved side
- Normal gait
- No Trendelenberg with single leg stance/descending stairs
- Normal bilateral squat

Phase III – Advanced strengthening and endurance training

Week 6 to 12

Please do not discharge patient prior to 3 months without approval from Dr. Mullen or Dr. Schroepfel

Manual therapy

- STM as needed - particularly glutes, adductors, hip flexors, abductors
- Gentle joint mobilizations as needed for patients lacking ER or FABER range of motion
- May begin trigger point dry needling for glutes, quads, adductors
 - No hip flexor tendon until week 8.
- Assess FMA and begin to address movement dysfunctions



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Exercise progression

- Continue with muscle activation series (quadruped or straight leg series)
- Introduce movement series to increase proprioception, balance, and functional flexibility
- Progress core program as appropriate
- Advanced glute and posterior chain strengthening
- Leg press and leg curl
- Squat progression (double to single leg - add load as tolerated)
- Lunge progression
- Step-up progression
- Walking program
- Week 6
 - Outdoor biking
 - Pool running program (at least 75% unloaded)
- Week 8 (if range of motion adequate): swimming – breast stroke kick

Criteria for progression to Phase 4:

- 12 weeks post-op
- Hip abduction and extension strength 5/5
- Single leg squat symmetrical with uninvolved side
- Full range of motion
- No impingement with range of motion

Phase IV – Return to sport program

Week 12 to 20

- May begin elliptical and stair climber at 12 weeks
- May begin return to run program if phase 4 criteria are met

Manual therapy

- STM as needed particularly glutes, adductors, hip flexors, abductors
- Gentle joint mobilizations as needed for patients lacking ER or FABER range of motion
- Trigger point dry needling for glutes, TFL, quads, adductors, iliopsoas, iliacus
 - May continue to benefit patients with tightness or mild range of motion restrictions

Exercise progression

- Maintain muscle activation series, trunk, hip and lower extremity strength and flexibility program
- Introduce and progress plyometric program
- Begin ladder drills and multidirectional movement
- Begin interval running program
- Field/court sports specific drills in controlled environment
- Pass sports test
- Non-contact drills and scrimmaging – must have passed sports test - refer to specific return to sport program
- Return to full activity – per physician and passing PT sport test