Connecticut Orthopaedics

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Hip Arthroscopy-Labral Reconstruction
Post-Operative Protocol

Phase I – Maximum Protection
Weeks 0 to 4:

- Toe-touch weightbearing for 4 weeks
- Lie on stomach 2 or more hours per day

Range of motion restrictions x 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° and 90°
- Abduction 0° to 45°

Exercise progression (POD 1 to 7)

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

Exercise progression (POD 8 to 21)

- Hip IR/ER isometrics (2x/day)
- Initiate basic core: pelvic tilting, TVA and breathing re-education
- Beginning POD 21: quadruped rocking

Exercise progression (POD 21 to 28)

- Standing abduction/adduction - full weightbearing on uninvolved side only

Criteria for progression to Phase 2:

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

Phase II – Progressive Stretching and Early Strengthening
Weeks 4 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
  - Note: If IT Band was used for labral reconstruction, will likely need increased scar and soft tissue work to IT Band and lateral hip.
- 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

Weeks 6 to 12:

Please do not discharge patient prior to 3 months without approval from Dr. Wolf

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

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

Weeks 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, ilioposoas, 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 functional hip test