(PROTOCOL #23) HIP ARTHROSCOPY PROTOCOL

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The following is a set of general guidelines. It is important to remember that each patient is different. The progression of the patient depends on many factors including age and medical health of the patient and physician preferences.

PHASE	FUNCTIONAL PROGRESSION/ACTIVITIES	GOALS/RESTRICTIONS
Post-op to 3 weeks	Gentle hip mobilization and distraction techniques: a. Inferior glide (patient supine, hip & knee at 90°) force on anterosuperior thigh b. Posterior glide (patient supine, hip & knee @ 90°) force applied through knee and/or quadruped rocking Day of surgery begin isometric quadriceps, glut, hamstring, hip adductor and hip abductor muscle strengthening sets Isometric hip flexion, extension, abduction, adduction, internal rotation, and external rotation	Protection of the post-surgical hip through limited weight bearing and education on avoiding pain(approximately 3/10) with range of motion exercises Restore normal hip range of motion Normalize gait Restore leg control Use axillary crutches for normal gait and wean from crutches slowly when gait is normalized and pain free (without pain medications), which normally takes 2 to 3 weeks Avoid active hip flexion past 90° and avoid pushing range of motion to the point of pain in any plane x 4 weeks Avoid exercises that engage the iliopsoas during the first several weeks after surgery. Iliopsoas tendonitis is a known side effect of hip arthroscopy but can be avoided with appropriate post-operative care, including avoiding exercises that have high activity of the iliopsoas (such as straight leg raises, resisted hip flexion, abductor strengthening that incorporates significant co-contraction)

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4 to 6 weeks	Stationary bike Gait and functional movement drills in the pool once portal sites are healed Continue standing hip abduction and extension, single leg bridging, sidelying leg raises with leg in internal rotation and prone heel squeezes with hip extension Quadriceps strengthening Hip Active range of motion using D1 and D2 patterns with proprioceptive neuromuscular facilitation Stretching for patient specific muscle imbalances	Regain and improve muscular strength Progress off crutches for all surfaces and distances Single leg stand control Good control and no pain with functional movements, including step up/down, squat, partial lunge Post-activity soreness should resolve within 24 hours No ballistic or forced stretching Avoid post-activity swelling or muscle weakness Be cautious with repetitive hip flexion activities, such as treadmill and Stairmaster Patients undergoing microfracture continue the microfracture precautions
10 to 12 weeks	Multi-planar strength progression, including forward, lateral and diagonal lunges Impact control exercises beginning 2 feet to 2 feet, progressing from 1 foot to other and then 1 foot to same foot then progress from single plane drills to multi-plane drills Progress to running program once patient is able to demonstrate good single leg landing control in a repetitive fashion without pain Hip and core strengthening Stretching for patient specific muscle imbalances	Improve muscular strength and endurance Good control and no pain with sport and work specific movements, including impact activities Post-activity soreness shoulder resolve within 24 hours No ballistic or forced stretching Avoid post-activity swelling or muscle weakness Be cautious with repetitive hip flexion activities, such as treadmill and Stairmaster Patients undergoing microfracture continue the microfracture precautions

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		Normal gait on all surfaces Dynamic neuromuscular control with multi-plane activities, without pain or swelling

Approved By: Physician reserves the right to adjust these protocols for each patient.

Signature: _____ Date: _____
Robert Doane, M.D., P.C.

Signature: _____ Date: _____
Balu Pisupati, PT