

BENJAMIN G. DOMB, M.D.

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Hip Open Surgical Dislocation Surgery Physical Therapy Protocol

The intent of this protocol is to provide guidelines for your patient's therapy progression. It is not intended to serve as a recipe for treatment. We request that the PT/ PTA/ ATC should use appropriate clinical decision making skills when progressing a patient forward.

Please email BenjaminDombMD@hoasc.com to obtain the operative report from our office prior to the first post-op visit. Also please contact Dr. Domb if there are any questions about the protocol or your patient's condition.

Please keep in mind common problems that may arise following hip arthroscopy: hip flexor tendonitis, adductor tendonitis, sciatica/piriformis syndrome, ilial upslips and rotations, LB pain from QL hypertonicity and segmental vertebral rotational lesions. If you encounter any of these problems please evaluate, assess, and treat as you feel appropriate, maintaining Dr. Domb's 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 for timelines and use the following precautions during your treatments. Thank you for progressing all patients appropriately and please email all progress notes to Dr. Domb at BenjaminDombMD@hoasc.com, or hand deliver with the patient themselves. **Successful treatment requires a team approach, and the PT/PTA/ATC is a critical part of the team! Please contact Dr. Domb at any time with your input on how to improve the therapy protocol.**

Please Use Appropriate Clinical Judgment During All Exercise Progressions

Initial Pre-op Assessment

Assess bilateral hips
ROM – flexion, extension, IR, ER, abd, add
Gait – look for Trendelenburg gait
Impingement test – flexion/adduction/IR often reproduces pain
Ober test
Strength – abduction, flexion, extension

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Phase 1- Immediate Rehabilitation (0-6 weeks): Begin therapy POD #1

Goals:

Protection of the repaired tissue
PROM within guidelines
Prevent muscular inhibition and gait abnormalities
Diminish pain and inflammation

Precautions:

20 lb. heel-touch weight-bearing post-op, duration per Dr. Domb's orders depending on procedure
Do not push through pain or pinching, gentle stretching will gain more ROM

Initial Exercises

PROM: within range limitations, pain free.

ROM Guidelines (pain free)

Flexion: 70° x 6 weeks

Ext: 0° x 6 weeks

Abd: NO ACTIVE ABDUCTION

IR: 70 deg. hip flexion: 0 deg x 6 weeks; neutral (prone): within comfort zone

ER: 70 deg. hip flexion: 30 deg x 6 weeks; neutral (prone): 20 deg x 6 weeks

After 6 weeks, gradually progress ROM as tolerated, **within pain-free zone*

- STM (scar, anterior, lateral, medial and posterior aspects of hip, lumbar paraspinals, quad/hamstring)
- Stationary bike with no resistance
- Isometric (quad setting, gluteal setting, TA isometrics with diaphragmatic breathing)
- Prone lying (modify if having low back pain)
- Avoid any active contraction of iliopsoas**

Phase 2 – Intermediate Rehabilitation (7-12 weeks)

Criteria for progression to phase 2

Non weight bearing exercise progression may be allowed if patient is not progressed by MD to full weight bearing

Goals:

Protection of the repaired tissue
Restore Full Hip ROM – (ROM must come before strengthening)
Restore Normal Gait Pattern
Progressive Strengthening of Hip, Pelvis, and LE's
Emphasize gluteus medius strengthening (non-weight bearing)

Precautions:

No forced (aggressive) stretching of any muscles
No active abduction
Avoid inflammation of hip flexor, adductor, abductor, or piriformis

Intermediate Exercises

Gentle strengthening; ROM must come before strengthening

- Stationary bike no resistance, add resistance at 10-12 weeks
- Hooklying progression: pelvic clock, TA w bent knee small range ER, marching, add isometric w kegel ball, isometric abduction with ring.
- Prone progression: IR/ER AROM, prone on elbows with glut setting-press ups, hip extension, alternating arm/leg raise.

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-Sidelying progression: clams 30 deg hip flexion to 60 deg hip flexion, hip abduction straight leg raise, side plank on elbow.

-Joint mobilization: **ONLY VERY GENTLY**

(week 3): oscillations, caudal glide with passive hip flexion

(week 4) : post/inf glides to decrease posterior tightness

Address pelvic and lumbar alignment

-1/2 kneel: gentle pelvic tilt for gentle stretch of iliopsoas

-Bridge progression

-Balance progression: double leg to single leg balance

-Pelvic floor strengthening

-Elliptical / stair stepper: 6-8 weeks

-Step and squat progression

-Slide board: hip abduction / adduction, extension, IR/ER. No forced abduction. Stop short of any painful barriers.

-Continue to avoid any active contraction of iliopsoas

Phase 3 – Advanced Rehabilitation (13-16 weeks)

Criteria for progression to Phase 3:

Full ROM

Pain free Normal gait pattern

Hip flexor strength of 4/5

Hip abd, add, ext, and IR/ER strength of 4+/5

Goals:

Full Restoration of muscular strength and endurance

Full Restoration of patient's cardiovascular endurance

Emphasize gluteus medius strengthening in weight bearing

Precautions:

No contact activities

No forced (aggressive) stretching

Exercises:

-No treadmill walking until 16 weeks

-4-pt lumbar / core stabilization progression

-Anterior / side plank progression

-Crab / monster walk

-Lunges all directions

-Single leg squat

-Continue progressions of exercises in phase II.

Phase 4 – Sport Specific Training > 16-18 weeks

Criteria for progression to Sport Specific Training:

Hip flexor strength 4+/5

Hip add, abd, ext, IR/ER 5-/5

Cardiovascular endurance equal to pre-injury level

Demonstrates proper squat form and pelvic stability with initial agility drills, stable single-leg squat.

Return to sport activities as tolerated without pain, consistent with MD orders.

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Exercises:

- Develop customized strengthening and flexibility program based on Patient's sport and/or work activities
- Z cuts, W cuts, Cariocas
- Agility drills
- Jogging
- Gradual return to sport

Surgical release of Iliopsoas or piriformis may have been performed. See operative report and consider the following therapeutic techniques.

-Piriformis Release:

- POD #1 begin stretch piriformis (flexion, adduction, ER) without causing anterior hip pain and sciatic nerve flossing (Phase 1)**
- Gentle active release of piriformis (Phase 2)

-Iliopsoas Release:

- Begin gentle stretch beginning with prone lying (Phase 1).
- Gentle active release of iliopsoas (Phase 2)

-Microfracture:

- 20 lbs FFWB with crutches x 8 weeks
- Can progress from Phase 1 to non-weight bearing strengthening portions of Phase 2, then begin full weight bearing at 8 weeks

Recommended sitting position when having to sit for longer durations.
(Right leg in picture is surgical leg)



Examples of Strengthening

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Heel Squeeze

Sitting in a chair with good posture and feet well supported, turn your heels in towards one another so that they are touching (toes/knees apart) and gently squeeze together. Hold 10 seconds. Come back to the center so that toes are pointing straight ahead and relax 10 seconds. Add theraband to progress.

Toe Squeeze

Sitting in a chair with good posture and feet well supported, turn your toes and knees in towards one another so that they are touching (heels apart) and gently squeeze toes together. Hold 10 seconds. Come back to the center (so that toes are pointing straight ahead) and relax 10 seconds. Progress using ball between knees.



-Bridge. Gently squeeze your buttocks as you raise your hips off the ground, knees bent and feet shoulder width apart.

-Bridge (knees together and feet apart)
-Bridge (knees apart and feet together)

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Slideboard Exercises (Small range
avoiding hip discomfort)
-Abduction / Adduction
-Extension
-Internal/External Rotation
-Twist