EOC

EVANGELISTA ORTHOPEDIC CLINIC

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HIP ARTHROSCOPY WITH LABRAL REPAIR
OUTPATIENT DISCHARGE INSTRUCTIONS
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This protocol is to provide guidelines for your patient's therapy progression. Your PT/ PTA/ ATC should use appropriate clinical decision making skills when progressing forward. Please keep in mind common problems that may arise following hip arthroscopy: for example, tendonitis, hypertonicity and vertebral rotational issues. If your therapist encounters any of these problems please have them evaluate, assess, and treat as they feel appropriate, maintaining the 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.

1. **Week #1**:

    a. Passive range of motion
        i. Flexion to 90 degrees only x 4 weeks
        ii. Abduction as tolerated
        iii. Internal and external rotation log rolling as tolerated
    b. Pillow/Towel adductor squeezes
    c. Quadriceps/hamstring sets
    d. Belt abduction isometrics
    e. Pelvic tilts
    f. Ankle dorsi flexion/plantar flexion isometrics against crutch
    g. Toe-touch weight-bearing with crutches

2. **Week #2-3**:

    a. Passive range of motion to active assisted range of motion
    b. Bike with no hip flexion beyond 90 degrees
    c. Pain free prone lying. Not up on elbows
        i. Progress to prone knee flexion AAROM week 3
        ii. No pain and no end range stretching. ROM only
    d. Prone hip internal rotation passive range of motion with knee at 90 degrees
    e. Standing hip active range of motion as supine motion improves
    f. Seated knee extension AROM
    g. Crunches
    h. Ankle strengthening in all planes against Theraband

3. **Week #4-5**:

a. Full active range of motion while supine
b. Prone IR/ER active assistive range of motion as tolerated
    i. Do not push into pain
c. Isometric leg press to standard leg press as able
d. Bridging with 2" of core work
e. Standing hip Theraband strengthening:
    i. Adduction
    ii. Extension
    iii. Flexion as able
f. Seated knee extension and hamstrings curls on machine or with Theraband
g. Toe raises
h. Weight shifts
i. Weight-bearing:
    i. At 4 weeks from surgery begin bearing more weight while continuing to use gait aide (crutches, walker etc.)
    ii. Start with 25-40 pounds and progress over next two weeks
    iii. Goal is pain-free, non-antalgic gait by 6 weeks post-op (goal will be WBAT at 6 weeks)
j. Pool:
    i. Wounds must be completely healed. No scab
    ii. Depending on weight-bearing status, work on walking in chest deep water
    iii. Active range of motion of hip in all planes as tolerated

4. **Week #6-7**:

a. Gentle end range stretching
    i. Begin with 10 second holds and advance to 30 second holds as comfort allows. Do not stretch into pain
        1. Standing adductor stretch
        2. Prone knee flexion with end range stretch
        3. Prayer stretch
        4. Hamstrings stretch
        5. V-sit
        6. Supine iliotibial band
b. Single leg balance
c. Step ups
d. Mini squats
e. Standing hip abduction against Theraband if abduction isometrics are improving
f. Core training:
    i. Multifidus hip lift
    ii. Prone plank on knees and elbow
    iii. Side plank on knees and elbow
    iv. Bridge with knee extension
    v. Tall kneeling cable lift/chop

5. <u>Week #8-11</u>:

a. Continue with previous exercises that are still challenging
b. Patient should ambulate without gait aides. If not, address hip/core stability or mobility issues
c. "Y" balance exercise
d. 1⁄2 kneeling hip flexor stretch
   Quadriceps stretch
e. Core training:
   i. Assisted lunges with tubing advance to body weight as able
      1. Once patient demonstrates proper form and volume tolerance, add weight to exercise
   ii. Step pelvic drops
   iii. Back bridge advancing to single arm dumbbell fly while doing BB
   iv. Quadruped bird dog
   v. Ipsilateral split stance cable rows
   vi. Elliptical trainer, Stairmaster, or bike
      1. Build up to 30 minutes at low to moderate intensity

6. <u>Week #12-24</u>:

a. "Y" balance test is performed to help assess patient's functional return status
b. Address any problems in mobility found in hip and lower extremities
   i. These will need to be changed prior to athletes advancing into sports specific training
c. Multi-planar stretching:
   i. Pretzel
   ii. 1⁄2 kneeling hip flexor with trunk rotation or side bending
d. Core training:
   i. Lunges with weight
   ii. Hockey side lunge body weight advancing to weight as able
   iii. Dead lift
      1. Non-athlete = suitcase dead lift
      2. Athlete = traditional dead lift
   iv. Squats:
      1. Hips do not drop below knees
      2. Incorporate frontal plane stress into exercise
   v. Single leg dead lift
      1. Address any side to side differences
   vi. Physio ball walk out advancing to over and under as able
e. Agility:
   i. Athletes:
      1. Low level agility drills including ladder
      2. Promote foot quickness and movement skills rather than vertical motion
f. Energy system training:
   i. Athletes should begin performing 4 minute aerobic intervals to help improve VO2 max
   ii. Training should continue to be non-impact

7. **Week #24**:

    a. "Y" balance test.
    b. Functional movement screen.
        i. Address any movement faults found.
    c. Core training:
        i. Core training should involve multiple planes when able.
        ii. Core training should address stability in all three planes of motion.
        iii. Core training should address sports specific concerns.
    d. Energy system training:
        i. Anaerobic intervals with appropriate work to rest ratios.
        ii. Continue with aerobic intervals.
        iii. Begin to add in impact loading.
            1. Treadmill running vs. land.

Adapted from published Mayo Labral Repair post-op pro