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ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

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Arthroscopic Gluteus Medius Repair Physical Therapy Protocol

Please use appropriate clinical judgment during all exercise progressions. The specific exercises given in this protocol are provided for guidance, but it is important to use clinical judgment when determining appropriate progressions withing the physician provided WBing and ROM restrictions. Any questions/concerns, please do not hesitate to contact the office at (920)430-8113.

Operative Diagnosis: Please ALWAYS refer to the operative note for a comprehensive description of the procedure performed. There is a separate protocol for:

- Labral repair with capsular repair/closure
- Labral repair with capsular plication
- Labral repair with capsulotomy
- Iliopsoas lengthening
- Gluteus medius/minimus repair: If the patient also had a gluteus medius and/or minimus repair, disregard the labral repair protocol and follow the gluteus medius protocol, as it is more restrictive.

Weightbearing: The patient will begin FFWB as directed below post-op through week 5. At 6 weeks post-op, patient will begin PWB progressing to ~50% bodyweight by week's end with bilateral crutches or walker. After week 6, patient may progress to WBAT with continued use of AD (bilateral crutches or walker). PT may progress to unilateral crutch/cane at week 7 if pain levels are low and there is minimal to no gait deviation.

- Please Note: FFWB should be done to avoid anterior hip irritation caused by holding the hip in flexion. The patient should be instructed to set his/her foot on the floor without putting weight on it. The PT referral will state if weight bearing restrictions vary from this.

PHASE I, Immediate Rehabilitation (Weeks 1-4)

Begin therapy post-operative day #1-7

Goals:

- Protection of repaired tissue
- Restore ROM within guidelines
- Prevent muscular inhibition and gait abnormalities
- Diminish pain and inflammation
- Teach caregiver to perform circumduction 1x/day as appropriate

Precautions:

- Do NOT aggressively push through pain/pinching
- Progress cautiously with signs of hip flexor tendonitis, trochanteric bursitis, and synovitis

PROM Restrictions:

- Flexion: Gradually increase hip flexion past 90 degrees after 3 weeks
- ER: 0 degrees x 6 weeks
- Adduction: 0 degrees x 6 weeks
- Extension: 0 degrees x 4 weeks
- Abduction: 25-30 degrees x 3 weeks, then progress as tolerated
- IR: 0 degrees x 4 weeks (once started: do gently, keep pain-free)
- After 6 weeks- ROM as tolerated

Initial Exam Suggestions:

- Measure Non-op Hip
    - Seated AROM hip IR, ER; supine AROM hip flexion; supine PROM hip flexion, IR, ER
- Measure Op-Hip
    - PROM supine hip flexion
- Manual Treatment: long axis traction with circumduction (for circulating synovial fluid and, therefore, cartilage health), long axis traction with gentle PROM abduction, PROM flexion in pain/pinch free ranges
- HEP given at initial evaluation: hamstring stretch, single knee to chest, quad sets, ankle pumps, glut sets at 25% effort

Weeks 1-3:

- PROM to hip within ROM guidelines – avoid pain/pinch: long axis traction with circumduction, long axis traction with gentle abduction, PROM flexion
- Exercises: hamstring stretch, single knee to chest, prone quad stretch, quad sets, ankle pumps, glut sets at 25% effort, transverse abdominal activation, hip adduction isometrics
- Consider adding stationary bike without resistance at 3 weeks, maximizing seat height to avoid psoas irritation
- Manual Considerations: scar massage, STM/MFR to: ilipsoas TFL, ITB, psoas, iliacus, hip adductors, quadratus lumborum, paraspinals. Avoid pressure to the gluteus medius tendon.
- Modalities for pain control and swelling as appropriate

Weeks 4-5:

- Continue with previous exercises and manual techniques
- PROM: Add IR and extension at 4 weeks post-op. Consider manual hip flexor stretching (gentle, no pain). Continue to progress flexion to full range (gentle, no pain).
- Exercises: As tolerated, add an off edge of table hip flexor stretch (provide assistance to get in/out of stretch as needed to minimize pain); sub-max, pain-free hip flexion -avoid hip flexor tendonitis; quad and hamstring isotonic exercises
    - Week 4: Sub-max hip abduction isometrics in minimal abduction (feet shoulder width apart) in varying degrees of hip flexion: 1) supine with legs extended (avoid ER) 2) legs over a bolster 3) hook lying
- Gait training: Week 5, begin PWB with maximum of 50% bodyweight with bilateral crutches or walker. Be conscious of amount of activation of gluteus medius during the gait cycle with regards to fatigue and pain levels.

PHASE II, Intermediate Rehabilitation (Weeks 6-12)

Criteria for progression to Phase II:

- Pain levels are low with minimal muscular irritation
- ROM is progressing at an appropriate rate
- If there are concerns regarding a patients progress and you feel they are not yet appropriate to begin PWB with bilateral AD at 5 weeks, please inform Dr. Enright and hold on WBing progression until their follow-up appointment

Goals:

- Protection of repaired tissue
- Restore full hip ROM- **ROM must come before strengthening**
- Restore normal gait pattern with goal of discharging AD by approximately 8-10 weeks
- Progressive strengthening of the hip, pelvis, and lower extremities with focus on functional strengthening for ADL performance

Precautions:

- Progress to WBAT at 6 weeks with walker or bilateral AD if pain levels are low and there is minimal gait deviation. If clinically appropriate, the patient may progress to ambulation with unilateral AD at 7 weeks postoperatively
- No forced/aggressive stretching of any muscles
- Avoid inflammation of hip flexor, adductor, abductor, and piriformis

Weeks 6-12:

- At 6 weeks post-op, initiate ER PROM. Continue PROM in all planes to tolerance as needed. Continue phase I stretches to maintain ROM/flexibility throughout strengthening, as patients will often tighten as they gain strength.
- At 6 weeks post-op, add prone IR/ER and BKFO stretches to patient tolerance.
- Progress to FWB with minimal pain and minimal gait deviations prior to initiating full weight bearing strengthening. Begin with bilateral lower extremity strength exercises prior to unilateral.
- Stationary biking: increase resistance as tolerated. Elliptical can be initiated at week 10 for patients with very low pain levels who are no longer challenged by the bike.
- Initial strengthening: Progress into weight bearing exercises as tolerated with focus on strengthening supporting musculature with limited gluteus medius involvement. Consider: core stabilization, hamstring curls, LAQ, bridges, shallow mini-squatting, step ups, standing hip abduction/extension with slow progressions of gluteus medius activation.
- Progress strengthening and proprioception exercises as tolerated to: clam shells, single let balance, lateral step ups, non-resisted sidesteps, eccentric tap downs, with caution regarding cumulative activity of gluteus medius. S/L hip abduction can be added no sooner than 10 weeks postop due to the intensity of gluteal activation this exercise involves.

- **Throughout phase II: If patients experience a flare up: focus on ROM, stretching, manual therapy, transverse abs, gluteal firing patterns, and continue with non-painful strengthening as tolerated. Do not push through pain**

PHASE III, Advanced Rehabilitation

Weeks 12-16

- Criteria for progression to this level
  - Full ROM
  - Pain free, normal gait pattern
  - Hip flexor and glut med strength 4/5 or better
  - Hip add, ext and IR/ER strength of 4+/5 or better
- Exercises:
  - Maintain all ROM and flexibility of all muscle groups with self-stretching/home program
  - Progress core, hip, LE strength and endurance. Focus on functional strength gains at this phase.

- Increase gluteus medius strengthening
- Resisted side steps, lateral movements
- Wall squats
- Lunges (multi-angle)
- Advanced single leg balance/core; deadlift, pelvic drop
- Side bridge/plank

Precautions

- Time frames for strengthening progressions are approximate and will vary from individual to individual.
- No contact activities until released by MD
- No impact activities until released by MD

Protocol adopted with permission from Dr. Laskovski

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