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ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

Green Bay • Fox Valley • Marinette

2223 Lime Kiln Road, Green Bay, WI 54311 • Phone: 920-430-8113 • Fax: 920-430-8124

osmsgb.com

Hip Arthroscopy Labral Repair with Capsulotomy 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.

** If the patient had a microfracture, the patient will be foot flat weight bearing for the first 2 weeks. This will be noted in the operative report.

Weightbearing: The patient is 50% weight bearing for the first 2 weeks post-operatively. Restrictions in op note and in PT referral. The patient may begin WBAT as directed at 2 weeks post-op, initially with bilateral crutches or walker, and the patient may progress to a unilateral crutch if pain levels are low and there is minimal gait deviation. If clinically appropriate, the patient may progress to ambulation without an assistive device.

- Please Note: 50% WB should be done to avoid anterior hip irritation caused by holding the hip in flexion while standing. The patient should be instructed to set his/her foot flat on the floor while standing. 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
- Gentle stretching will gain more ROM
- No straight leg raises

PROM Restrictions:

- Flexion: within tolerance
- Extension: 0 degrees x 4 weeks
- Abduction: 25-30 degrees x 3 weeks
- IR: 0 degrees x 3 weeks (IR can be assessed at the first visit, but do not begin doing repetitions until 3 weeks post-op)
- ER: within tolerance
- After 3 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, ER, IR (PROM IR should not be initiated until 3 weeks, but it is good to get a baseline measurement)
- Manual Treatment: long axis traction with circumduction (for circulating synovial fluid and, therefore, cartilage health), long axis traction with gentle PROM abduction, PROM flexion and PROM ER- all in pain/pinch free ranges of protocol limits
- HEP given at initial evaluation: bent knee fallout, seated hamstring stretch, single knee to chest, prone quad stretch, quat sets, gentle glute sets, ankle pumps
- Consider adding stationary bike without resistance, maximizing seat height to avoid psoas irritation

Weeks 1-2:

- See guidelines for Initial Exam

- Manual Considerations: scar massage, TFL, ITB, psoas, iliacus, hip adductors, piriformis, quadratus lumborum, paraspinals
- Modalities for pain control and swelling as appropriate

Weeks 3-4:

- PROM: Add IR and extension at 3 weeks post-op. Manual hip flexor stretching (gentle, no pain). Continue in all other planes, progressing towards full, pain-free range.
- Consider stationary bike without resistance, maximizing seat height to avoid psoas irritation
- Exercises: As tolerated, add prone IR/ER, supine hip flexor stretch off edge of table (provide assistance to get in/out of stretch as needed to minimize pain), piriformis stretch (modified to keep non-op foot on table), FABER stretch, adductor isometrics (use judgment if patient has adductor pain), abductor isometrics, SAQs, transverse abs isometrics
- Gait training: Progress to a unilateral crutch at week 3 if pain levels are low and there is minimal gait deviation. If clinically appropriate, the patient may progress to ambulation without an assistive device.
- Manual Considerations: scar massage, TFL, ITB, psoas, iliacus, hip adductors, piriformis, quadratus lumborum, paraspinals
- Modalities for pain control and swelling as appropriate

PHASE II, Intermediate Rehabilitation (Weeks 4-12)

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 progress to Phase II at 4 weeks, please the surgeon and hold on Phase II until their 6-week follow-up appointment

Goals:

- Protection of repaired tissue
- Restore full hip ROM- **ROM must come before strengthening**
- Restore normal gait pattern
- Progressive strengthening of the hip, pelvis, and lower extremities

- Progress to a unilateral crutch at 3 weeks if pain levels are low and there is minimal gait deviation. If clinically appropriate, the patient may progress to ambulation without an assistive device.

Precautions:

- No forced/aggressive stretching of any muscles
- Avoid inflammation of hip flexor, adductor, abductor, and piriformis

Weeks 4-12:

- Continue PROM as needed. Continue phase I stretches to maintain ROM/flexibility throughout strengthening, as patients will often tighten as they gain strength
- Full weight bearing with minimal pain and minimal gait deviations prior initiating strengthening exercises.
- Stationary biking: increase resistance as tolerated. Elliptical can be initiated at week 6 for patients with very low pain levels who are no longer challenged by the bike.
- Initiate strengthening and proprioceptive exercises. Progress into weight bearing exercises as tolerated. Consider: clams, bridges, shallow squatting, step ups, lateral step ups, balance, medial step down, etc.
- Avoid SLR initially due to potential psoas irritation. Consider other forms of iliopsoas strengthening: step ups, isometric straight leg holds, marching in hook lying position, prone planks, etc.
- Focus on core and gluteus medius/maximus strength to help improve alignment in SLS and to avoid common pre-operative FAI movement patterns (i.a. femoral IR, knee valgus, foot/ankle pronation).
- ** 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 /Return to Sport

Criteria for progression to Phase III:

- AROM symmetrical to non-operative side
- Normalized gait pattern
- Hip flexor strength ≥4/5
- Hip abduction, adduction, extension, ER and IR strength of ≥ 4+/5
- SLS balance 30 seconds without loss of balance
- Medial tap down without valgus collapse

Goals:

- Full (5/5)/ Symmetrical muscular strength
- Restoration of pre-operative cardiovascular endurance

Precautions:

- Use clinical judgement to determine if lunge/jump/hop/jog training appropriate for patient lifestyle and goals
- No contact activities
- No stretching into pain or pinch

Exercises Weeks 12-18:

- Squat progression (Functional Test: Star Excursion Balance Test or Single leg squat test)
  - Double leg press → Double leg squat → Single leg mini squat on total gym with partial weight → Single leg mini squat in standing → Lunges in all directions → Single leg squat within controllable range → single leg squat on unstable surface
- Jump Progression (Functional Test: 10 sec tuck jump)
  - Double leg hop on total gym with partial weight → Double leg hop on trampoline → Double leg hop on hard surface → Double leg vertical jump → Double leg tuck jump with controlled landing and even weight distribution
  - Depth jumps off of block
  - Box jumps with even weight distribution
- Hop Progression (Functional Test: Hop tests x 4)
  - Single leg hop in place (vertical → forward/backward over line → side to side over line)
  - Single leg hop for distance
  - Triple hop for distance
  - Consecutive single leg forward hops
  - Consecutive single leg cross over hops
- Jog Progression
  - Complete the following with good technique and without pain prior to adding jogging:
    - Ladder drills (lateral, anterior, z cuts)
    - Carioca
    - Slide board 50% max speed → full speed
    - Elliptical with resistance
  - Walk to run progression

- Phase I: Run 1 minute, Walk 1-5 minutes, Repeat 2x
- Phase II: Run 2 minutes, Walk 1-4 minutes, Repeat 2x
- Phase III: Run 3 minutes, Walk 1-3 minutes, Repeat 2x
- Phase IV: Run 4 minutes, Walk 1-2 minutes, Repeat 2x
- Phase V: Run 5 minutes, Walk 1 minutes, Repeat 2x

** Complete each phase for 2 days. Do not progress to the next phase if you experience an exacerbation of pain.**

Source:https://osuwmcdigital.osu.edu/sitetool/sites/sportsmedicinepublic/documents/rehab_protocols/2012_return_t o_running_basic.pdf