



## Hip Arthroscopy Labral Repair Protocol

<b>Applicability:</b> Physician Practices	<b>Date Effective:</b> 09/2013
<b>Department:</b> Rehabilitation Services	<b>Date Last Reviewed:</b> 1/2021
<b>Supersedes:</b> N/A	<b>Or</b> <b>Date Last Revision:</b>
<b>Administration Approval:</b> Deanna Orfanidis VP, Chief Nursing Officer	

**Purpose:** Define the protocol to be followed for all patients referred from Northwestern Orthopedics after the above procedure has been performed.

**Policy Statement:** Treatment will follow the defined protocol below and be carried out by Physical Therapist, Athletic Trainer and/or Physical Therapy Assistants.

**Background:** N/A

**Definitions:** N/A

**Procedure:**

Outpatient Physical Therapy starts at post-op day 2-5

***Basic Rehab Principles:***

Precautions and limitations during the initial post-op period will be dependent on procedure(s) performed, refer to the MD order and surgical report for the procedure. Post-op weight bearing is based on procedure and the need to protect repair/bone healing. There may be significant reflex inhibition and poor muscle firing due to penetration of the hip with arthroscopic instruments and traction applied during the procedure. Even in patients who are WBTT progression off crutches should be based on sufficient muscle control to allow normal gait pattern and not on pain alone. Maximum motion in ANY plane is determined by where the patient feels discomfort and “stretching” is only encouraged to this limit. Pushing extremes of motion will increase discomfort and prolong rehab. Some procedures require ROM and strengthening to be limited in particular ranges to allow appropriate healing. Iliopsoas tendonitis is a known complication of hip arthroscopy. Avoid exercises engaging the iliopsoas for the first six weeks for femoral osteoplasty, labral repair and microfracture. Patients with debridement only can perform these exercises as long as no symptoms are present ( ex. SLR, resisted hip flexion, abduction requiring significant co-contraction, trunk curls with hip flexion).

***Post-Op Debridement without Chondroplasty, Osteoplasty or Microfracture:***

*Gait:* WBAT with crutches-may advance off crutches if no pain and normal gait pattern



*Dressing:* Removed at first PT visit, cleansed and band-aids applied

*Exercise Recommendations:* Avoid supine straight leg raise, trunk curls with hip flex, resisted hip flexion, hip extension beyond neutral, lunges where the hip in back extends past neutral and hip rotation under a load x 4 weeks or until no symptoms are present. Patient can perform the same exercises as before surgery once they can perform them without symptoms.

**Labral Repair with Chondroplasty, Osteoplasty or Microfracture:**

**PHASE 1 (0 to 6 weeks)**

*Goals:*

1. Decrease pain and joint effusion
2. Prevent muscle inhibition
3. PROTECT surgically repaired tissue/bony structures
4. Maintain static joint alignment
5. Increase awareness of joint protection
6. Independent, safe gait with assistive device and compliance with weight bearing status
7. Increase sitting tolerance

*Precautions:*

1. Hip flexion < 90 degrees and minimize hip adduction/IR (avoid impingement position)
2. No resisted hip flexion x 6 weeks
3. No supine SLR or sidelying hip abduction x 6 weeks
4. ROM in painfree range only

*Dressing:* Removed at first PT visit post-op day 3, cleansed and band-aids applied

*Gait:* TDWB x 6 weeks

Microfracture TDWB x 6 weeks and then PWB x 2 weeks

*Edema Control:*

- Ice
- Kinesiotape as indicated
- ESTIM as indicated

*Suggested Exercises:*

- Ankle pumps, quad sets and glut sets
- heel slides < 90 degrees of hip flexion
- supine hip abduction with knee extended and in slight ER
- gentle hip ER/IR with knee extended



Prone lying to stretch psoas  
Isometrics for hip add, abduction, hamstring and transverse abdominis  
Sitting hip flexion allowed due to shorter lever arm- reclined trunk to keep hip flex < 90  
Stationary bike at 2 weeks with no resistance, upright trunk and seat adjusted to keep hip flex < 90 degrees. No recumbent bike due to constant recruitment of hip flexors  
Progress to SLR, sidelying hip abduction/adduction and prone SLR at 6 weeks

***Criteria to advance***

1. ROM > 75% of uninjured
2. Sidelying hip abduction without substitution
3. Painfree SLR

**PHASE 2 REHAB (post op 6 weeks if criteria met):**

*Goals:*

1. ROM to functional range
2. Strengthen hip and core
3. Gait painfree without device(6-8 weeks dependent on procedure)
4. Good leg control at low velocity of movement

*Precautions:*

Avoid excessive hip hyperextension with lunges, elliptical and treadmill.  
Avoid hip extension where hamstring contraction is > glut maximus which increases anterior joint reaction force.

*Gait:*

Progress to WBTT without device as protocol allows once pattern is good no pain  
Consider orthotics/superfeet if needed to improve biomechanical alignment

*Suggested Exercises:*

ROM/soft tissue flexibility exercises to tolerance  
Supine SLR, prone SLR, hip abd/add progress to weights as tolerated  
Theraband strengthening all directions (avoid excessive hip extension)  
Bridging with hip extension to neutral  
Sidelying clam shell (hip abd/ER) progressing to theraband  
Core strengthening  
Modified squats no > 45 degrees to avoid impingement  
Stationary bike with gradual resistance (upright posture, no recumbent or toe clips)  
Elliptical and Treadmill  
May swim with "bob" between knees to prevent hip flexion once wounds are healed  
May perform gentle flutter kick without "bob" at 6 weeks if no hip flexor pain

*Patient Education:*



1. Motions and activities should not increase pain.

**Criteria to advance from Phase 2 to Phase 3**

1. Normal gait pattern without Trendelenburg
2. Full anti-gravity AROM with good muscle control with minimal to no pain.
3. at least 8 weeks post-op

**PHASE 3 (begin when criteria met and at least 8 weeks post op)**

*Goals:*

Good hip and core strength  
Correction of faulty movement patterns  
Good control and no pain with work or sport specific simulated movements as appropriate

*Suggested Exercises:*

Continue and progress strengthening from Phase 2  
Avoid leg press and prone resisted hamstring curls x 12 weeks  
Balance and proprioceptive exercises

*Patient Education:*

1. Continued education to correct faulty postures and movement patterns especially knee and hip hyperextension in standing and excessive hip ER.
2. Work modifications as patient condition warrants.
3. Patient education re: continued joint pathology (chondral lesions, OA, dysplasia) and joint protection techniques
4. Begin discussion with patient and MD about modified fitness options if surgeon recommends patient not return to previous recreational/sport activities.
5. Motions and activities should not increase pain.

**Criteria to advance from Phase 3 to Phase 4 (weeks 12+)**

1. Full hip AROM without pain
2. Hip MMT 5/5 without pain
3. Good core strength
4. Normal gait on all surfaces
5. At least 12 weeks post-op

**PHASE 4 (12+ WEEKS):**

*Goal:*

1. Safe effective return to previous activity level or modified activity level as indicated by ongoing pathology in joint.

*Suggested Exercises:* may be primarily HEP



1. Progressive hip and core strengthening
2. Sport /work specific balance/proprioceptive activities as indicated

*Patient Education:*

1. Full maturation of hip labral tissue takes 18 months
2. Avoid deep knee bends/squatting x 12-18 months
3. Success rates are more limited with worsening degrees of labral tear and secondary OA changes as well as the presence of chondromalacia.
4. Motions and activities should not increase pain.

**Note Well:** N/A

**Related Policies:** N/A

**References:** N/A

**Reviewers:**

**A. Key Stakeholders:**

- Dr. Andrew Myrtue – Medical Director, Ortho & Rehab
- Karen Staniels –Director, Ortho, Rehab & Occupational Health

**B. Committees:** N/A

**C. Key Process Owner (KPO):** Kristy Cushing – Manager, Rehab Services

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***Keywords - Not part of policy:* [ADD Key words for policy search if end user didn't know the name]**