POST-OPERATIVE REHABILITATION PROTOCOL

Hip Arthroscopy with Osteoplasty & Labral Repair

William McLaughlin, MD | Sports Medicine Surgery | Advanced Bone & Joint

Therapy 2-3 times per week for 6 weeks. Procedure: Hip Arthroscopy, Labral Repair, Proximal Femoral Osteoplasty, Capsular Closure.

General Instructions: At 3 weeks from surgery, patient may begin to progress off of crutches — progress from TTWB with 2 crutches to FWB with 2 crutches for 2-4 days, then move to FWB with one crutch (opposite side of surgical leg) for 3-5 days. Once comfortable, may discontinue crutch use. Focus on gait training during this transition week.

Active and passive hip flexion to 90° within patient comfort level. No IR/ER x 4 weeks.

Phase I | ~0-4 Weeks Post-Op

GOALS FOR THIS PHASE

- Protect repaired tissue, restore ROM, and control pain and inflammation.
- Restore neuromuscular control.
- Avoid intra-articular adhesions and irritation of the hip flexor (iliopsoas).

Precautions

- Passive hip flexion limited to 90° within patient comfort level to avoid hip flexor irritation. Active hip flexion under 60° OK for ADLs; do not force active flexion with exercises (e.g., SLR).
- No resisted IR/ER x 4 weeks. Avoid abduction and IR/ER past 20° (40° arc) until 2-3 weeks post-op; no aggressive stretching.

Mandatory in Phase I

- Passive hip circumduction 2-3 times per day at PT, with instruction for home program inclusion.
- Two positions: leg/knee straight with hip flexed ~30°; knee bent with hip flexed 50-60°.
- CPM to 60° hip flexion for at least 4-6 hrs/day for 3-4 weeks.
- Ice 2-4 times per day x 20-30 minutes.

Weight Bearing

- Foot-flat weight bearing up to 30% of bodyweight for the first 3-4 post-op weeks.
- May progress to full weight bearing by 4 weeks post-op or when able to ambulate without compensation.
- Can use 1 crutch on contralateral side for transition period.
- Cue to lift heel quickly after mid-stance.
- Avoid twisting/rotation of acetabulum on femur under loaded conditions.

Exercises

- Isometrics for hips and legs (quad sets, glute sets, abd, add).
- Ankle pumps.
- Heel slides to 90° (AROM/PROM within comfort — may use towel/belt around thigh).
- Active/active-assisted ROM in all planes within precautions and patient comfort.
- Side bridge with adductor facilitation — knees bent.
- Standing hip abduction.
- DL bridges.
- Light DL press or shuttle between 0-60° hip flexion.
- Weight shifts to DL and SL proprioception progression as patient transitions to WBAT.
- Upright (not recumbent) stationary bike, minimal resistance — may start day after surgery.
- Stretch hamstrings and gluteals if needed (hip in 90/90 flexion position).

ADLs

- Sit to stand: scoot forward, keep knees over feet, may straddle feet (foot back on uninvolved side).
- In/out of car: backside faces seat, sit and move hips and trunk together; may assist with hands to lift involved hip.
- Sleeping: supine — pillow under knee; side-lying — pillow between knees; prone — pillows under hips.

Joint Mobilization

- None until 4 weeks post-op to protect capsular repair/closure.

Criteria to Progress to Phase II

- WBAT.
- Minimal pain with activity during rehab and ADLs.
- Proper muscle firing patterns at hip.

Phase II | ~4-8 Weeks Post-Op

GOALS FOR THIS PHASE

- Protect repaired tissue, restore ROM, and restore normal gait pattern.
- Progressively increase strength with global neuromuscular control.
- Monitor deep hip flexion motions of impingement; release myofascial restrictions of hip musculature.
- Focus on core control.

Precautions

- Hip ROM within patient comfort level. Do NOT push hip ROM.

- Avoid forceful or ballistic stretching; no treadmill.
- Prevent loaded and prolonged excessive hip flexion or FADIR position.

Weight Bearing

- Progression to full weight-bearing per MD.

Exercises

- Aquatic exercise — cleared suture sites required, at least 50% WB. OK to begin flutter kick with kick board.
- Weight shift and proprioception progressing to side-stepping in standing, then with Theraband resistance above knee.
- Aerobic activity — progress resistance of upright bike, elliptical, aquatic therapy.
- Quadruped: rocking backward within patient comfort.
- OKC straight-leg raises — only hip abduction and extension. No flexion or adduction.
- Closed-chain strengthening in accordance with WB status: step-ups, wall squats.
- Bent-knee fall-out, trunk rotations.
- Planks / core strengthening.
- LE flexibility program within patient comfort.
- Soft tissue mobilization / massage / modalities for iliopsoas mobility.

Joint Mobilization

- May begin low-grade hip joint mobs.

Criteria to Progress to Phase III

- Pain-free gait and ROM.
- Hip flexion strength > 60% of uninvolved side.
- All other hip motions (abd, add, ext, IR, ER) strengths > 75%.

Phase III | ~8-12 Weeks Post-Op

GOALS FOR THIS PHASE

- Further restore muscular endurance and strength.
- Improve low-impact cardiovascular fitness.
- Optimize global neuromuscular control and proprioception.
- Monitor deep hip flexion motions of impingement.

Precautions

- Avoid forceful or ballistic stretching.
- No treadmill jogging/running.
- Prevent loaded and prolonged excessive hip flexion or FADIR position.

- No high-impact sport-specific activity.

Exercises

- Hip rotation — resisted LR with hip extended (standing — Theraband around foot) and hip flexed (sitting — Theraband around ankle).
- Proprioceptive training progression — single-leg focus.
- Advance core and bridging program.
- Cable column hip strengthening.
- CKC multidirectional activities for strengthening including SL stance (progress using TRX or shuttle to FWB activities).
- Basic stretching and myofascial release with focus on hip flexors and adductors.
- Progress low-impact CV fitness: cycling, elliptical, aquatic therapy.

Criteria to Progress to Phase IV

- Hip flexion strength > 75% of uninvolved side.
- All other hip motions (abd, add, ext, IR, ER) strengths > 80%.
- Adequate CV fitness.

Phase IV | Return to Sports / Running | > 12 Weeks Post-Op

GOALS FOR THIS PHASE

- Progress toward returning to sport / activity-specific competition.
- Clearance is criteria-based, not timeline-based.

Precautions

- Do not progress too quickly.
- Introduce dynamic and high-impact activities progressively to allow neuromuscular control.
- Avoid irritation of hip flexor musculature.

Exercises

- Lunge matrix / tri-planar movements (not too deep).
- Progressive return to running/jogging program starting at week 12.
- Functional agility drills including gradual progression of dynamic warm-up.
- Sport-specific drills starting with low-level plyometrics and progressing as tolerated.
- Dynamic balance drills.
- Maintain stretching / soft tissue mobilization / modalities as needed.

CRITERIA FOR RETURN TO SPORT / FULL ACTIVITY

- Full pain-free ROM.

- Completion of a sport-specific loading and functional training program at full speed without complications or pain.
- Cardiorespiratory fitness at pre-injury level.
- Strength testing ≥ 90% of the uninvolved side.
- Dynamic balance ≥ 90% of the uninvolved side.
- Single-leg hop tests ≥ 90% of the uninvolved side.

This protocol is a general guideline. Progression is patient-specific and at the discretion of William McLaughlin, MD.