ADVANCED
Center for Orthopedics
and Plastic Surgery

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TOTAL HIP ARTHROPLASTY PROTOCOL (ANTERIOR APPROACH)

4 TO 6 WEEK GOALS:

1. Walk without a limp or assistive device.
2. Stairs with a reciprocal pattern and NO railing to assist to ascend. Rail use ok to descend
3. Single leg stance ≥ 10 seconds
4. Stand from chair without upper extremity assistance

D/C INSTRUCTIONS FROM THE HOSPITAL:

1. Follow Anterior Hip Precautions
   a. No lunges for 6 weeks- excessive hip extension in weight bearing could result in dislocation.
   b. After 6 weeks, patients may perform lunges as long as motion is in the straight plane. Avoid combinations of motions such as extension with abduction or hip rotation.
2. Gait – **WBAT**
   a. Ambulate with assistive device for 2 weeks. Progress to no A.D. when pt. is able to walk without pain or gait deviation
   b. Limit walking to 10 min/hour for the first 1-2 weeks with**gradual progression** afterwards
3. Wear TED hose on both legs for 6 weeks during the day. Remove at bedtime.
4. Remove waterproof bandage 8 days post-op. If pt. has visible drainage from the incisional area at 8 days post-op, contact medical staff at (509) 946-1654.
5. NO WEIGHT MACHINES OR RESISTANCE ON CARDIO MACHINES FOR INTIAL 3 MONTHS
6. NO TREADMILL FOR INITIAL 6 WEEKS.
7. NO CUFF WEIGHTS OVER 2 LBS FOR INITIAL 6 WEEKS. DO NOT PROGRESS BEYOND 5 LBS FOR 3 MONTHS.

PHYSICAL THERAPY: 1x/week for 4-6 weeks, D/C @4 wks unless gait deviations persist

1. **Heat** prn before exercises and **ice** after.
2. **MASSAGE & TISSUE WORK**: may begin week 1 post-op:
   a. Hip Flexors, IT Band, Adductors, Piriformis, and Gluteal muscles often exhibit adaptive shortening and spasms
   b. **SCAR MASSAGE –INITIATE AT 3 WEEKS POST-OP!** The surgical scar and the soft tissue immediately surrounding this area tend to become adhered and extremely thickened if ignored. Aggressive, frequent tissue work in the clinic is often necessary. Patients should continue daily scar massage for 3 months.
3. **STRENGTHENING**: Focus on gluteals& hip rotators (abd/ER/ext) to eliminate limping and to prevent hip flexor overuse.
   a. Side lying SLR- initiate by end of week 2.
   b. Clams- initiate by beginning of week 3. Hips should be positioned at ≤ 45 degrees of flexion in order to avoid compensation by hip flexors and irritation of the anterior hip. Roll top hip slightly forward of bottom hip.
   c. Bridging- AVOID full hip extension in order to prevent irritation of the surgical area.
   d. **Open chain hip flexor strengthening tends to irritate the tendon. NO SUPINE SLR FOR 6WEEKS POST-OP.**
   e. Closed chain/functional hip flexor strengthening (such as wall squats, step-ups) is the preferred option.
4. **FLEXIBILITY:**
   a. Hip Flexor Stretch: week 1 prone–lying ok, week 2 may begin prone hip flexor stretch
   b. Precaution- Limit excessive hip flexor stretching to avoid irritation of the surgical area.
   c. Long-sitting hamstring stretching. Begin @2 weeks post-op.
   d. Anterior pelvic tilts — perform in sitting. Begin @ 2 weeks post-op.
   e. Supine knee to chest stretch. Begin @ 2 weeks post-op.
   f. Figure 4 stretch. Begin @ 3 weeks post-op.

SPECIAL CONSIDERATIONS:

1. **Complaints of MID-THIGH PAIN WITH WEIGHT BEARING @ 3 WEEKS post-op. Contact Dr. Kerns.**
2. If patient develops large **hematoma** at surgical hip (typically occurs in first 1-2 weeks as a result of overuse), stop all therapy and home exercises and contact Dr. Stanfield. Hematoma most commonly occurs around incision.
3. **DO NOT GIVE SHOE/HEEL LIFTS—** It is normal for patients to complain of feeling "uneven" after surgery. The surgeon will address this issue at the patient's 6 week check-up.

PLEASE CALL US WITH ANY QUESTIONS