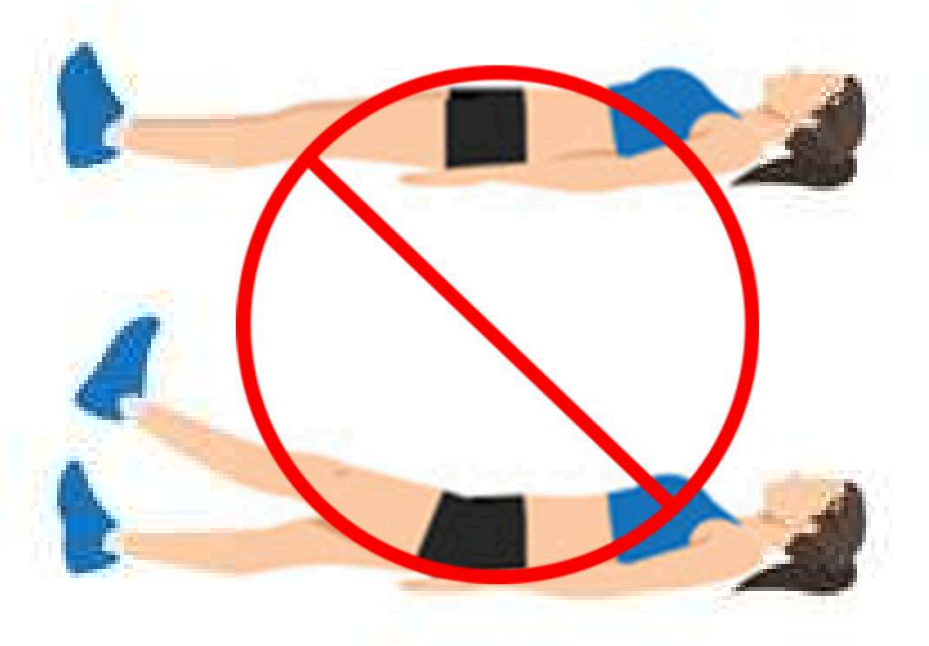
# Dr. Wolff Hip Arthroscopy Rehab Protocol

## Labral Repairs / Reconstructions & FAI Correction

# Physical Therapist Information

Please read the entire protocol prior to initiating therapy. May reference our website for helpful videos of key exercises. This is a unique recovery process and the rehab will require frequent adjustments pending the patient's pain level and tolerance. Pain management strategies should be prioritized, especially early on and also during flare ups, which are inevitable for most patients. Patients may progress slower than the given timeline, but should never progress faster regardless of how well they may appear to be doing.

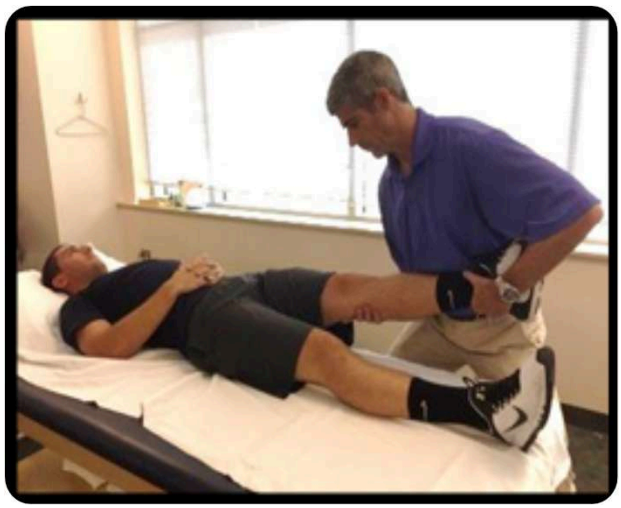
- Please do not hesitate to contact Dr. Wolff's office with questions or concerns by texting 202-838-8837.
- This protocol is written to be followed by a licensed Physical Therapist. Patients should not attempt to follow this on their own without the proper guidance from a provider.
- **NEVER push beyond limitations created by pain.**
- Rest is a vital component of recovery from hip arthroscopy. **LESS IS MORE.**
- Manual therapy (including modalities, dry needling, ART, etc.) is an important part of recovery. It is often helpful even beyond the initial post-op phase to help maintain ROM and regulate pain. Feel free to start these whenever you deem them beneficial.
- Utilize the exercises given as a guide. They are not intended to serve as a substitute for clinical decision-making; adjust within given guidelines and precautions as needed.
- Do Not do every exercise in the protocol.
- Do Not do all exercises daily.
- Patients' progression will vary widely. It is rare to have a patient progress through this rehab protocol without setbacks.
- Good recovery depends on the therapist and patient monitoring the effects of each particular exercise. **If it hurts, don't do it!** – regardless of the time from surgery.
- Skipping all exercises when sore is the right thing to do.
- Post-operatively, patients have a daily budget for what their hip will tolerate. Do NOT exceed their budget. Keep in mind the cumulative effect of activity and exercise. Patients that require faster resumptions of ADLs (such as returning to work/school) should spend less time on PT exercises.
- If you have access to a pool, please see Aqua Therapy Protocol found on Dr. Wolff's website. These can be performed on days you do NOT do other therapy exercises (i.e. do them as a substitute), no more than 2-3 times per week.
- Reference videos on website for further instruction on proper technique.



Hip Flexor Strengthening is counterproductive during recovery from Hip Arthroscopy. Do not do it! A supine straight leg raise should never be performed. Psoas Tendonitis is the most common post OP complication & oftentimes occurs with little provocation. Rest, Pain Management & Gluteal Activation are the ideal tools to get through it.

# Phase 1: Weeks 1-2

Initially, therapy sessions should be dedicated to manual techniques and gait/crutch training. Isometrics should be completed at home. **Circumduction PROM is the most important exercise in this phase.** Use circumduction videos as a guide to perform these at home at least once daily with a partner.



## Goals

- Diminish pain & inflammation.
- Restore Range of Motion (ROM) within comfortable range.
- Prevent muscular inhibition.
- Restore normal gait.

## Precautions

- **Do not push through hip pain or pinching.**
- No distraction or joint mobilizations in this phase.
- No scar massage using lotions until incisions are completely healed (usually 10-14 days post stitch removal).
- No ROM restrictions (unless otherwise noted), but should stay in a comfortable range.
- Hook foot of non-surgical leg under ankle of surgical leg to assist with supine to sit transfers and vice versa (minimizes stress on hip flexor).

## Weight Bearing Restrictions: WBAT

It is vital to establish a normal gait pattern as soon as possible. Immediate post-op weight bearing with flat foot is necessary, and normal gait with crutches should be established within the first 1-2 weeks. Stand up straight and walk normally! As long as the foot is flat and there is no limping or hopping, the percentage of weight bearing is less important. **Even if patient can walk normally without pain soon after surgery, they should not get rid of the crutches early.** This will lead to overuse and setbacks.

## Crutches

- Crutch training videos: **https://andrewwolffmd.com/cruch-training/**
- Patient should walk with 2 crutches for a minimum of 1-2 weeks at all times, and a minimum of 4 weeks outside of the house. It is sometimes necessary to still use 1 crutch for 1-2 weeks after the initial month to allow for a smoother transition.
- The goal is to protect the hip from overuse and to re-establish a normal gait pattern.
- Should not walk without crutches until patient no longer walks with pain or limp.

# Crutch Restrictions For Additional Procedures (Will Be Listed On PT Prescription)

## Capsular Plication

Should walk with both crutches outside of the house for a minimum of 4 weeks, and 1 or 2 crutches weeks 4-6. Should not be crutch free until 6 weeks at the earliest.

## Microfracture Or Osteochondral Allograft

Should walk with both crutches outside of the house for at least 6 weeks maintaining roughly 30-50% WB, and can wean to 1 crutch for the following 2 weeks while increasing WB. Should not be crutch free until 8 weeks.

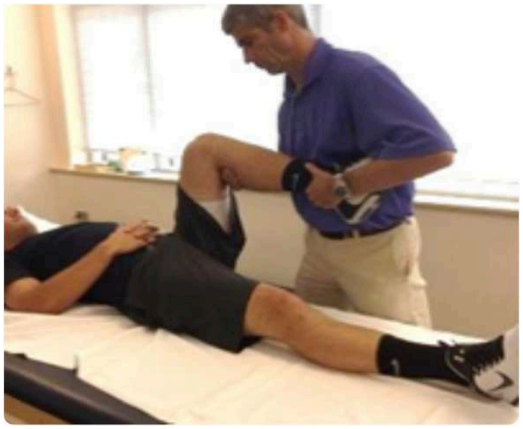
# Exercises

**Gait Training**

- Posterior Pelvic Tilt/Transverse Abdominis Contraction.
- Diaphragmatic breathing.
- Ankle Pumps.
- Weight Shifts (all directions to tolerance).
- Quad Sets.
- Glute Sets.
- Bent Knee Fall Outs within comfortable range - focus on controlling pelvis.
- Quadruped Position as tolerated - cat cows, breathing, core activation.

# Stretches

- Prone Lying or "Tummy Time" - 10-15 minutes at a time a few times a day as tolerated. This will help gently loosen anterior hip. May gently push up onto elbows if tolerated.
- Prone Quad Stretch.



# Passive Range Of Motion

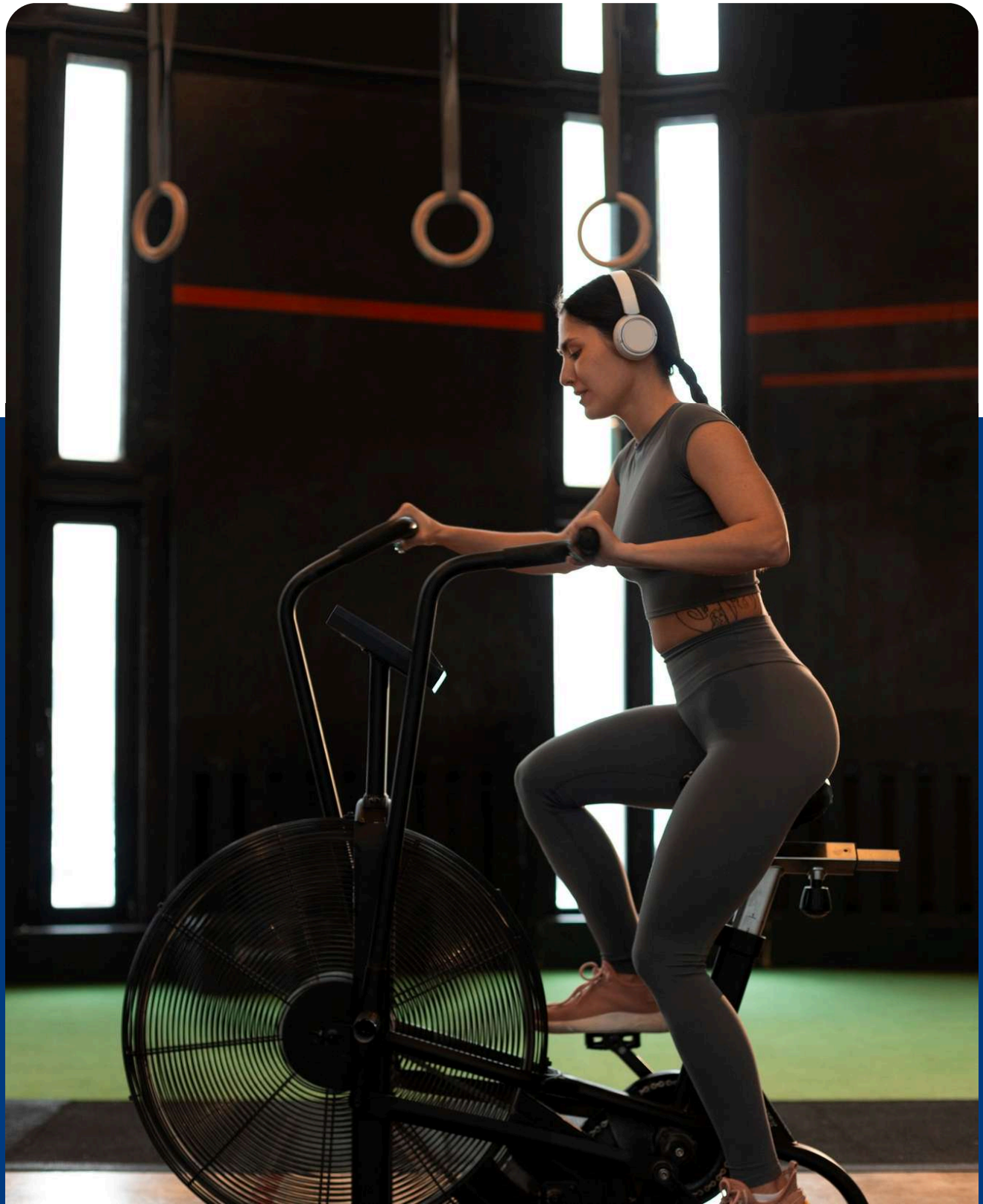
- To be performed 1-2 times daily by therapist and ideally by a partner at home on days PT is not attended. PROM is the most important part of Phase 1.
  - Circumduction in Flexion and in Neutral: Clockwise and Counter Clockwise.
  - Flexion.
  - Abduction.
- Patient should NOT assist with motion; this will increase pain.
- Do NOT force motion or push beyond point of pain.

## Soft Tissue Massage

Once a day to mobilize and gently flush out edema and post-op swelling.

## Stationary Bike

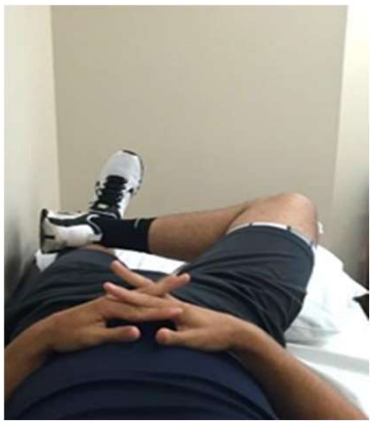
Up to 20 minutes a day without resistance for the first 4 weeks. Can start this anytime postop as long it doesn't increase pain. Upright bike or recumbent bike ok, just adjust to avoid going beyond 90 degrees of hip flexion. Needs to be comfortable, or don't do it.



# Phase 2: Weeks 3-6

## Precautions

- Same as Phase 1, but may start scar tissue massage if incisions are healed.
- No added weights or bands on exercises.



## Goals

- Crutch Weaning.
- Restoration of ADLs with minimal discomfort.
- Begin FABER stretching.

## Exercises

- Continue all from Phase 1, with continued emphasis on daily PROM
- Double leg Bridges
- Prone hip extension with pillow under hips and bent knee (or prone on end of table with bent knee if they are having difficulty on table)
- Standing Hip Abduction
- Prone Hamstring Curls
- Double Leg Knee Bends
- Gait training - backwards walking, side stepping with upper body support (no resistance)

## Stretches

- **FABER/Figure 4 stretch: This is important for all patients.** Waiting too long beyond protocol instructions will result in increased tightness and scar tissue formation. Only as tolerated, do NOT force or push through pain. Helpful to place pillows under the knee and allow it to hang and stretch for several minutes. If a patient is unable to cross ankle over knee, just continue with bent knee fall outs until full figure 4 can be performed.
  - **For patients that received a capsular plication or have a history of hypermobility, wait until week 6 to implement a full FABER stretch to allow healing of anterior capsule** (bent knee fall outs still ok).
- Continue all from Phase 1.
- Kneeling Hip Flexor Stretch - control core here and DO NOT OVERSTRETCH (particularly those with hypermobility). Avoid this if it creates psoas irritation.
- Standing Adductor Stretch.
- Cobra Pose.

Continue soft tissue massage and stationary bike. May gradually add resistance and time on bike after 4 weeks as tolerated. Do not increase time and resistance on the same day.

# Phase 3: Weeks 7-12

## Precautions

- Avoid increasing activity too quickly.
- Do not add several new exercises at once (this way is pain increases, can understand trigger).
- Do not push through pain or fatigue (be mindful of daily budget).
- **No isolated hip flexor strengthening** (supine SLR, weighted marches, excessive steps, standing hip flexion with band).
- Joint mobilizations ok only if indicated.
- **Not all exercises need to or should be performed every day.**
- Specific HEP at discretion of therapist.
- If strengthening exercises are not well tolerated, patient should focus on ADLs, walking, proper muscle activation, and gentle ROM.

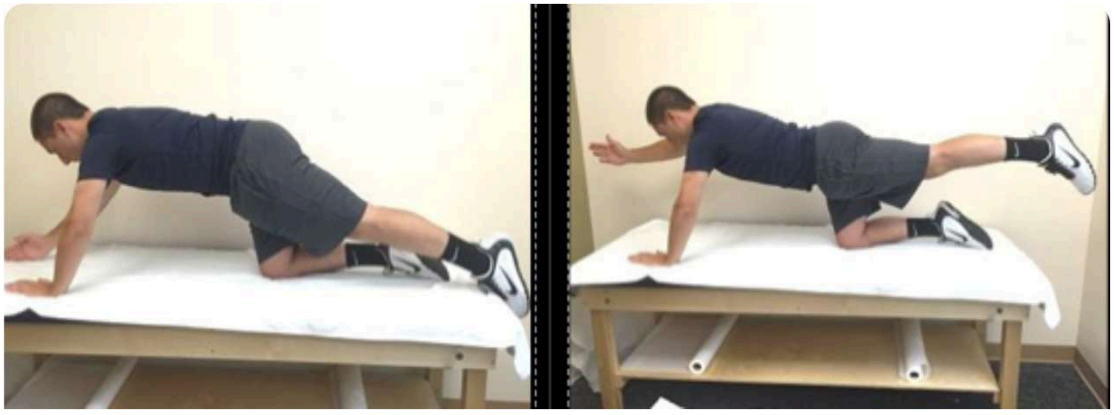
**Note** that not all patients will be ready for Phase 3 at the same time and progression is based on their function, strength and stability. Ie: If a patient cannot walk without crutches at all times they should not be progressing to this phase. These exercises are just a guide and not all patients will tolerate all of these. It's important to watch for compensation and avoid exercises they cannot perform properly.

## Goals

- Walking a mile and gradually increasing distance as tolerated.
- Ascending and descending stairs normally.
- Begin gluteal strengthening.

# Exercises

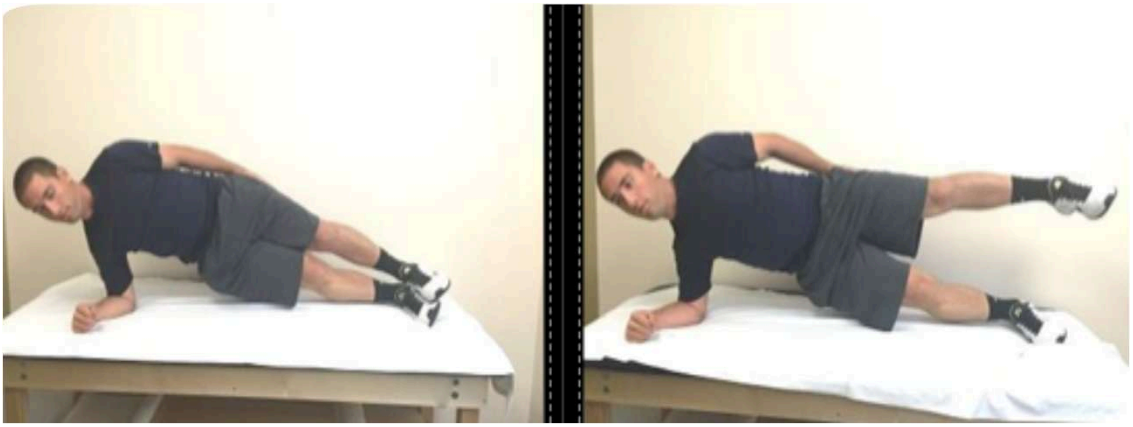
- May discontinue phase 1 exercises.
- May gently add resistance/bands to Phase 2 exercises as tolerated.
- May start gentle reformer pilates.
- Elliptical ok if tolerated.
- Side lying Hip Abduction.
- Clamshells.
- **Squat Variations:**
  - Body Weight Squats (do not go past parallel) - progress to balance board/bosu.
  - Standing Clamshell at Wall (captain Morgan).
  - Standing Clamshell (foot against Wall).
- **Quadruped Progression:**
  - Hip Extension.
  - Opposite Arm/Leg Extension.
- **Bridge Progression:**
  - Bridge hold into march (bent knee).
  - With Alternating Knee Extensions.
  - Single Leg with bent knee.
- **Plank Progression (DO NOT DO IF PATIENT HAS PSOAS TENDINITIS):**
  - On Wall.
  - On Bench.
  - On Knees (level ground).
  - On Toes.
  - With Alternating Hip Extension.
  - With Alternating Hip Abduction.
- **Side Plank Progression:**
  - With Top Hip Abduction.
  - With Top Hip Clamshell.
- Lunges (Forward, Side, Forward with Trunk Rotation).
- Side Stepping with Resistance.
- Single Leg Balance Progression (floor, foam pad, bosu/balance board).

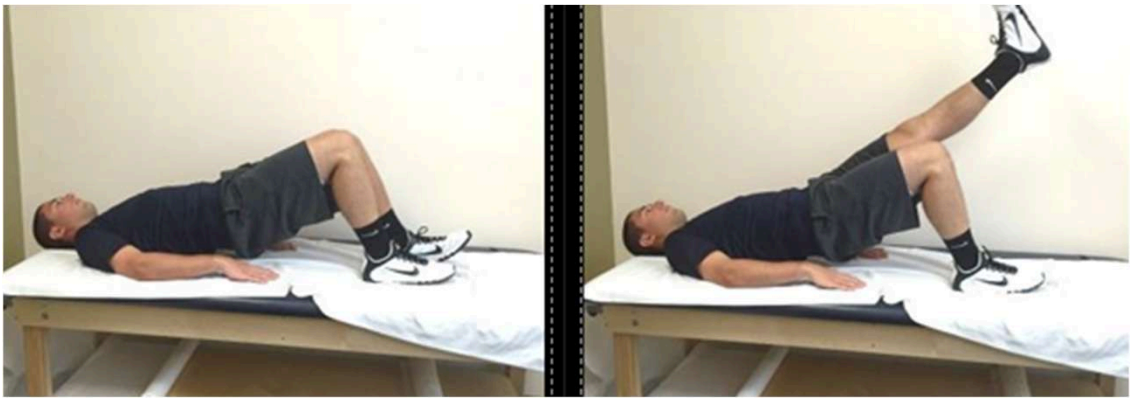


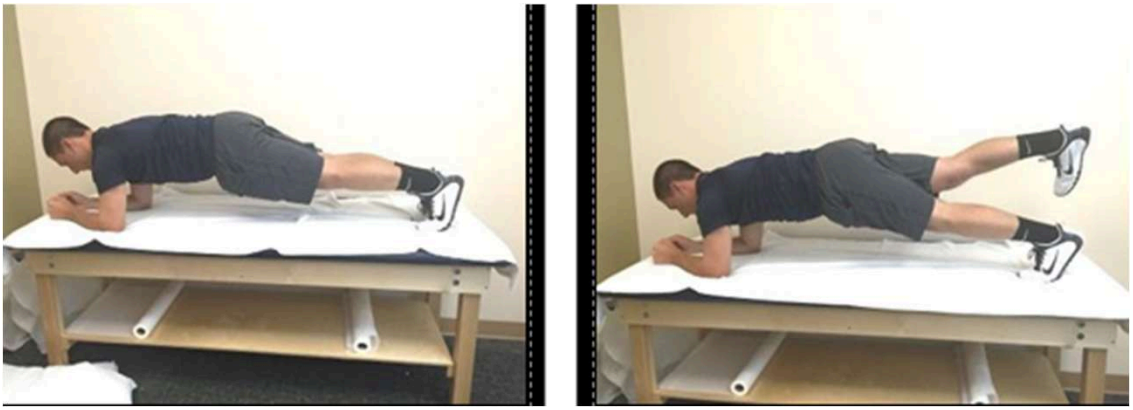
Core exercise examples/progressions not to be started before 6 weeks and only added in as appropriate. (DO NOT DO IF PATIENT HAS PSOAS TENDINITIS).

- Marching Bridges.
- Isometric dead bug Dynamic dead bug .
- Planks (see plank progression).
- Modified bird dog.
- Static bear hold .
- 1/2 kneeling wood choppers .
- Farmers carry.

**Continue all stretches, but DO NOT OVERSTRETCH.**







# Phase 4: Weeks 13+

## Precautions

- This phase will vary widely dependent on patient's personal exercise goals.
- Many patients may not need to even progress into this phase.
- Do not progress too quickly.
- As new exercises/activities are added, remove others.

## Goals

- Slow return to exercise goals.
- Return to run.

## Return To Running

- Should be able to tolerate comfortably walking 2+ miles before attempting jog.
- Can be started no sooner than 3 months with physician approval.
- No sooner than 4 months for those with capsular plication unless other approved by physician, and no sooner than 6 months for those receiving microfracture or chondral procedure.
- **Protocol found here:** https://andrewwolffmd.com/wp-content/uploads/2017/12/Return-to-Running-Protocal-Pages-1-and-2.pdf
- STOP if pain occurs.
- Allow soreness to subside before progressing.
- May need to move slower than protocol - this is just a guide.

## Return To Sport

- Agility/ladder drills.
- Sport specific exercises/drills.
- FOCUS ON QUALITY OF MOVEMENT AND GRADUALLY BUILD INTENSITY AND ENDURANCE.
- Focus on restoring squat pattern, hinge pattern, incorporate push/pull/carry exercises.
- Non contact play/practice is roughly 5 months.
- Unrestricted return to sport is no earlier than 6 months and is dependent on physician approval.