WOLFF ORTHOPAEDICS
ATHLETIC HIP INJURY & HIP PRESERVATION

SURGERY INSTRUCTIONS AND PREPARATION

Please carefully review the following information and reach out to our team with any questions at
202-838-8837.

Medical (non-billing) questions related to the surgical procedure and recovery can be directed to our PA in the Spruce App

(scan to download Spruce to message your care team directly)

https://spruce.care/wolfforthopaedicspc.

Surgery with Dr. Andrew B. Wolff

Please read through this Surgery Packet and all documents given to you for your surgery, in their entirety. We understand that surgery is no small matter and are happy to discuss all questions you have, but please know that the answers to most questions can be found in the documents provided to you. We have specifically developed all surgery documents for hip arthroscopy and they are tailored with great detail to your procedure. So, we ask that you please take the time to read this information to ensure the best surgical experience and care for you.

Dr. Wolff performs 6-8 hip arthroscopies per week and this type of injury/surgery comprises the vast majority of his practice. We also want you to know that Dr. Wolff is out of network with all commercial insurances.

While every insurance company has their own policies regarding coverage for arthroscopic hip procedures, we have experience with nearly all of them. Please understand that our goal is to provide you with the best possible care in every aspect. Part of that is understanding and demystifying the billing process which can be intimidating and scary. Please take the time to speak with our billing office about the particulars of your procedure as it relates to your specific insurance plan as these vary widely. We will advocate on your behalf to make this process less time-consuming and financially feasible.

Similarly, we will often ask for your help in this process to minimize your out-of-pocket expenses. Following surgery, Dr. Wolff's billing staff may reach out and ask that you get involved to help with ensuring coverage by your insurance company. You may be asked to draft a letter, make a phone call or just be responsive with communications regarding paperwork and/or payments you receive from your insurance company. We ask that you are prepared and ready when we do reach out as there are often tight timelines associated with the requests we may ask of you. The more helpful and responsive you are, the quicker this process will go.

Our office will do our best to be as responsive as possible should you have questions or concerns. We are all on the same team and look forward to working with you!

Thank you for your understanding and patience through this process. We are happy to help in any way we can. Our ultimate goal is to provide the best possible care to all of our patients.

Sincerely,

Dr. Andrew B. Wolff and Staff

Understanding Your Anatomy and Labral Tears

To simplify things, think of the hip as a ball that fits into a socket. The hip labrum is a rubbery protective ring that sits on the rim of the socket (acetabulum) of your hip joint.

The labrum's role is to hold the top of your femur securely within your hip socket, to decrease pressure on your articular cartilage and to provide stability.

A labral tear is defined by the detachment of the labrum from the rim of the socket. These usually are not acute injuries, rather damage to the labrum accrues gradually with time. This depends on the anatomy of your bones, but also the surrounding musculature—as well as with your activity level. Tears can vary in severity, but it is important to note that oftentimes that does not correlate directly with severity of symptoms. In fact, many people will have labral tears for which they compensate for years before becoming symptomatic. While MRI imaging is important, we do not rely solely on images to determine a treatment plan for you as this is often a multifactorial problem.

It's very important to also factor in your level of pain and function and weigh those against your goals when deciding how to treat you. Prior to recommending surgery, it is important for us to ensure that the hip is indeed the root cause of your symptoms.

Symptoms of a labral tear are variable but typically involve a deep pain in the hip, oftentimes in the front of the hip or groin area. The pain can move around the hip (front, back, side, etc.) and is often accompanied by some degree of muscle soreness in the muscles that control the hip, some tenderness around the hip, and often by some loss of motion. More often than not, symptoms just show up one day and are not brought on by a specific trauma. The vast majority of the time, there is a shape or an orientation to the bones of the femur (the ball), the acetabulum (the socket), or both, that puts the labrum at risk of a tear. Far and away, the most common problem is…

Femoroacetabular Impingement (FAI)

There are two types of FAI: **CAM-type**, which describes an irregular shape of the femur (ball), and **Pincer-type**, which describes an over coverage of the acetabulum (socket). While CAM is the more common type, these two types can, and often do, co-exist.

In **CAM-type FAI**, the ball isn't perfectly round. When it tries to fit into a round socket, there is a shearing force on the rim of the socket. The labrum, sitting at the rim of the socket, can get repetitively displaced overtime, often along with delamination (shearing off) of the adjacent articular cartilage. We worry about the articular cartilage in the hip because this is what keeps the bone of the ball from rubbing on the bone of the socket. When we lose this, we call this osteoarthritis. **With too much loss of cartilage (arthritis), hip arthroscopy will not be effective and the surgical options are limited to hip replacement.** Because CAM-type FAI is the most common reason for osteoarthritis, this is something that we would prefer to correct (when symptoms warrant) to decrease your risk of this developing over time.

In **Pincer-type FAI**, the socket is too deep, either in one area, or more globally. This brings the rim of the socket into closer contact with the neck of the femur. This puts the labrum in a position where it can get crushed and cause pain.

If you have been told you have FAI, don't freak out. Think of FAI as a risk factor for getting symptomatic labral tears (and arthritis), not as necessarily a problem in and of itself.

Surgical Intervention

As there are many people with labral tears who compensate for them (possibly including you prior to when your hip started bothering you), in most cases Dr. Wolff would recommend that you try to compensate for this via non-surgical means. Surgery is not usually recommended unless it has become clear that non-surgical means are not likely to work.

Most Common Procedures

Arthroscopic Labral Treatment

If Dr. Wolff encounters a labral tear at the time of surgery, there are 2 treatment options: **Repair** or **Reconstruction**. There are many studies showing great benefit both biomechanically and functionality to having a well-functioning, healthy labrum. We don't always know based solely on imaging which technique will be used at the time of surgery, though most Dr. Wolff's cases are labral reconstructions. The reason for this is that if you think of FAI and the resultant labral tear as a gradual process of breakdown that happens over time, simply putting a damaged labrum back where it started does not completely address the damage to the tissue of the labrum itself that has accrued over time. It also does not address the often insufficient tissue which remains after removing damaged and painful tissue.

Repair

If the labral tissue is still of good quality but is simply detached from the bone, Dr. Wolff may choose to repair it back to the bone. This is done with plastic suture anchors that go into the bone and have sutures attached which are passed thru and/or around the labrum. When these sutures are tied, they hold the labrum to the bone where it will heal.

These sutures and the anchors aren't absorbable but don't need to be removed because they don't cause a problem unless they are misplaced at the time of surgery. There is NO metal implanted.

Dr. Wolff will typically only employ the repair technique in younger patients with little damage and sufficient good labral tissue. With more time, more damage has typically accrued and the remaining tissue is of poor quality which may put you at risk of needed another surgery to reconstruct the labrum.

Reconstruction

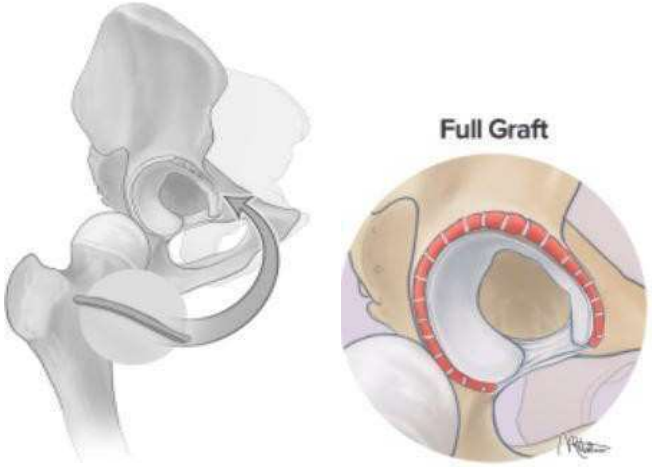
Labral reconstruction is performed when there is insufficient healthy labral tissue to repair.

In this case because we know that patients do better with a well-functioning labrum and have a high failure rate when segments of the labrum are missing or are non-functional, the labrum is taken out and replaced with a donated fascia lata allograft crafted and sized to serve as a new labrum.

This also serves the purpose of eliminating damaged tissue which can be a significant pain generator and replacing it with healthy tissue which your body will incorporate over time. If you had a labral reconstruction, don't be worried or see this as a failure. Rather it is a means to reduce your risk of failure in the future. Rest assured, our goals align with yours. We want you to get better with the least amount of intervention and surgery as possible.

In fact, in Dr. Wolff's experience, which he has shared in multiple peer-reviewed international publications and conferences, labral reconstructions in his hands with his technique fare just as well if not better than the repair patients despite often having to overcome larger challenges (worse labral damage, previous failed surgery, longer duration of symptoms, etc).

Also, don't lose sleep over the use of donated tissue (also known as allografts). These have been used with excellent success and safety profiles for many uses over many years all over the body. The donated tissue does not have antigens on the surface like a donated organ would (think kidney, liver, heart, etc.), therefore your body does not recognize it as foreign and cannot "reject" it in that way.



Cam (Femoral) Osteoplasty

This is the contouring/shaving of the femur bone to make the ball round so the labrum won't continue to tear, and the articular cartilage won't continue to break down. If it has been determined you have a CAM lesion, this will always be corrected at the time of surgery. We use advanced computer navigation software intra-operatively to help ensure that it is corrected in its entirety. Restoring as close to normal mechanics as possible gives you the best chance of a well-functioning hip for the short-, medium-, and long-term.

Pincer (Acetabular) Osteoplasty

This is the contouring of the acetabular (socket) bone to an ideal depth so as to continue to provide structural stability while positioning the labrum in the most functional position.

Synovectomy

The synovium is the cells that line the capsule of the joint and produce joint lubricating fluid. When the synovium gets inflamed, it can be quite painful. A synovectomy is performed by cauterizing the inflamed synovial cells. After the mechanics of the hip have been corrected, when the synovial cells regrow, they will do so in a normal fashion (i.e. not inflamed).

Chondroplasty

This is the process of smoothing irregular and loose edges of articular cartilage. This is only employed if there is some early damage to the articular cartilage.

Microfracture

Small, controlled perforations of the bone are created to stimulate new cartilage to grow. This is only used in certain select situations where there is a small area of missing cartilage. Sometimes we will combine this with another type of graft (osteochondral allograft) to replace the area of missing cartilage. Neither procedure is likely to work in the setting of diffuse cartilage loss (osteoarthritis).

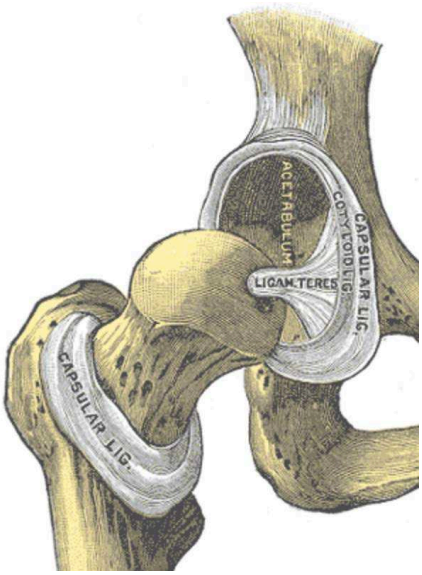
Osteochondral Allograft

When larger areas of cartilage are missing, we will use a donor osteochondral allograft to restore the articular cartilage (with a very thin layer of bone) to the area in which it has been lost. This has been quite effective and durable in situations where the damage is confined to a

limited region of the hip.

Ligamentum Teres Reconstruction

The ligamentum teres is a ligament that runs between the ball and the socket deep in the hip. In some people, it likely plays little role in the overall stability and functioning of their hip, while in others, it likely plays a crucial role. This is more common in patients with hypermobility disorders (e.g. Ehlers-Danlos syndrome) and/or evidence of hip instability. To reconstruct this ligament, a donor tissue graft is placed through the neck and head of the femur and across to the acetabulum and fixed on both ends in an analogous way ACL reconstructions are performed in the knee.



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SURGERY

YOU ARE NOW ON A PATH TO RECOVERY!

HERE IS A BRIEF TIMELINE AS TO WHAT TO EXPECT BOTH BEFORE THE SURGERY AND DURING YOUR RECOVERY

Schedule

- Surgery should be scheduled with Dr. Wolff's assistant at one of the three locations he operates.

Cost

- Make sure you have spoken with our billing specialist to ensure you fully understand the billing and insurance process, as well as your financial obligation.
- Our goal is full transparency and to be your advocate thoughout the process.

Pre-Op

- Dr. Wolff's PA will let you know if there is any pre-operative testing needed.
- Find a physical therapist -- we can assist you with this!
- Secure your ice machine and other recovery tools.
- Ensure we have your correct pharmacy information on file.

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RECOVERY

When will I be back to normal?

Please understand that this is a very patient specific process. Though there are general timelines, every patient heals at a different rate. We ask that you be patient, listen to your body and have a positive outlook as minor setbacks are very common and can be frustrating. Communication about how you are progressing with Dr. Wolff and your physical therapists is key.

Be patient and don't get discouraged!

Crutches

- Expect to use crutches for approx 4 weeks.
- Begin putting weight on your leg right away. Typically try to put about half of the normal amount on it and walk with your crutches.

Physical Therapy

- Begin PT with the first week following surgery -- Expect 2x per week for 3-6 months.
- Therapy shouldn't make you unreasonably sore during or after sessions.
- Think of the protocol as a schedule for when certain motions and activites are **safe to perform**. NOT necessarily when you should be completing and performing them.
- The protocol is set to be a guideline of when certain exercises are tolerated and safe to try.

Return to Full Function

- **Patient specific and variable.**
- Most patients are able to get back to normal life activities quickly, but higher level exercise and athletics will take longer.
- Use pain as your guide and work closely with Dr. Wolff's team and your therapy team to gradually increase your load as you tolerate more.
- Some soreness is normal as are minor setbacks. Avoid continued activity causing worsening pain.

Frequently Asked Questions

Questions regarding Insurance/Financial Obligations:

Our office discloses all pricing for Dr. Wolff's professional fees prior to surgery. We encourage you to call your insurance company so that you are aware of your surgery benefits. Our office will call for professional prior authorization only.

***** Please note: the surgical facility and anesthesia are billed separately*****

We will file your claims for you and advocate on your behalf for payment from your insurance company to limit your personal financial obligation as much as possible. For all questions regarding payment of surgery please contact Dr. Wolff's billing office. If you do not already have this contact information, please contact Dr. Wolff's assistants so that she can ensure your information is accurate and accessible to the billing office prior to your call so that they may be prepared to speak with you.

*****Please note: the professional fees and facility fees for surgery are billed separately*****

Please be sure to contact the facility at which you will have your surgery performed at for any questions concerns/regarding financial obligations for facility fees for surgery.

Do I need a pre-operative clearance?

Dr. Wolff typically does not require a pre-operative clearance unless you have an adverse health history. However, the facility where you are having surgery may require it. Be sure to tell us if you have a history of bleeding/clotting disorders, heart valve defects, diabetes, hypertension, high cholesterol etc. and ensure that we are up to date on your current medications. We will inform you if you need a pre-op exam.

Where do I get my crutches?

You will be given crutches on the day of surgery at the surgery center if you do not have them.

What else can I do to prepare for my recovery?

Ice: The most effective way to control your pain and swelling following surgery is the use of ice and compression. We recommend one of the two following devices.

GameReady Machine: WRS Group is an outside company that will provide this unit and is separate from Wolff Orthopaedics. WRS Group will handle your service and questions. This unit is shipped to your home and typically runs as a 2-week rental with the option to extend. You can contact them directly through their website here info.wrs.us/gr

Proventus Hip Wrap: You can purchase these wraps directly from our office or bring them to the surgery center on the day of your surgery. These wraps come with two gel packs that can be placed in the refrigerator or freezer and offer customizable compression for a pneumatic fit with a hand pump.

What are the instructions for icing?

Whether it be with a machine or ice packs? You will need to cover as much of the surgical area as possible (including the groin) - the more you cover, the better. Ice as much as possible for 30 minutes on and 20-30 minutes off for the full time the device is prescribed. Ice helps tremendously with pain control the first couple of weeks. As long as the wrap is not directly on your skin (wear shorts) you can ice throughout the day and night as needed.

Nutrition: Surgery places increased demands on your body. Adequate protein and key nutrients play an important role in tissue repair, immune function and recovery.

Thrive Protocol: I have found that a structured nutrition protocol designed specifically for surgical patients has a tremendous positive effect on my patient's outcome. Thrive Protocol is a supplement drink that provides high-quality protein, essential amino acids and nutrients that support healing and recovery. Follow the link here or scan the QR code for more information and ordering instructions.
https://mythriveprotocol.com/pages/dr-andy-wolff

Is this type of surgery performed preventatively?

No, it is not a surgery that should be performed unless you are experiencing symptoms caused by the labral tear or femoral acetabular impingement (FAI). It is not recommended that it be performed based solely on an abnormal imaging result.

How many labral repairs has Dr. Wolff performed? Dr. Wolff performs approximately 250 arthroscopic hip surgeries per year. He has been in practice since 2008.

How many labral reconstructions has Dr. Wolff performed? Over 2,000. He performed his first in 2009 and is considered a pioneer in this field. He has shown his technique to be equally or more effective than labral repair.

What type of allograft is used for the reconstruction? A part of a donated Iliotibial band/fascia lata is custom sized and shaped to reconstruct the patient's labrum

If too much arthritis is found during surgery, will Dr. Wolff perform a total hip replacement instead? No, Dr. Wolff will not perform a total hip replacement if too much arthritis is found. Finding too much arthritis in surgery is something that Dr. Wolff tries to prevent, which is why so many imaging studies are carried out before surgery including x-rays, high quality MRIs, CT scans, etc.

What is Dr. Wolff's success rate for this surgery? Over 90% in general. There are, however, factors including arthritis, dysplasia and most commonly, patient non-compliance that may lower this number. Other factors such as patient health, age, and post-operative demands may alter this number. Please remember, all patients are different and heal at their own pace. Please be patient and listen to your body.

When can I drive after surgery? About 1.5 to 2 weeks after surgery.

When do I get my stitches out? 5-14 days after surgery. This will be done at your first post-op appointment the week following surgery.

When can I start Physical Therapy? You may start physical therapy within the first week after surgery. You will be assigned to one protocol after your surgery. The protocols can be found on this website: https://andrewwolffmd.com/pt-overview/.

Additional emphasis on Physical Therapy

Please note: The most important part of therapy is that you are compliant with Dr. Wolff's physical therapy protocols.

Keys:

- **Don't do things that hurt or push through pain.**
- **A good physical therapist will listen to you and adjust based on how your recovery is going, how you have responded in the past and how you are feeling that day.**

Dr. Wolff prefers that you use a therapist that is convenient for you so that you will be able to easily and regularly attend sessions.

Dr. Wolff and staff are always willing to speak with any therapist. If they have any questions, please give them his assistant's contact information.

We are happy to help you find a good therapist if you don't have one.

Surgery Information

What time is my surgery? In most cases, we cannot provide the exact time for the surgery more than 1-2 weeks out. This is because I will need to coordinate laterality between the surgery center and possible surgical patients with comorbidities. The surgery center always has the final say in times and they will call you to confirm the day prior.

How long do the surgeries typically take? Surgery typically takes anywhere from 2 to 3.5 hours.

Surgery Center: You will be given a check list of instructions and information for the surgery and the center where your surgery will be located **INCLUDING THE ADDRESS AND PHONE NUMBER TO THE LOCATION OF YOUR SURGERY**. This checklist should be utilized to make sure nothing is missed prior to surgery.

Post-op Appointment: This appointment is scheduled for you. Details are found in your

surgery packet email and checklist. Future appointments can be scheduled by contacting our office. After the initial post-op, appointments will not be automatically scheduled.

Insurance/Finances: Our office discloses Dr. Wolff's pricing prior to your surgery. We encourage you to call your insurance company, so you are aware of your surgery benefits. **Please note**: the facility fee is billed separately. We will file your claims for the professional fees and advocate on your behalf for payment from your insurance company. For any and all questions regarding payment of surgery please contact Dr. Wolff's office.

Medication: We will prescribe your medications before your surgery and send them all electronically to your pharmacy the week prior. **Please save for AFTER your surgery. Do NOT take these medications before surgery**. If you are experiencing pain please call the office and speak with his assistant to request a different medication prior to surgery. Please read through the post-op medication documents included on the following page for instructions on how and when to take these medications.

Will pre or post-op antibiotics be prescribed? No. During surgery you will receive an IV dose of antibiotics to help prevent infection. Unless there is reason to believe you may have an infection after surgery, we do not provide antibiotics.

If You Have Additional Questions

Questions: Please contact Dr. Wolff's assistant at (202) 838-8837 or contact us through the Spruce App and we will be happy to assist you**. (Please note Spruce is oftentimes the most efficient form of communication.)** You may also visit andrewwolffmd.com for more information regarding your surgery.

Scan to Download Spruce

Post-Operative Medications

The following prescriptions will be e-prescribed to the pharmacy that you have provided in your intake forms. If you prefer they be sent to a different pharmacy than what we have on record, please reach out to let us know at least a week prior to surgery. These are all for AFTER surgery.

Percocet (oxycodone-acetaminophen) 5/325mg – Post-op pain medication to be taken as needed. You should only need this for 2 to 4 days following surgery and may not need it at all. Regular Tylenol (acetaminophen) can also be taken with this or instead of this.

Keep in mind that the maximum dosage of acetaminophen per day is 4,000mg, and each Percocet tablet contains 325mg.

A common side effect of narcotics is constipation, so it's helpful to also use a stool softener like MiraLAX or Colace to combat this. Percocet may also cause nausea, vomiting and sedation, which is why we do not recommend taking it "pre-emptively."

Mobic/Meloxicam 15 mg (with food) -- Once a day for 30 days following surgery. You may start the day of surgery when you get home and have eaten. It may cause an upset stomach or GERD or acid reflux-like symptoms. Let us know if they are not resolved with the antacid (Prilosec or Omeprazole).

We also give 1 refill of this medication. Once you finish the first 30 days of the prescription, see how you feel. If you have pain after stopping the anti-inflammatory, refill the medication and start taking it again. You may try to decrease the dose slowly (skipping daily doses).

Alternatively, you may be prescribed a different anti-inflammatory (Ibuprofen, Celebrex, Naproxen, etc.). Use this as directed. ***Do not take more than one of these different medications at a time.***

Prilosec (omeprazole) 20mg – Antacid to be taken for 14 days to prevent possible side effects (acid reflux) caused by taking meloxicam AND aspirin.

If you are already prescribed an antacid, you may continue your prescription and disregard any that we may have called in for you.

Zofran (Ondansetron) ODT 4mg tablets – Anti-nausea medication to be taken as needed immediately following surgery to prevent nausea and vomiting that may occur after anesthesia. If the pain medication causes nausea, you may also use this medication to help reduce the effects.

Enteric-coated Aspirin 81mg -- This is an anti-coagulant to be taken starting **THE DAY AFTER SURGERY** for a full 14 days after surgery to prevent blood clotting.

If you are 25 years old and under and have no risk factors (no personal or family history of blood clots, are not taking oral contraceptives, non-smoker, etc.), you may not be given this. Alternatively, if you believe you are at an increased risk for whatever reason, please let us know.

Losartan Potassium 25mg -- To be taken for 6 weeks postoperatively for the prevention of adhesions/scar tissue formation in your hip. Losartan is commonly used as a blood pressure medication, but this is a low dose and should have minimal effect on blood pressure.

If you are already taking any type of blood pressure medication, please let us know before starting the losartan. We recommend taking this one at night before going to bed.

Please contact our Physician Assistant Grey Davenport at grey@andrewwolffmd.com if you have any questions regarding the use of these medications.

Hip Arthroscopy Discharge Instructions

Bandages

Your hip will have a waterproof bandage on it after surgery. You may shower with this on. It is not uncommon for the bandage to become soaked from the inside out with reddish/pink fluid. This is because there is fluid continuously pumped through the hip during surgery and some of it may leak out afterwards.

If the bandage becomes too wet, either from the inside out or the outside in, you may remove it and place a dry bandage or band-aids over your incisions. Otherwise remove the dressing 3 days after surgery and cover the incisions with band-aids and gently pat them dry after showering. Do not scrub them.

Do not submerge your hip in water (i.e., no bathtubs, hot tubs, swimming pools) until wounds are fully healed (usually 10-14 days AFTER stitch removal). **DO NOT** use antibiotic ointment on your incisions, you may use vaseline or aquaphor for wound protection after bandage is removed. If you are concerned about how the incisions look, please reach out to us with a picture.

Ice

If you ordered the Proventus hip wrap, patients have the option of picking the wraps up at our office location or having it brought to them at the surgery center.

If you requested a GameReady machine, it will be shipped to you directly. As soon as you get home you may begin using it. You may set this at any level of temperature and or compression that is comfortable.

If you have questions about the settings or working of the machine, **please contact the GameReady representative directly** here's the link: https://info.wrs.us/gr.

If you do not find it comfortable, you may remove it and use a bag of ice or alternative ice wrap. You should keep a layer of clothing between the device and your skin. In general, the more you can ice your hip, the less pain you will have in the first few days following surgery. As more time passes following surgery, cooling becomes less helpful. After the immediate post-operative period, you will likely find it most helpful after you do your therapy exercises or after

exertion/at the end of the day.

Things to watch out for

It is normal for you to have soreness around your hip after surgery.

There can be varying degrees of soreness and sometimes numbness throughout the surgical leg from the traction used at surgery. These will gradually resolve on their own.

It is also not uncommon to have some numbness on the side of your thigh after surgery. This is due to surgical irritation of branches of a sensory skin nerve to your thigh (LFCN). This is also normal and usually resolved with time. It does not have any bearing on your muscle function or recovery; it is a sensory nerve only.

Contact Dr. Wolff at 202-838-8837 if you have any of these symptoms

- A large amount of bright red bleeding through the dressing
- If you are excessively dizzy
- Excessive vomiting
- Fever is over 101.5 degrees
- Foul smelling or pus like discharge
- Your medications do not stop your discomfort
- Chest pain or shortness of breath

Getting Around

Crutches

You should begin putting weight on the leg which had surgery immediately post-op while walking.

You should, however, use crutches to assist in weight for a minimum of 4 weeks (this may be longer depending on your exact surgical procedure) outside of the house.

Around the house, you may begin to go without crutches sooner (1-2 weeks post-op) if you are not having pain or limping when you walk. **Do not limp**.

If you are limping, you must stay on crutches until you can walk without a limp. Using 1 crutch around the house is helpful to allow for a free hand; the crutch goes on the NON-OPERATIVE side.

When you use crutches, you should try to walk as normally as possible while putting less weight on your operative leg than you ordinarily would--the rest should be on your hands and the other leg.

Do not hop on the crutches. Keep your operative side foot flat on the ground and use it to walk--just put less weight through the leg.

It is easier on your hip to rest your leg on the floor than to use all of the muscles around your hip to hold your foot/leg off the floor. Unless specifically instructed otherwise by us, you will be weight bearing as tolerated after surgery.

This means NO LESS than 30% weight bearing on the operative leg regardless of any procedure, but you can put as much weight as feels ok through the leg as long as you are using the crutches.

The crutches are not solely for decreasing weight bearing; they slow you down and help prevent overuse of the muscles around the hip, which is the most common problem post-op.

Please take the time to review our videos on how to use the crutches:
https://andrewwolffmd.com/cruch-training/

Hip Flexion

One of the most common complications after hip arthroscopy is Hip Flexor Tendinitis.

This is an irritation and inflammation of the muscles and tendons that lift the leg. These muscles are particularly at risk after hip arthroscopy because of their location and function. If hip flexor tendinitis develops, it can be very painful and significantly slow down recovery from surgery.

To minimize the risk of this complication, avoid actively lifting your surgical leg when possible. Use your hands or non-surgical leg to support and lift the surgical leg when getting in and out of the car, bed, the bathtub, etc.

The goal is not to avoid all hip flexor activity, just try to minimize it and avoid overuse. You will typically need to assist leg lifting for the first month or so but should do it until you are able to lift it on your own without pain. **This will be further discussed in the PT protocol, but hip flexor strengthening should NOT be a part of your rehab.**

Bed Mobility and Transfers

When moving around in bed, the car, couches, and chairs you may find it painful and difficult to maneuver your surgical leg at first.

As instructed in the previous section, using your arms and non-surgical leg to help support and lift your surgical leg should help to improve your mobility and comfort.

Sitting

Sitting upright can be uncomfortable for a while after hip arthroscopy, especially for long periods.

To avoid discomfort, try not to sit perfectly upright with the hips at a 90-degree angle and try not to sit with your back unsupported. If you need to sit for long periods, try reclining slightly and having a good back support to take pressure off your hips.

You should notice that with time, you are able to sit for longer amounts of time without discomfort. It typically takes months to have no discomfort with prolonged sitting.

Sleep Positioning

Sleep is an important part of recovery. Our bodies do most of their healing when we're resting, so getting a good night's sleep is an essential part of surgical rehabilitation. Like sitting, sleeping can be and often is difficult after hip surgery.

There are no strict guidelines for sleep positioning, but we recommend that you sleep on your back with pillows underneath your whole surgical leg or sleeping on your non-surgical side with a long pillow between your legs/knees.

Sleeping on your stomach is also ok if it does not feel like it pulls too much in front of your hip.

While we do not recommend sleeping on your surgical side for several weeks, do not panic if you inadvertently end up that way in your sleep. While it may result in some increased pain and discomfort, it doesn't ruin the surgery.

Bracing

Bracing is only used for some patients that undergo gluteal or hamstring repairs. If you require a brace, you will be fit for this before or on the day of surgery.

If you have been given a brace, you should wear this when you are going to be up and around for an extended period.

This is used to protect the repair of your hip and to unload some of the pressure from your hip. You do not need to wear this while sitting or in bed. You also may forgo the use of the brace for short distances around home or office.

CPM Machine

We do not use these - they tend to be quite cumbersome and have not provided additional benefit in our experience.

Sequential Compression Devices (SCDs)

You may have been given these at the surgery center to prevent blood clots. These devices go on your lower legs after surgery. They come with a charger and will need to be charged after about 8 hours of use. You should wear them when you will be immobile for a prolonged period of time in the first 2 weeks after surgery. You can wear them at night if you wish, however it's not required (they can be a bit noisy and we want you to get good sleep!).

Ankle Pumps

Ankle pumps are to be done primarily during the first 2 weeks when you are relatively sedentary. They help improve circulation and can help relieve some of the pain and stiffness in the foot and ankle that is common after surgery.

They can be done with the leg elevated, lying down or sitting. Flex the ankle of the operative leg toward the knee as far as possible and hold for five seconds.

Then push the ankle down like stepping on the accelerator pedal of a car and hold this for five seconds.

Repeat this motion ten times and do these in sets of ten as often as possible during the day (at least ten times a day).

Driving

Assuming you have a driver's license, you may drive as soon as you have stopped taking narcotic pain medications and can safely control your leg (typically 1.5 to 2 weeks after surgery).

Particularly if you have had surgery on your right leg, you should practice driving in an empty parking lot prior to driving on a street to be sure that you are safe to be on the road. If you drive a stick shift, it may be a few additional days before you can drive. Just try it out first and see how you feel, if you have pain or feel like you're not up to controlling the vehicle, wait and then try again a few days later.

We are committed to doing everything we can to get you back to your lifestyle.

Contact us if you have any questions.

Additional mobile friendly resources can be found here https://linktr.ee/AndrewWolffMD