

Center for Hip Pain and Preservation Hip Surgical Dislocation Guidelines[©] *

The following hip surgical dislocation guidelines were developed by the Sports Rehabilitation and Performance Center and Pediatric Rehabilitation staff at Hospital for Special Surgery. **Progression is both criteria-based and patient specific. Phases and time frames are designed to give the clinician a general sense of progression.** The rehabilitation program following hip surgical dislocation must be tailored to the exact surgical procedure performed, taking into account tissue and bone healing properties. The program is developed to balance healing, while gently restoring hip range of motion and developing muscular balance and stability in the core, pelvic floor and hip. Special attention is given to not irritating the psoas muscle during patient education of ADLs and in physical therapy exercises. Underlying etiology to this hip pathology is closely examined during the rehabilitation process to ensure mechanics throughout the kinematic chain are not contributing factors in this pathological process.

Follow physician's modifications as prescribed

POST – OPERATIVE PHASE I (DAY 1 – WEEK 6)

GOALS:

- Patient education
- Compliance with self-care, home management, activity modification
- Normalize gait with appropriate assistive device
- 0/10 pain at rest and ambulation
- ROM: Full knee ROM and able to sit comfortably at less than 90° hip flexion

Emphasize:

- PROTECTING SURGICAL SITE
- Minimizing pain and inflammation
- Patient compliance with activity modification

PRECAUTIONS:

- Capsular irritation
- Ambulation to fatigue
- ROM: no rotation, no hip flexion >75° (x 4 wks), >90° (4-6 wks)
- Pivoting or rotating hip during ambulation
- Symptom provocation during ambulation, ADLs, therapeutic exercise
- Active hip flexion with long lever arm, such as SLR
- No active abduction; do not lift your operated leg out from your body in bed transfers or in upright activity
- NO open chain or isolated hip muscle activation, unless isometric.
- Protective WB (30%) x 4 weeks, then progress to 75% weight bearing until 6 weeks MD visit

TREATMENT RECOMMENDATIONS:

- Treatment focus on core and hip stability exercises utilizing isometrics and co-contractions of muscle groups.
- CPM should be used at home for 6 weeks from 0° to 30° for 6-8 hours a day.
- Home exercise program to include: abdominal setting supine, prone abdominal setting with gluteal setting with pillow under hips, quadriceps setting and ankle pumps. Patient education: activity modification, bed mobility, positioning, transitional movements. Gait training with appropriate assistive device on level surfaces and stairs.
- Walking in the water with the water height at chest level is recommended at 4 weeks post-operatively.

CRITERIA FOR ADVANCEMENT:

- Control of pain
- Program may be advanced prior to 6 weeks as per MD

MODIFICATIONS TO PHASE I:

POST – OPERATIVE PHASE 2 (WEEKS 6-12)

GOALS:

- Normalize gait without an assistive device
- Full hip ROM
- 0/10 pain during ADLs
- Ascend/Descend 8” step with good control
- Core control during low demand exercises
- Adequate pelvic stability to meet demands of ADLs

Emphasize:

- Minimizing pain and inflammation
- Patient compliance with activity modification
- Continued protection of hip flexor and faulty movement patterns

PRECAUTIONS:

- Premature discharge of assistive device. Continue to use assistive device until non-antalgic gait
- Symptom provocation during ADLs or therapeutic exercise
- Faulty movement patterns, posture
- Active hip flexion if symptomatic
- Premature use of gym equipment for hip strengthening

TREATMENT RECOMMENDATIONS:

- Core control progression either from upper extremity movement patterns or functional, closed chain movements. Hip strengthening in closed chain function and stability movements; open chain for hip extension and abduction. Functional strength to include: leg press, squats, step up/step downs, contralateral stability with elastic bands, Windmills. Hip Range of Motion with a stable pelvis: bent knee fall out, heel slides. Proprioception and balance exercises: progress from double limb to single limb support.

CRITERIA FOR ADVANCEMENT:

- Range of motion within functional limits
- Able to Ascend/Descend 8”step with good pelvic control
- Good pelvic control during single limb stance
- Normalized gait without an assistive device

MODIFICATIONS TO PHASE II:

POST – OPERATIVE PHASE 3 (WEEKS 12-16)

GOALS:

- Independent home exercise and gym program, as instructed
- Optimize range of motion
- Core control: Level II-III/V based on *Sahrmann scale
- 5/5 lower extremity strength
- Good dynamic balance
- Pain-free ADLs

* Sahrmann abdominal strength scale is used as a measuring tool of progress, not as an exercise progression.

PRECAUTIONS:

- Symptom provocation
- Ignoring functional progression
- Sacrificing quality of movement for quantity

TREATMENT RECOMMENDATIONS:

- Instruction of Range of Motion at end range. Demonstration of moderate level core exercises in functional patterns in quadruped, standing diagonals. Cross training: elliptical trainer and bicycle observing for good core and pelvic control. Initiate plyometrics with an adequate strength base.

CRITERIA FOR ADVANCEMENT:

- Good dynamic balance
- 5/5 lower extremity strength
- Level II-III/V core control (Sahrmann progression)
- Range of motion to meet demands of activities
- Pelvic control with single limb activities

MODIFICATIONS TO PHASE III:

POST – OPERATIVE PHASE 4 (WEEKS 16-20)

GOALS:

- Independent home exercise and gym program, as instructed
- Minimize post-exercise soreness

PRECAUTIONS:

- Symptom provocation
- Ignoring functional progression
- Maintaining adequate strength base

TREATMENT RECOMMENDATIONS:

- Home exercise and gym program, as instructed: strength training and flexibility exercises. Advance plyometric training; initiate running program: interval training. Dynamic balance activities, cutting/agility skills. Advance training of core for strength and endurance. Continue to address muscle imbalances

CRITERIA FOR ADVANCEMENT:

- Core and hip strength and stability to maintain pelvic control
- 0/10 pain with advanced activities
- Optimal range of motion

MODIFICATIONS TO PHASE IV:

For any inquiries regarding the guidelines, please contact one of our physical therapists below:

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