# Rehabilitation Guidelines For Total Hip (Anterior) Arthroplasty

These rehabilitation guidelines are presented in a criterion-based progression. General time frames are given for reference to the average, but individual patients will progress at different rates depending on their age, comorbidities, pre-surgical range of motion, strength, health/functional status, rehabilitation compliance, learning barriers and complications. Specific time frames, restrictions and precautions are given to protect healing tissues and surgical reconstruction. Attention may be given to other musculoskeletal issues in areas above the replaced joint that can influence the outcome of the total hip arthroplasty. The goal of this procedure is to restore daily function and allow return to an active, healthy lifestyle.

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## Outpatient Rehabilitation Guidelines for Total Hip Arthroplasty

| Phase I (surgeryto about 2 weeks after surgery) | | Post-Operative Guidelines |
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| **Appointments** | • Rehabilitation begins 3–5 days after surgery. 1–2 visits per week for 2 weeks<br>• Physician appointment at 10–14 days | • Postoperative dressing is used for the first two weeks/first appointment unless there is a wound problem or bandage begins to fall off.<br>• After day seven, the incision may be uncovered (at home). Nursing Home patients must keep the incision covered.<br>• No baths for two weeks or until incision is fully healed.<br>• Incision care:<br>– Original dressing should be left in place until day 14. If there is drainage, please change the Mepilex with the provided dressing.<br>– Shower at day 5–7 with occlusive wrap over incision (towel/pad/ saran wrap).<br>– Dr. Wollaeger's patients can shower at day two with Mepilex dressing in place.<br>– Shower uncovered after two weeks.<br>– No swimming/soaking/submerging of incision for six weeks.<br>• Protect anterior hip capsule.<br>• Limit SLR in first 4–6 weeks |
| **Rehabilitation Goals and Priorities** | • Protection of the postsurgical hip and incision<br>• Pain control and swelling reduction<br>• Initiate gentle, pain-free range of motion (ROM)<br>• Independent movement with assistive device | |
| **Suggested Therapeutic Exercises** | • Initiate gentle active assistive/passive ROM in all planes<br>• Supine heel slide/leg press<br>• Quad set<br>• Hook-lying core instruction/stabilization<br>• Hook-lying hip flexion<br>• Partial double leg bridge<br>• Standing Hip AROM<br>• Heel raises<br>• Mini squats<br>• Gait training—lateral and stride stance weight shifts; forward/retro gait<br>• Rhomberg and modified tandem balance | |
| **Treatment** | • Soft tissue mobilization to musculature, as needed<br>• Ice and elevation of the leg above heart level 3–4 times a day for 10–20 minutes for pain relief and swelling reduction<br>• Wrap swelling, as needed | |
| **Precautions** | • Weight bearing as tolerated (WBAT)<br>• Protect anterior hip capsule; do not stretch or move into extension beyond what is needed for normal gait | |
| **Progression Criteria** | • Full hip ROM within precautions<br>• Normal gait without an assistive device<br>• Sit to stand from a chair with equal weight bearing and no upper extremity assist<br>• Reciprocal gait ascending stairs with use of railing | |

## Phase II (begin after meeting Phase I criteria, usually 3–6 weeks after surgery)

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| **Appointments** | • 1–2 rehabilitation appointments for 4 weeks. Schedule with PT every 3–4 visits (frequency modified per PT discretion based on patient progression)<br>• Physician appointment at 6 weeks |
| **Rehabilitation Goals and Priorities** | • Restore hip ROM within anterior hip precautions<br>• Maintain pain control/patient comfort<br>• Normalize gait. Patient may discontinue use of assistive device when able to ambulate without a significant limp.<br>• Muscle re-education and motor control of post-op leg<br>• Incision management<br>• Sit to stand from a chair with equal weight bearing and no upper extremity assist<br>• Reciprocal gait ascending stairs with use of railing |
| **Suggested Therapeutic Exercises** | • Continue AROM progression to strengthening<br>• May swim when incision is fully healed<br>• Bridge progression<br>• Clamshell<br>• Side lying hip abduction/adduction progression<br>• Core stabilization progression<br>• Forward step-ups/downs<br>• Balance progression (tandem, foam, wobble board, SLS)<br>• Squat progression<br>• Dynamic gait progression (side stepping, tandem, low hurdles)<br>• Cardiovascular training<br>• Mobility training |
| **Treatment** | • Soft tissue mobilization to musculature, as needed<br>• Wrap edema swelling, as needed<br>• Ice and elevation of the leg above heart level 3–4 time a day for 10–20 minutes for pain relief and swelling reduction |
| **Precautions** | • Continue to avoid end-range extension and external rotation (ER) |
| **Cardiovascular Exercise** | • STM/DTM/MFR as indicated<br>• Initiate scar massage/mobilization once incision is fully healed<br>• Avoid long axis leg distraction mobilization |
| **Progression Criteria** | • Improvement in ROM, muscle function and gait |

## Phase III (begin after meeting Phase II criteria, usually 7+ weeks after surgery)

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| **Appointments** | • Frequency based on need<br>• Physician appointment at 3 month or 1 year, as needed |
| **Rehabilitation Goals and Priorities** | • Restore functional hip strength<br>• Single leg balance with proper hip control<br>• Proper control of the hip/leg with pain-free functional movements<br>• Continue to address Trendelenburg gait<br>• Return to full work and daily activities (high impact not recommended)<br>• Emphasize importance of continued HEP performance |
| **Suggested Therapeutic Exercise** | • Advanced balance training<br>• Lateral step-ups (8–12")<br>• Functional training<br>• Scar massage as needed<br>• Advanced OKC/CKC hip abduction strengthening<br>• Return to work/sport specific activities |
| **Treatment** | • Not anticipated |
| **Precautions** | • Avoid aggressive/forceful stretching of anterior hip capsule in passive, active and functional situations |

These rehabilitation guidelines were developed collaboratively between UW Health and UnityPoint Health - Meriter Rehabiliation and the UW Health Joint Replacement Surgeons.

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## References

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