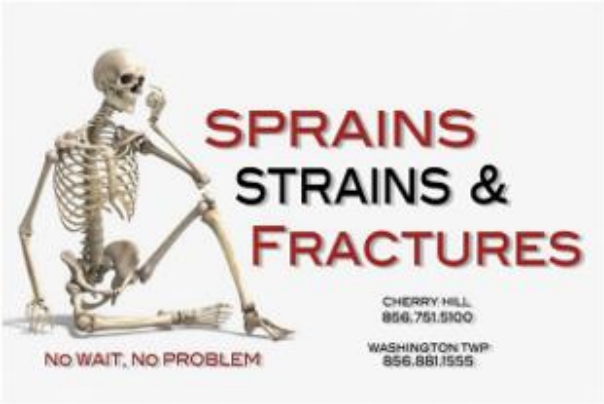

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Hip Arthroscopy Rehab Protocol

Introduction

This rehabilitation protocol is designed for patients undergoing hip arthroscopy for conditions including femoroacetabular impingement (FAI), labral repair or reconstruction, chondral procedures, loose body removal, capsular repair, and related hip preservation procedures.

The goal of rehabilitation is to safely restore hip mobility, dynamic stability, neuromuscular control, strength, and functional movement while protecting healing tissues. Recovery after hip arthroscopy requires a gradual, criterion-based progression. Although many patients begin feeling improved early in recovery, biological healing of the labrum, capsule, cartilage, and surrounding soft tissues continues for several months.

This protocol is intentionally conservative and designed to minimize postoperative irritation, muscular compensation, persistent inflammation, and overload of healing structures.

Progression should always be individualized based on:

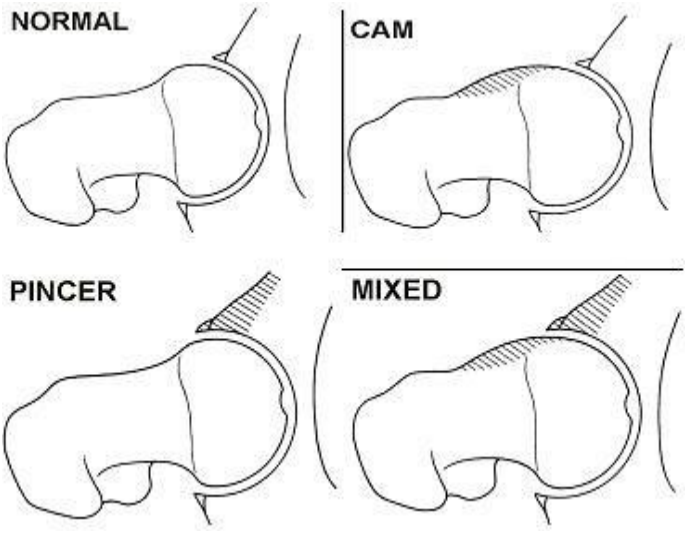
- Surgical findings and procedures performed
- Tissue quality
- Pain and inflammation response
- Range of motion restoration
- Movement quality
- Strength progression
- Functional recovery goals

Communication between the patient, physical therapist, athletic trainer, and Dr. Ford is strongly encouraged throughout recovery.

Surgical Conditions Commonly Treated with Hip Arthroscopy

Femoroacetabular Impingement (FAI)

FAI occurs when abnormal bone morphology leads to mechanical conflict between the femoral head-neck junction and the acetabular rim. This can happen due to genetics or can be related to certain sports at a young age, such as horseback riding, gymnastics, and hockey.



Cam Impingement

A bony prominence forms along the femoral head-neck junction, decreasing clearance during hip motion and increasing stress on the labrum and cartilage. This can lead to pain with bringing your hip and knee up towards your chest or with rotating the hip inward. Over time, this "impingement" can cause tearing to the labrum.

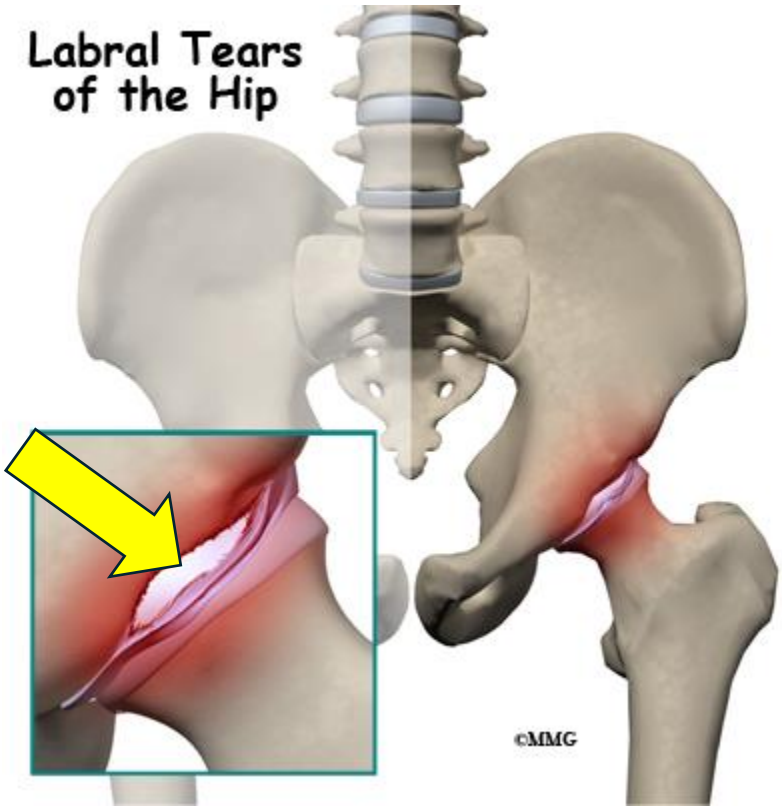
Pincer Impingement

A pincer lesion is when there is "extra bone" on the hip cup side. Excess acetabular coverage causes abnormal contact against the femur, often resulting in labral injury and cartilage overload. It can head to loss of hip motion and pain with certain hip rotations.

Many patients present with a combination of both cam and pincer morphology.

Labral Tears

The acetabular labrum is a fibrocartilaginous structure that deepens the hip socket, contributes to joint stability, and helps maintain the hip suction seal. Injury to the labrum may produce groin pain, clicking, catching, stiffness, or instability. The pain will be felt in the groin and your symptoms may become more noticeable with flexing your hip up towards your chest or



Chondral Injury

Focal cartilage damage may occur alongside impingement or labral pathology. Arthroscopy may involve chondroplasty, microfracture, or cartilage restoration techniques depending on lesion characteristics.

Loose Bodies

Loose fragments of cartilage or bone may become trapped within the joint and cause locking, pain, or mechanical symptoms.

Internal Snapping Hip Syndrome

Tightness or irritation involving the iliopsoas tendon (hip flexor) can contribute to painful snapping sensations within the anterior hip.

Postoperative Considerations

Normal Early Symptoms

The following symptoms are common during early recovery:

- Hip tightness or stiffness
- Mild groin discomfort
- Fatigue with prolonged standing or walking
- Gluteal weakness
- Hip flexor irritation
- Mild swelling or bruising
- Temporary gait abnormalities

Contact Dr. Ford If You Experience:

- Fever greater than 101°F
- Significant calf pain or swelling
- Increasing redness or drainage from incisions
- Shortness of breath
- Progressive numbness or weakness
- Severe uncontrolled pain

General Rehabilitation Principles

Early Priorities

- Protect healing tissue
- Reduce inflammation
- Restore pain-free range of motion
- Normalize gait mechanics
- Prevent muscular inhibition
- Restore core and pelvic control

Long-Term Priorities

- Rebuild gluteal strength
- Restore rotational control

- Improve single-leg stability
- Correct movement compensations
- Gradually return to sport-specific loading

Rehabilitation Timeline Overview

** Note you will not need a brace post-surgery

Phase	Timeline	Primary Goals
Phase I	Weeks 0-2	Protection, pain control, mobility
Phase II	Weeks 2-6	Normalize gait, restore ROM, initiate strength
Phase III	Weeks 6-12	Progressive strengthening and neuromuscular control
Phase IV	Months 3-4	Dynamic strengthening and controlled impact
Phase V	Months 4-6+	Return-to-running and sport progression

PHASE I — PROTECTION & EARLY MOBILITY

Weeks 0-2

Goals

- Protect surgical repair
- Control pain and inflammation
- Restore gentle mobility
- Prevent hip flexor irritation
- Initiate gluteal and core activation
- Normalize weight-bearing progression

Weight Bearing

- Partial weight bearing with two crutches
- Typically 20-50% body weight depending on procedure performed
- Progress only when gait mechanics normalize

Range of Motion Guidelines

- Hip flexion: gradual progression to 90°
- Avoid aggressive external rotation and extension
- Avoid painful impingement positions
- Respect surgeon-specific restrictions

Recommended Interventions

Mobility

- Circumduction exercises
- Passive hip flexion within limits
- Gentle posterior pelvic tilts
- Supine heel slides
- Hamstring stretching
- Hip flexor mobility
- Piriformis and gluteal stretching

Muscle Activation

- Quad sets
- Glute sets
- Transverse abdominis activation
- Isometric adduction
- Gentle bridges
- Standing weight shifts

Cardiovascular

- Upright stationary bike with minimal resistance once tolerated

Avoid

- Straight-leg raises if hip flexor irritation develops
- Aggressive stretching
- Pivoting or twisting
- Prolonged sitting
- Active hip flexor overuse

Criteria to Progress

- Pain well controlled
- Minimal inflammation
- Independent ambulation with crutches
- Tolerates phase I exercises without flare-up

- Improved neuromuscular control

PHASE II — MOTION RESTORATION & FOUNDATIONAL STRENGTH

Weeks 2-6

Goals

- Normalize gait mechanics
- Restore pain-free ROM
- Improve gluteal activation
- Develop pelvic stability
- Initiate closed-chain strengthening
- Improve muscular endurance

Weight Bearing

- Gradually progress to full weight bearing
- Discontinue crutches only after normalized gait pattern achieved

Recommended Interventions

Mobility

- Progressive hip ROM
- Capsular mobility within tolerance
- Dynamic mobility drills
- Thoracic and trunk mobility

Strengthening

- Double-leg bridge progression
- Clamshell progression
- Side-lying hip abduction
- Mini squats
- Step-ups
- Leg press (light resistance)
- Heel raises
- Quadruped stability exercises

Neuromuscular Control

- Single-leg balance
- Lateral weight shifts
- Core stabilization
- Pelvic control drills

Cardiovascular

- Stationary bike
- Elliptical as tolerated
- Pool therapy if incisions healed

Precautions

- Avoid hip flexor overload
- Avoid painful pinching sensations
- Avoid compensatory lumbar extension
- Avoid deep squatting

Criteria to Progress

- Full weight bearing without limp
- Near full ROM with minimal pain
- Improved pelvic stability
- Ability to perform single-leg stance with good control
- Minimal post-exercise inflammation

PHASE III — STRENGTH & NEUROMUSCULAR CONTROL

Weeks 6-12

Goals

- Restore lower extremity strength
- Improve dynamic pelvic control
- Develop rotational stability
- Improve endurance and movement quality
- Prepare for controlled impact progression

Recommended Interventions

Strengthening

- Split squats
- Reverse lunges
- Romanian deadlifts
- Lateral band walks
- Single-leg bridges
- Cable resisted hip exercises
- Progressive leg press
- Hamstring strengthening

Neuromuscular Training

- Single-leg balance progressions
- Step-down control drills
- Multi-directional reach patterns
- Dynamic core stabilization
- Reactive balance drills

Cardiovascular

- Elliptical
- Incline treadmill walking
- Swimming
- Bike intervals

Movement Quality Focus

- Avoid hip drop during single-leg loading
- Maintain trunk control
- Avoid dynamic valgus collapse
- Emphasize controlled eccentric mechanics

Criteria to Initiate Running Progression

- Pain-free walking
- Symmetrical squat mechanics
- Good single-leg balance and control
- Adequate hip and core strength
- No reactive inflammation after strengthening

PHASE IV — ADVANCED STRENGTH & RETURN TO IMPACT

Months 3-4

Goals

- Develop power and muscular endurance
- Improve dynamic force absorption
- Restore athletic movement patterns
- Initiate controlled impact progression

Recommended Interventions

Strength & Power

- Progressive single-leg strengthening
- Lateral lunges
- Bulgarian split squats
- Deadlift progression
- Sled work
- Medicine ball training

Plyometrics

- Double-leg landing mechanics
- Box step landings
- Jump rope progression
- Low-level pogo drills
- Controlled lateral hopping

Running Progression

- Walk/jog intervals
- Gradual volume progression
- Avoid sprinting initially
- Progress only if symptom-free

Sport Preparation

- Agility ladder
- Controlled change-of-direction drills
- Rotational control drills

- Deceleration mechanics

Criteria to Progress

- Pain-free running progression
- Good landing mechanics
- Symmetrical strength and balance
- No post-activity flare-up

PHASE V — RETURN TO SPORT

Months 4-6+

Goals

- Achieve full lower extremity strength
- Restore high-level neuromuscular control
- Return to unrestricted athletic participation
- Reduce reinjury risk

Advanced Training

- Sprint progression
- Cutting and pivoting drills
- Multi-planar agility
- Reactive sport drills
- Acceleration/deceleration mechanics
- Advanced plyometrics

Return-to-Sport Considerations

Return to sport is individualized and based on:

- Procedure performed
- Symptom response
- Strength recovery
- Dynamic movement quality
- Psychological readiness
- Sport-specific demands

Most athletes return to unrestricted participation between 5-7 months following surgery depending on procedure complexity and sport demands.

Physical Therapy Communication Notes

Please contact the surgical team with concerns regarding:

- Persistent hip flexor irritation
- Failure to progress ROM
- Recurrent mechanical symptoms
- Significant gait abnormalities
- Persistent inflammation
- Concerns for instability
- Delayed recovery milestones

Final Notes for Patients

Recovery after hip arthroscopy is a gradual process. Early improvements are encouraging, but long-term success depends on restoring strength, mobility, movement quality, and pelvic stability over time.