LAKE COOK ORTHOPEDICS
T: 847.381.0388
F: 847.381.0811

Total Hip Arthroplasty/Replacement

Post-Operative Rehabilitation Protocol
Dr. Oryhon
Lake Cook Orthopedics

The intent of this protocol is to provide the clinician with a guideline for the postoperative rehabilitation course of a patient that has undergone a total hip replacement with Dr Oryhon. This protocol is no means intended to be a substitute for one's clinical decision making regarding the progression of a patient's post-operative course based on their physical exam/findings, individual progress, and/or the presence of rare post-operative complications. If a clinician requires assistance in the progression of a post-operative patient they should consult with the referring surgeon.

General Instructions/Information:

Use pain medication when the hip hurts.
Take pain medication before doing exercises and apply ice to the hip after exercises.
Ice hip frequently – up to 20 minutes 2-3 times a day.

Antithrombotic compression stockings (TED hose) are suggested for 4 weeks.

Do **not** use heat or heat creams on the operative hip.
Do **not** use pain/anesthetic patches on the hip incision
Do **not** immerse the operative hip under water (no bathtubs/pools x6 weeks)
Do **not** drive until cleared to do so by the doctor (typically 3-6 weeks)

For Mini-Posterior Surgical Approach*:
Follow posterior hip precautions for 6 weeks to allow soft tissues to heal and prevent dislocation
- These are common-sense restrictions and **should not in any way scare the patient**
- Limit flexion past 90° (i.e. bending over, tying shoes, getting up from low chair)
- No internal rotation (turning foot inward) – especially combined with flexion
- Avoid adduction (crossing legs) – especially combined with flexion
- Patient's **can** sleep as comfortable (suggest a pillow between knees when on side for comfort)
- External rotation (foot/ankle on contralateral knee) is permitted and progressively encouraged

For SuperPath Surgical Approach*:
- No specific precautions but avoid extremes of motion for 6 weeks to allow soft tissues to heal
- Avoid repetitive hip flexion exercises (i.e. high-stepping, marching, straight leg raises)
- Refer to specific SuperPath rehab protocol

Physical Therapy/Rehabilitation:

General Guidelines

Weight Bearing as Tolerated (WBAT) unless otherwise instructed
Walker or crutches should be used until able to progress to a cane on advice of therapist (usually progressing to 1 cane/crutch within 1-3 weeks)
Change position at least once an hour, while awake, to avoid stiffness

Active participation in the rehab and diligent performance of prescribed exercises is absolutely essential for optimal outcome

Phase I – Immediate Postoperative Phase (days 1-10)

Goals:

1. Safe and independent use of walker. Progress to cane as appropriate.
2. Understand and adhere to hip precautions; **discontinue foam hip abduction pillow** (when used)
3. Safe and independent transfers
4. Control of swelling, inflammation, bleeding and clotting risk

Exercises:

Quad sets
Gluteal sets
Heel slides
Laying supine abduction & adduction
Short-arc quads/knee extension
Seated long-arc quads/knee extension

Phase II – Intermediate Phase (weeks 2-6)

Goals:

1. Safe and independent use of cane. Wean cane as appropriate.
2. Continue hip precautions
3. Enhance muscular strength/endurance
4. Establish return to functional activities and normalize gait

Additional Exercises:

Mini squats
Calf raises
Bridges
Standing hip abduction and extension
Low step-ups
Stationary bike (high seat so no flexion 90°)

Phase III – Normalization Phase (weeks 6-12)

Goals:

1. Normalize gait – no limp
2. Discontinue hip precautions
3. Increase range of motion (put on shoes/socks easily, foot care)
4. Advance to Home Exercise program
5. Return to work

Additional Exercises:

Stretching (quads, hamstrings, psoas, IT band)
Cardio fitness
Laying side abduction
Balance and proprioception

Phase IV – Advanced Activity Phase (weeks 13+)

Goals:

1. Allow return to recreational sports (golf, tennis, swimming, etc.)
2. Maintain/Improve strength and endurance
3. Return to normal lifestyle

Continued Exercises:

Stretching (quads, hamstrings, psoas, IT band)
Laying side abduction (with resistance?)
Cardio
Core
Weight training

Antibiotic Prophylaxis

It is **strongly** recommended that joint replacement patients take prophylactic antibiotics before any dental work, ear/nose/throat or other invasive procedures (GI scopes are excluded) to prevent normal body bacteria entering the bloodstream from reaching and attaching to the prosthetic joint causing serious infection. The surgeon recommends this for life. Most dental practices have protocols in place but the surgeon will be happy to write the prescriptions for these antibiotics and/or discuss with the treating doctor any concerns that may arise. **In addition**, seek medical treatment **immediately** for suspected urinary tract infections, skin infections (boils, etc) or other infections. If the replaced joint should ever become red, hot, swollen and painful suddenly and the patient is not on antibiotics, **DO NOT** let any doctor give antibiotics until consulting with the orthopedic surgeon (this may seriously complicate the treatment if the joint is found to be infected).

*A note about surgical approach: My clinical experience and the continually emerging orthopedic literature has convinced me that the specific surgical approach I (or any surgeon) uses to accomplish total hip replacement has arguably **no effect** on the early recovery (and certainly none on the long-term outcome) from the operation. I only use minimally invasive surgical techniques in primary hip replacement surgery. These surgical techniques combined with multi-modal pain management

strategies, advances in blood loss management and rapid recovery rehab protocols have resulted in the quicker recoveries we see in hip replacement patients over the past 10 years. Again, surgical approach to the hip is only a small part to this. Patient factors (age, body-type, weight, preop activity, preop muscle strength, stamina, attitude, motivation, expectations, pain tolerance, etc.) most importantly drive the observed rapidity of recovery. The contemporary orthopedic literature does not favor one surgical approach/technique over another. There remains a misconception among the public (particularly on the internet) that anterior approach to total hip replacement is superior to the other approaches. This is not the case based on the evidence. I preformed anterior hip replacement for about a year in my practice and decided in the spring of 2015 to no longer use this technique. This decision was based on multiple clinical factors in addition to the mounting evidence that the specific surgical approach has no significant effect on outcome. I have much more personal confidence in the minimally invasive posterior approaches to accomplish this surgery for all of my patients.