

Hip Arthroscopy (FAI / Labral Repair) Rehab Protocol

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Patient: _____ **DOS:** _____

Surgeon Parameters

20 lb foot-flat WB ____2____ wks	Crutches minimum ____3____ wks	CPM duration ____3____ wks
Brace duration ____3____ wks	Brace — Flexion 0 – ____90____°	Brace — Abduction limit ____45____°
Microfracture: ☐ Labral Reconstruction: ☐ Other Precautions: _____		

Parameters above are patient-specific and supersede the general timeframes below. In general, brace and ROM limitations end together at ≈3 wks. If microfracture is performed, foot-flat weight-bearing with crutches is extended to 6 wks. Supervised PT is most critical during the first 6–12 wks. Therapist to use clinical judgment to individualize exercise selection and pace within each phase.

Phase	Goals	Precautions	Treatment Focus
Phase 1 Weeks 0–6	Goals - Protect labral repair, capsular closure, and osteoplasty site; control pain/swelling/inflammation - Restore early passive motion (≈75–80% of contralateral) and prevent capsular/portal adhesions - Restore gluteal and core activation; prevent hip flexor inhibition/overactivity - Progress weight-bearing and normalize gait; wean crutches no earlier than wk 4	Precautions 20 lb foot-flat WB with crutches x 2 wks (preferred over TTWB to limit hip flexor, knee, and Achilles tightness) - Wks 2–4: slow WB progression; keep crutches through wk 3, wean once gait is non-antalgic - Brace x 3 wks: flexion 0–90°, abduction ≤45°, no ER; no extension past neutral - Avoid active SLR, sitting >30 min or on low/soft surfaces, crossing legs, and pivoting on operative leg If microfracture: foot-flat WB with crutches x 6 wks	Treatment Focus - CPM x 3 wks within brace limits - Upright stationary bike, no resistance, from POD 1 (≈20 min/day, high seat) - PROM within limits: flexion, log-roll/IR, circumduction - Prone lying 1–2 hrs/day to prevent flexion contracture - Isometrics: glute sets, quad sets, TA/core bracing, submax add/abd - STM: adductors, TFL, iliopsoas, QL; portal scar mobilization - Aquatic therapy encouraged once incisions healed (≈wk 2–3) - After brace off: quadruped rocking, bridges, gait training - Ice/modalities PRN pain-swelling
► Advance to Phase 2 when: crutches discontinued with normalized, non-antalgic gait (no Trendelenburg), minimal pain, PROM ≈75–80% of contralateral, no hip flexor irritation.			
Phase 2 Weeks 6–12	Goals - Restore full, symmetric, pain-free ROM - Normalize gait for prolonged ambulation and reciprocal stairs - Progress to dynamic strengthening, bilateral → single-leg - Restore lumbopelvic and single-leg neuromuscular control	Precautions - Avoid hip flexor/adductor irritation — progress volume by response, not calendar - No ballistic or aggressive end-range stretching - No running, jumping, cutting, or impact If microfracture: progress WB and wean crutches wks 6–8; begin closed-chain loading once full WB and pain-free	Treatment Focus - Bike with progressive resistance; elliptical as tolerated - Full PROM/AROM all planes incl. ER and extension; posterior/inferior glides PRN - Bridge → single-leg bridge; mini squat → split squat; step-ups/downs - Lateral band walks, side-plank and core progressions - Single-leg balance/proprioception progression - Gentle hip flexor loading (eccentric psoas) once pain-free - Continue STM and aquatic program PRN
► Advance to Phase 3 when: full symmetric pain-free ROM, normal gait with prolonged ambulation, good pelvic/knee control on single-leg squat and step-down.			

Phase	Goals	Precautions	Treatment Focus
Phase 3 Weeks 12–16	Goals • Restore strength, power, and endurance • Begin return-to-run progression (≈12 wks) • Customized higher-level, multiplanar movement for work/sport demands	Precautions • Before running: pain-free brisk walk ≈30 min and controlled single-leg squat • Advance run volume or intensity, not both, in a given week • Watch for groin/anterior hip pain and compensations (hip drop, valgus, femoral IR) • No cutting, pivoting, or contact	Treatment Focus • Continue Phase 2 program; advance load (machines → free weights) • Hinge, lunge (multiplanar), lateral lunge, adductor (e.g., Copenhagen) progressions • Walk–jog interval program (anti-gravity treadmill if available) • Low-level double-leg plyometrics → submax agility (ladder, lateral shuffle) • Introduce work-/sport-specific drills
► Advance to Phase 4 when: continuous jog ≈20–30 min without pain or compensation, hip strength ≥80% contralateral, pain-free with basic plyometrics.			
Phase 4 Weeks 16+ (≈ Month 4–6)	Goals • Symmetric hip strength (flexion, extension, abd/add, IR/ER ≥90% contralateral) • Pass functional testing (hop tests LSI ≥90%, Y-balance, 5-10-5 agility) • Complete graduated sport-specific progression; confirm psychological readiness (Hip-RSI) • Independent long-term maintenance program	Precautions • Clearance is criteria-based, not time-based alone • Hop/agility testing generally no sooner than ≈16 wks • Contact/high-demand pivoting sports typically held toward ≈6 months • Back off volume with any flare or tendinopathy	Treatment Focus • Advanced plyometrics (box jumps, lateral bounds, single-leg hops) • Cutting, acceleration/deceleration, sport drills at progressive speed and load • Power/performance training • RTS testing: HHD/isokinetic strength, hop battery, Y-balance, 5-10-5; Hip-RSI • Continue STM/ROM PRN
► Full Release (typically 4–6 months / 16–24+ wks): pain-free full ROM, strength and hop LSI ≥90%, no compensation, sport-specific progression completed, psychologically ready, cleared by physician.			

Special Considerations

- Persistent hip flexor/adductor irritation or groin pain is the most common pitfall — reduce volume and address soft tissue before advancing
- Assumes arthroscopic osteoplasty ± labral repair with capsular closure unless noted otherwise; concurrent procedures (e.g., microfracture, labral reconstruction, abductor repair) may modify WB, ROM, and loading. Framework consistent with the 2024 ISHA physiotherapy consensus

Thank you for taking care of our patient.

This protocol serves as a general guideline and outline only. Our team defers to the clinical judgment and expertise of the treating physical therapist to make appropriate adjustments and modifications based on the individual patient's presentation, progress, and response to treatment. For any questions regarding this protocol, please contact Dr. Wollenman directly at (561) 215 – 0184.