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Document Approvals

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This is a controlled document and is intended to be viewed via Q-Pulse therefore printed hardcopies expire within 24 hours from 16:37:52, 27/11/2012.
1.0 Policy Statement
   1.1 It is the policy of Cappagh National Orthopaedic Hospital to provide a patient focused physiotherapy service delivered by chartered physiotherapists and support staff working in a well-equipped environment.

   1.2 It is the policy of Cappagh National Orthopaedic Hospital to provide health professionals and the public with the necessary advice and guidance on physiotherapy rehabilitation.

2.0 Purpose
   2.1 The purpose of this guideline is to advise health professionals and patients on the physiotherapy rehabilitation of a person undergoing a hip arthroscopy.

3.0 Scope
   3.1 This guideline applies to all staff involved in the care of a person undergoing a hip arthroscopy, community staff involved in the pre and post-operative care of the patient, the patient and their family.

4.0 Health & Safety
   4.1 There are health and safety risks involved in patient care, namely risk of physical injury to patient and staff, risk of infection.

   4.2 Physiotherapists have the necessary qualifications and clinical experience to carry out this guideline and to supervise unqualified support staff.

   4.3 They must be eligible for membership of their professional body, the Irish Society of Chartered Physiotherapists (ISCP).

   4.4 They undertake mandatory manual handling, basic life support training, fire safety, infection prevention and control and risk management.

   4.5 They complete a minimum of 100 hours continuing professional development every three years as required by the ISCP.

5.0 Responsibilities
   5.1 It is the responsibility of physiotherapists to implement this guideline.
6.0 Definitions and Abbreviations

Hip Arthroscopy is a minimally invasive surgical procedure in which an examination and sometimes treatment of damage of the interior of a joint is performed using an arthroscope that is inserted into the joint through a small incision.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>ROM</td>
<td>Range of Movement</td>
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<tr>
<td>SLR</td>
<td>Straight Leg Raising</td>
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<tr>
<td>NWB</td>
<td>Non Weight Bearing</td>
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<tr>
<td>PWB</td>
<td>Partial Weight Bearing</td>
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<tr>
<td>ADL</td>
<td>Aids to Daily Living</td>
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<td>HEP</td>
<td>Home Exercise Program</td>
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7.0 Guideline

This is a guideline and any instructions should be guided by the patient’s symptoms and functional ability and/or any specific consultant requirements. All exercises should be performed within the patient’s tolerance level.

7.1 Rehabilitation Phase 1 (Day 1 to Week 4)

7.1.1 Goals

Manage pain and swelling, increase range of movement (ROM) within tolerance, increase strength, protective weight bearing, and correct gait pattern with crutches.

7.1.2 Interventions

7.1.2.1 Monitor weight-bearing status and gait with crutches:

- Always check the weight bearing status with a consultant.
- For procedures requiring bony resection weight bearing is usually restricted to non weight bearing (NWB) or partial weight bearing (PWB) for 4 to 6 weeks.
- If the capsule was involved, the patient is usually required to PWB for about 2 weeks (Cavenaugh, 2006).

7.1.2.2 Hip ROM exercises within pain tolerance:

- Active range of motion is usually initiated 14 days after surgery (Enseki et al, 2006).
- For capsule involvement: avoid external rotation and hyperextension.
- For bony resection: limit flexion to 90 degrees. Full passive range of motion is allowed by 2 weeks (for capsular modification e.g. thermal assisted, placation - by 4 weeks) (Enseki et al, 2006).
- ROM exercises within pain tolerance – heel slides, ankle dorsi/plantar flexion, and internal rotation.

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7.1.2.3 Isometric exercises:
- Gluteals (static bridge, external rotation in prone, squeeze), quadriceps, adductors squeeze, hamstrings (static bridge, heel digs) (Villar, 2008, Distefano et al 2009).

7.1.2.4 Begin core stability work to prepare patient for more advanced exercises in later stages – transversus abdominus in supine.

7.1.2.5 Manual therapy – physiological mobilizations (Villar, 2008).

7.1.2.6 Strengthening exercises of knee and ankle:
- Open chain exercises with elastic band - knee extension, knee flexion in standing, and plantar flexion;
- Hydrotherapy can be started when there is an adequate wound healing - walking in pool (respectively to weight bearing status);
- Continuous passive motion (CPM) device can be used for up to 8 hours per day for 2 to 4 weeks (Enseki et al, 2006).

7.1.2.7 SLR (straight leg raising) in supine should be avoided in the early phase as it may cause pinching in the groin and can put excessive pressure onto the anterior structures within the hip and is often associated with an increased inflammatory response (Enseki et al, 2006).

7.1.2.8 SLR also increases acetabular contact pressure, therefore should not be performed if the articular surface is involved.

7.1.3 Precautions
7.1.3.1 Take care to avoid:
- Capsular irritation
- Ambulation to fatigue
- Pivoting during ambulation
- Symptom provocation
- External rotation, bridging, gluteal sets following capsular procedure.
- Active hip flexion with a long lever (SLR)

7.1.3.2 Weight-bearing as per surgeon’s guidelines.

7.1.3.3 ROM as per surgeon’s guidelines (capsular procedure).
7.2 Rehabilitation Phase 2 (Weeks 5 to Week 10)

7.2.1 Goals
Normalise gait with or without an assistive device - depending on surgeon advice, 0/10 pain during ADL, increase ROM and flexibility within functional limits, continue patient education, improve core stability, begin ROM exercises following a capsular procedure and ligamentus teres repair.

7.2.2 Interventions

7.2.2.1 ROM exercises: quadruped rocking backward bent knee fall out, heel slides, etc.

7.2.2.2 Strengthening exercises:
- Clam shell in side-lying, leg press, squats, step progression.
- In standing: hip abduction, extension with knee extension and with knee flexion to neutral. Can progress to exercises against gravity.
- Hip resistance machine: hip extension with knee extension/knee flexion to neutral.

7.2.2.3 Stretching: hip flexors, gluteus, hamstrings, adductors.

7.2.2.4 Progress aquatic exercises – longer lever arm, more resistance, walking, jogging (no breaststroke for 4-6/52).

7.2.2.5 Pelvis alignment and postural re-education.

7.2.2.6 Progress core stability exercises (can use Pressure Biofeedback): e.g. heel slides in supine, bent knee fall out, quadruped rocking, abdominal curls, etc.

7.2.2.7 Functional exercise – start 6-8 week: squats, lunges, single leg bend, single leg stance, bridging, hip abduction/flexion/rotation/extension in standing with core control (progress with theraband, unstable surface).

7.2.2.8 Balance with single leg support on unstable surfaces (e.g. foam, rocker board, etc.).

7.2.2.9 Cardiovascular exercise: Walking, stationary bicycle, cross trainer, stepper.

7.2.2.10 Manual therapy - physiological and accessory mobilisations.
7.2.3 Precautions
   Take care to avoid:
   - Pain during ADL
   - Pain during exercises: abduction and flexion to tolerance
   - Faulty movement patterns, posture
   - Active hip flexion until pain subsides
   - Capsular and soft tissue irritation
   - Continue to use assistive device until non-antalgic gait is achieved

7.3 Rehabilitation Phase 3 (Weeks 11 to Week 16)

7.3.1 Goals
   Optimise ROM, 5/5 strength, good, dynamic balance, pain free ADL, good core control, improve muscular endurance for return to normal function

7.3.2 Interventions
   7.3.2.1 Core stability - quadruped extremity lifts.
   7.3.2.2 Diagonal patterns with elastic resistance can be progressed from a supported position in supine to weight transfer in standing.
   7.3.2.3 Strengthening program on hip machines as tolerated.
   7.3.2.4 To improve endurance and fitness: cross-trainer, bicycle, stair stepper.
   7.3.2.5 Balance training using a resistance cord, more dynamic movements and unstable surfaces.
   7.3.2.6 Dynamic /Power exercises: lunges, hopping, box jumps, ski fitter (Villar. 2008).
7.4 **Rehabilitation Phase 4 (Weeks 16 to Week 32)**

Return to sport (Enseki et al, 2006) - (Only with clearance from surgeon)

7.4.1 **Goals**

Independent Home Exercise Program (HEP), minimize post-exercise soreness.

7.4.2 **Interventions**

7.4.2.1 **IF REQUIRED:** Progress plyometric training to multiple jumps on two legs to one leg bounding, jumping for distance.

7.4.2.2 Running can be initiated when good pelvic control is demonstrated during single-leg dynamic exercises.

7.4.2.3 Continue ROM, strength, aerobic endurance and power exercises to maintain a good base for plyometric training.

7.4.2.4 Dynamic balance activities.

7.4.3 **Criteria for return to sport**

- Gluteal strength to maintain pelvic control
- VAS 0/10 with advanced activities
- Optimal ROM

8.0 **Related Documents**

Individual Physio tools exercise sheets

9.0 **Appendices**

N/A
10.0 References


