ANDREW L. MERRITT, MD — PROLIANCE ORTHOPEDIC ASSOCIATES

# YOUR HIP REPLACEMENT RECOVERY
# A GUIDE TO PHYSICAL THERAPY

## THE ROLE OF PHYSICAL THERAPY IN YOUR RECOVERY

Dr. Merritt performs hip replacement exclusively through the anterior approach — which means no muscles are cut or detached, and the joint is accessed from the front. This eliminates the dislocation risk and the motion restrictions associated with posterior approach surgery. There are no restrictions on hip bending, sitting in low chairs, or bending forward. The one thing to avoid is bridging exercise for six weeks, as it loads the anterior capsular repair. Walking begins immediately with crutches or a walker — most patients advance to a cane by Week 2 and no device by Week 4–6.

**Important:** There are NO restrictions on bending, sitting, or crossing your legs. You are not at risk of dislocation with the anterior approach. The only restriction is: no bridging exercise for six weeks.

## YOUR RECOVERY TIMELINE

| PHASE | TIMEFRAME | PT VISITS | WHAT YOU'RE WORKING ON |
|---|---|---|---|
| 1 | Weeks 1–2 | 2–3× per week | • Walk right away with walker or crutches — full weight as tolerated<br>• Ice the front of the hip 3–4× daily — keep the hip flexors calm<br>• No bridging exercise — the only restriction for 6 weeks<br>• No bending or sitting restrictions — move freely and comfortably |
| 2 | Weeks 2–6 | 2× per week | • Advance from crutches to a cane, then no device<br>• Hip abductor and gluteal strengthening — essential for normal gait<br>• Walking program — increase distance and pace daily<br>• Avoid aggressive hip flexor loading — keep early exercise modest |
| 3 | Weeks 6–12 | 1× per week then as needed | • Bridging now permitted — advance strengthening program<br>• Return to walking, cycling, swimming, golf, and pickleball<br>• Most patients reach their activity goals by 3 months<br>• Dr. Merritt clears return to specific activities at the 6-week visit |

Questions about your PT progress? Call our office or bring them to your next appointment. We are always glad to coordinate with your therapist.

Great activities after hip replacement: walking, cycling, swimming, elliptical, hiking, golf, and pickleball. Running is possible for motivated patients — discuss with Dr. Merritt.

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# TOTAL HIP ARTHROPLASTY — ANTERIOR APPROACH PHYSICAL THERAPY PROTOCOL

**Patient Name:** _____ **Surgeon:** Andrew L. Merritt, MD
**Date of Surgery:** _____ **PT Start Date:** _____

## Overview & General Principles

Dr. Merritt performs total hip arthroplasty exclusively via the direct anterior approach (DAA). This internervous, intermuscular approach does not detach any muscle insertions and avoids the posterior capsule entirely, eliminating the posterior dislocation risk that defines traditional posterior approach precautions. The anterior approach instead approaches the hip between the tensor fasciae latae and the sartorius, in proximity to the hip flexors. The critical rehabilitation consideration is protecting the hip flexors from overuse inflammation during early recovery — patients commonly feel well, do too much, and develop hip flexor tendinopathy in the first 1–2 weeks. A 'quiet hip' strategy — frequent icing, modest activity levels, and avoiding aggressive hip flexor loading — prevents this. Formal PT is completed by 3 months. After that, patients continue to advance activities independently.

- ANTERIOR APPROACH — NO POSTERIOR PRECAUTIONS: There are NO restrictions on hip flexion, sitting, bending forward, or low chairs. Patients are not at risk of posterior dislocation and should be explicitly told this. The sitting and bending restrictions associated with posterior approach surgery do NOT apply here.
- THE QUIET HIP — FIRST TWO WEEKS: Despite the absence of muscle detachment, the anterior soft tissue dissection creates local inflammation in proximity to the hip flexors. Patients who feel too good and become overly active frequently develop hip flexor tendinopathy in the first 2–4 weeks. Ice the anterior hip 3–4× daily, maintain a modest activity level, and avoid any exercise that loads the hip flexors against resistance.
- ONLY RESTRICTION — NO BRIDGING × 6 WEEKS: The single post-operative restriction in this protocol is avoiding bridging exercises for 6 weeks. Bridging places the hip in combined extension and loading that stresses the anterior capsular repair. All other functional activities — walking, sitting, bending forward, stairs — are unrestricted from Day 1.
- WBAT FROM DAY 1: Weight bearing as tolerated is permitted immediately after surgery. Crutches or a walker are used for the first 1–2 weeks for balance and confidence and are weaned as soon as gait is safe and pain-free.

## PHASE 1 — QUIET HIP RECOVERY (Weeks 0–2)

### INFORMATION FOR THE PATIENT — What to Expect This Phase

You had an anterior approach hip replacement, which means NO restrictions on sitting, bending, or walking. You do not have the typical hip replacement precautions — no height restrictions for chairs, no fear of bending to tie your shoes. Your one restriction is no bridging (lifting your hips off the bed) for six weeks. The most important thing in the first two weeks is to not overdo it. You will likely feel better than expected — resist the urge to be too active. Ice your anterior hip area frequently throughout the day. This prevents a painful hip flexor condition that comes from doing too much too soon.

### Goals:

- Safe and independent ambulation with crutches or walker on level surfaces

- Manage pain and anterior hip soft tissue inflammation
- Establish quad activation, ankle pumps, and gentle hip exercises
- Patient education: anterior approach — no sitting/flexion/bending restrictions
- Stair training with handrail

### Weight-Bearing Status:

Weight bearing as tolerated immediately post-op. Use walker for the first 1–2 weeks for safety and gait support. Wean to single crutch or cane as gait improves. Goal: normal walking pattern by Week 2–3.

### Range of Motion:

No ROM restrictions. Hip flexion, extension, rotation, and abduction are all unrestricted from Day 1. Gentle active ROM exercises begin immediately. There are no chair height, toilet height, or bend-forward restrictions.

### Bracing:

No brace required. No hip precaution restrictions apply to this approach.

### Exercises:

- Ankle pumps — every hour while awake (DVT prophylaxis)
- Quad sets — 3×15
- Heel slides (supine hip flexion/extension) — 3×10
- Supine hip abduction — 3×10
- Supine hip IR/ER gentle ROM (log rolls) — 3×10
- Seated knee extensions (terminal) — 3×15
- Standing hip abduction (support at counter) — 3×10
- Gait training: normal heel-toe pattern, symmetrical step length
- Stair training: up with good leg first, down with operated leg first
- ICE: anterior hip 20 min, 3–4× per day — do not skip
- Short flat walks 2–3× daily — stop before fatigue; build gradually

### Progression Milestones:

- Safe and confident ambulation on level surfaces
- Stair negotiation with handrail, step-over-step by Week 2
- Pain and anterior hip inflammation controlled
- Understanding of anterior approach — no sitting/flexion restrictions

### PHASE 1 PRECAUTIONS — QUIET HIP

- NO BRIDGING × 6 WEEKS — this is the only restriction in this protocol; bridging loads the anterior capsule and hip flexors in extension
- No resisted hip flexion exercises (straight-leg raises against resistance, hip flexor machine) — avoid loading inflamed anterior soft tissues
- No prolonged walking or standing beyond tolerance in the first 1–2 weeks — the anterior soft tissues are easily over-irritated despite minimal pain
- Ice anterior hip 3–4× daily regardless of pain level — prevents hip flexor tendinopathy from developing
- NO posterior approach precautions apply — sitting low, bending forward, and hip flexion are all permitted

*Rationale: The direct anterior approach is performed adjacent to the hip flexors and rectus femoris. Although no muscle is detached, local soft tissue dissection and retraction create inflammation in this region. Patients who are overly active or begin hip flexor exercises too early frequently develop anterior hip flexor tendinopathy in the first 2–4*

*weeks. This is preventable with a modest activity level, frequent icing, and avoiding loaded hip flexion during Phase 1.*

## PHASE 2 — PROGRESSIVE HIP STRENGTHENING (Weeks 2–6)

**INFORMATION FOR THE PATIENT — What to Expect This Phase**

Walking improves and you wean off crutches or a cane during this phase. Hip strengthening progresses — restoring hip abductor and extensor strength is the main driver of a normal, pain-free walking pattern. Continue icing after exercise. No bridging until Week 6.

### Goals:

- Ambulation without assistive device on level surfaces by Week 4–6
- Normal gait — no Trendelenburg, symmetric step length and cadence
- Hip abductor and extensor strength 4/5 MMT
- Functional independence: all ADLs
- Driving cleared (typically 3–4 weeks for right hip; 2 weeks for left with automatic transmission)

### Weight-Bearing Status:

Full weight bearing. Wean to single crutch or cane by Week 2–3. Cane in contralateral hand for community ambulation as needed. Goal: no assistive device on level surfaces by Week 4–6.

### Range of Motion:

Full, unrestricted. Continue ROM exercises as needed for flexibility.

### Bracing:

None.

### Exercises:

- Sidelying hip abduction — 3×15 (progress with resistance band at Week 3)
- Prone hip extension — 3×15 (progress with resistance band at Week 3)
- Standing hip abduction with resistance band — 3×15
- Standing hip extension with resistance band — 3×15
- Mini-squats (0–60°) — 3×15
- Step-ups (4–6 inch) — 3×10
- Standing hip flexion (body weight only — no resistance) — 3×10
- Stationary bike (low resistance, seat high) — 10–20 min
- Single-leg balance: firm surface — 3×20–30 sec
- Calf raises (bilateral → single-leg) — 3×15
- Walking program: progressive distance on flat and uneven surfaces
- Ice anterior hip after exercise — 20 min as needed

### Progression Milestones:

- Ambulating without assistive device on level surfaces
- Hip abduction and extension strength 4/5 MMT

- 20 min flat walking without pain
- Driving cleared by surgeon

**PHASE 2 PRECAUTIONS**

- NO BRIDGING until Week 6 — restriction continues through end of this phase
- No resisted hip flexion (machine or band) until anterior hip discomfort fully resolved — typically cleared at 6-week surgeon follow-up
- No running, jumping, or high-impact activities in Phase 2

*Rationale: Anterior soft tissue healing continues through Week 4–6. Hip flexor loading before this window is complete risks persistent tendinopathy. The bridging restriction continues through Week 6 to allow anterior capsular healing.*

## PHASE 3 — FULL STRENGTHENING & RETURN TO ACTIVITY (Weeks 6 — 3 Months)

**INFORMATION FOR THE PATIENT — What to Expect This Phase**

At Week 6 the bridging restriction is lifted and full hip strengthening begins. This phase is the most productive — strength recovers quickly once the full exercise program is underway. By 3 months, most patients have completed formal PT and are ready to continue independently. The goal is to leave PT with a program you can maintain on your own.

### Goals:

- Bridging and full hip strengthening program established
- Hip and quad strength ≥75–80% contralateral
- Stair negotiation without handrail
- Return to low-impact recreational activities: cycling, swimming, golf
- Patient independent with home maintenance program by Month 3

### Weight-Bearing Status:

Full, unrestricted.

### Range of Motion:

Full, unrestricted.

### Bracing:

None.

### Exercises:

- Glute bridges (bilateral) — 3×15 beginning Week 6
- Single-leg glute bridge — progress at Week 8–10
- Squats (progress depth and load through Month 3) — 3×15
- Leg press (bilateral → single-leg) — 3×12, progress resistance
- Step-ups (8 inch) and eccentric step-downs — 3×10
- Lateral band walks — 3×15 each direction
- Romanian deadlift — 3×12
- Resisted hip flexion with band (Week 6+) — 3×15
- Stationary bike (moderate resistance) — 20–30 min

- Elliptical trainer — 20–30 min
- Swimming (when incision healed) — all strokes
- Single-leg squat and single-leg balance progression — 3×10–12
- Hip flexor stretching program
- Golf: putting/chipping at Week 6–8; full swing at Month 3
- Hiking on flat and moderate terrain: Month 2+

### Progression Milestones:

- No bridging restriction — full hip strengthening program underway
- Hip and quad strength ≥75–80% contralateral
- Stair negotiation step-over-step without handrail
- Low-impact recreational activities (cycling, golf, swimming) without pain
- Independent home maintenance program established by Month 3

### PHASE 3 PRECAUTIONS

- No running or high-impact activities until surgeon clearance (typically Month 3+)
- Monitor anterior hip for tendinopathy with new exercises — if present, reduce resistance and ice after activity
- No pivoting sports or lateral cutting in this phase

*Rationale: Anterior capsular and hip flexor healing is complete by Week 6–8. Full progressive loading is now appropriate. Most patients complete formal PT by Month 3 with sufficient strength and function to continue advancing independently.*

## AFTER 3 MONTHS — INSTRUCTIONS FOR PATIENTS

### Criteria for Return:

- By 3 months, formal physical therapy is complete. You do not need to continue attending PT, but it is important that you keep exercising on your own. Your hip will continue to get stronger for up to a year after surgery — the work you put in at home makes a real difference.
- CONTINUE YOUR STRENGTHENING PROGRAM at home or at a gym 2–3 times per week. Focus on squats, step-ups, hip abduction with a band, and bridges. These exercises protect your new hip long-term.
- WALKING AND LOW-IMPACT CARDIO: Walking, cycling, swimming, and the elliptical are excellent long-term activities. Aim for 30 minutes most days of the week.
- GOLF: Full swing is typically cleared at Month 3. Listen to your body — if your hip is sore after a round, take a day off and reduce how much you play.
- HIKING: Flat and moderate trails are fine from Month 2–3. Use trekking poles on steep or uneven terrain to reduce hip load.
- RUNNING: If you wish to return to running, discuss this with Dr. Merritt. Some patients are cleared to run at 3–4 months; it depends on your implant and how your strength has recovered.
- WHEN TO CALL DR. MERRITT: Contact the office if you develop new groin pain, a clicking or clunking sensation in the hip, significant swelling, or any sensation that something has changed. These symptoms are uncommon but should be evaluated promptly.

### Clinical Note

- There are NO long-term restrictions on sitting, bending, or hip flexion with the anterior approach. Your new hip is stable in all positions. Continue to advance your activities as your strength and comfort allow.

**Surgeon Notes / Special Instructions:**