TOTAL HIP ARTHROPLASTY

Direct Superior Approach • Physical Therapy Protocol • Weeks 0–6

Adam J. Cien, DO - Adult Reconstruction, Hip & Knee Arthroplasty - South Bend Orthopaedics

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No hip precautions. One restriction only.

Direct Superior is muscle-sparing and posterior-sparing — the soft-tissue envelope that resists dislocation stays intact. These patients do **not** follow hip precautions. No 90° flexion limit, no adduction or rotation limit, no abductor pillow, no raised toilet seat. They may sit, sleep, bend, and cross their legs normally from day one.

The only restriction: no resisted hip rotation — against weight, band, or manual resistance — for the first 4–6 weeks. The muscular interval needs that time to seal, and resisted rotation loads that seam directly. Unresisted active rotation through functional range is fine.

Revision hips are different. Revision THA is done posteriorly and standard precautions do apply for 6 weeks. Those patients get a separate protocol — if you are unsure which approach a patient had, call my office before treating.

START OF OUTPATIENT PT	FREQUENCY	WEIGHT BEARING	APPROACH
Post-op day 5–10. Not sooner. If that lands on a weekend, start Monday.	3× per week for ~4 weeks. Walking and icing continue daily at home.	WBAT immediately. Walker week 1; most transition to a cane at week 2–4.	Direct Superior — muscle-sparing, posterior-sparing, external rotators preserved.

Phase-by-phase protocol

PHASE	PRIMARY GOALS	THERAPY FOCUS	CEILINGS & AIDS
Week 1 *Heal*	• Control swelling • Safe independent transfers • Household ambulation with walker • Volitional glute and quad contraction	• Ice over the hip and anterior thigh; elevate 30–40 min, several times daily • Short frequent walks — 5–10 steps every 1–2 hours, not long walks • Gait training: step length, stance time, walker mechanics, stairs one at a time • Isometric glute and quad sets, ankle pumps, gentle AROM — no formal strengthening yet	• Walker at all times • No resisted rotation • No abductor pillow needed • Standard toilet height is fine
Week 2 *Start to move*	• Swelling trending down • Symmetric step length with walker • Longer household and driveway distances	• Gait training remains the priority — quality over distance • Continue AROM; add supine/standing hip abduction and extension without resistance • Core and postural work; sit-to-stand mechanics from a firm chair • Begin light abductor activation — no bands, no cuffs, no manual resistance to rotation	• Walker; cane trial if gait is even • Dressing off ~day 14 • No driving
Weeks 3–4 *Build*	• Walker to cane for most • Gluteus medius control — level pelvis in single-limb stance • Community distances without a limp	• Progressive abductor strengthening: side-lying abduction, bridges, standing hip hikes • Closed-chain work as tolerated: mini-squats, step-ups, sit-to-stand progressions • Balance, proprioception, reciprocal stair training • Graded distance — do not double a tolerated walk. Still no resisted rotation.	• Cane by week 3–4 for most • Aid-free indoors is acceptable if gait is even • Resisted rotation still held
Weeks 5–6 *Graduate*	• Aid-free ambulation without a limp • Reciprocal stairs without a rail • Independent home program	• Advance abductor and extensor strengthening; progress load and single-limb work • Uneven surfaces, community distances, endurance • At 6 weeks, resisted rotation may be introduced and restrictions come off • Transition to an independent home or gym program	• Cane outdoors and on uneven ground as needed • Restrictions lift at 6 weeks

Functional milestones. These hips progress by gait quality, not range of motion. Do not advance distance or drop a device to hit a date.

END OF WEEK 1	END OF WEEK 2	WEEK 4	WEEK 6
Independent transfers, household walking	**Even step length; cane trial**	**Cane or aid-free indoors; level pelvis**	**Aid-free, no limp, reciprocal stairs**

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High-yield do and do not

What I want from therapy

- Gait, gait, gait. A limp at six weeks is almost always an abductor problem, and it is far easier to prevent than to correct.
- Build the gluteus medius. Level pelvis in single-limb stance is the single best predictor of how these patients look at six weeks.
- Reinforce that there are no precautions. Patients arrive expecting restrictions and self-limit anyway. Tell them explicitly they can sit, sleep, bend, and cross their legs.
- Short, frequent, low-load early. Ice and elevation over the hip and anterior thigh are treatment, not comfort measures.
- Progress distance gradually. A patient who tolerated twenty minutes should not attempt an hour the next day.

What I do not want in the first 6 weeks

- No resisted hip rotation — internal or external, against band, cuff weight, or your hand.
- No hip precautions. Do not issue a 90° limit, an abductor pillow, a raised toilet seat, or leg-crossing rules to a Direct Superior patient.
- No aggressive end-range stretching into flexion or rotation.
- No chasing distance or dropping an assistive device to hit a calendar date — gait quality decides.
- No pushing through a hip that is more swollen, warmer, or more painful than the prior session. Back off the load and add edema control.

Milestone triggers — when to call me

CHECKPOINT	IF THE PATIENT IS NOT MEETING THIS	DO THIS
Week 2	Still fully dependent on the walker with no improvement in step length, or swelling not trending down	Add edema control and reassess gait mechanics. Notify my office.
Week 4	Persistent Trendelenburg, or no progression off the walker	Call my office. Refocus on abductor strengthening before advancing distance.
Week 6	Still limping, still using a walker, or unable to do reciprocal stairs	Call my office the same week so we can look at it together.
Any time	Groin or thigh pain that increases with weight bearing, or progress that reverses week over week	Stop advancing, reduce load, and contact my office.

Stop therapy and contact my office the same day

Sudden severe hip or groin pain with an inability to bear weight, or a limb that appears newly shortened and rotated — send to the ER • Calf that is hard, tense, or asymmetrically swollen with pain • Fever above 101.5°F lasting more than 24 hours, or shaking chills • Incisional drainage that soaks a dressing, fresh spreading blood, or wound dehiscence • Spreading erythema around the incision • Sudden shortness of breath or pleuritic chest pain (call 911) • A new audible or palpable clunk with weight bearing

Logistics

Driving and return to work

- Driving: decided jointly by the therapist and my office. Two conditions must both be met — completely off narcotics, and enough strength and reaction time for an emergency stop. Typically 2–6 weeks; left knees sooner than right.
- Return to work: desk work is often reasonable at 3–4 weeks if the commute and seated time do not aggravate swelling. Standing, stairs, and lifting jobs: plan 6–12 weeks. Heavy labor is case by case — call me.

Communication with my office

- Send progress notes with gait status, assistive device, single-limb stance and Trendelenburg findings, hip AROM, and abductor strength.
- Notes are due before the 2-week and 6-week office visits.
- Call 574-247-9441 with any milestone concern — I would rather hear from you early than at week 10.
- Patient-facing materials, including the hip Week-by-Week Recovery Guide, are downloadable at DrAdamCien.com/recovery.

Where this protocol comes from. The early low-irritability framework is adapted in principle from Dr. Andrew Wickline's slow-rehabilitation work (Less Swelling, Less Pain), originally developed for total knee arthroplasty. The hip-specific milestones, restrictions, and progressions here are my own, based on Direct Superior technique and my practice volume.