REVISION TOTAL HIP ARTHROPLASTY

Posterior Approach • Physical Therapy Protocol • Weeks 0–6

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Precautions apply. This is not my Direct Superior protocol — do not treat it as one.

Revision hips are done posteriorly. The envelope behind the hip is taken down and repaired, and revision constructs carry a materially higher dislocation risk than a primary. **Standard posterior precautions apply for a full 6 weeks:**

- **No hip flexion past 90°**
- **No adduction past midline**
- **No internal rotation of the operated leg**

Abductor pillow at night. Elevated toilet seat, firm high-seat chair with armrests, no low or soft seating, no bending to the floor. Reinforce precautions every visit — many of these patients had a primary with no precautions and assume the same rules apply.

Confirm with my office before the first session

Revision cases are not uniform. The operative note governs, and these four items change what you can do:

Weight-bearing status (do not assume WBAT) • **Trochanteric osteotomy or abductor repair** (if either, no active or resisted abduction until I clear it) • **Bone graft or structural augment** (may extend protected weight bearing)

If any of these is unclear, call 574-247-9441 before treating. Do not advance weight bearing or lift a precaution on your own judgment.

START OF OUTPATIENT PT	FREQUENCY	WEIGHT BEARING	APPROACH
Post-op day 5–10 unless my office specifies otherwise.	3× per week for 4–6 weeks. Expect a longer course than a primary.	Per the operative note — confirm before session one. Walker through week 6 is typical.	Posterior. External rotators and capsule taken down and repaired.

Phase-by-phase protocol

PHASE	PRIMARY GOALS	THERAPY FOCUS	CEILINGS & AIDS
Week 1 *Protect*	• Precautions understood and demonstrated • Safe transfers within precautions • Household ambulation with walker • Control swelling	• Precaution training first — bed mobility, log roll, car transfer, toilet and chair heights • Gait training at the prescribed weight-bearing status; stairs step-to • Isometric glute and quad sets, ankle pumps, AROM strictly within precaution limits • Ice and elevate 30–40 min several times daily. No formal strengthening, no PROM into the restricted planes.	• Walker at all times • Abductor pillow at night • Elevated toilet seat • Flexion limit 90°
Week 2 *Stabilize*	• Independent, precaution-compliant transfers • Swelling trending down • Longer household distances	• Re-test precaution compliance every visit — do not assume it carried over • Continue gait training; emphasize step length and stance time • Standing hip extension and supported AROM within limits; sit-to-stand from an elevated firm surface • Isometric abduction only if the operative note confirms abductors are intact	• Walker • Precautions unchanged • No driving
Weeks 3–4 *Build within limits*	• Community distances with walker • Abductor activation if cleared • Improving gait symmetry	• Progressive abductor and extensor work in supported positions — only if cleared • Closed-chain work as the weight-bearing order allows: mini-squats above 90°, step-ups • Balance and proprioception; continue step-to stairs • Graded distance — revision patients fatigue earlier. Precautions unchanged.	• Walker still expected • Cane only if I have cleared it • Precautions unchanged
Weeks 5–6 *Transition*	• Steady gait at community distance • Ready to progress the device at 6 weeks • Independent home program	• Continue strengthening; add single-limb work and uneven surfaces as stability allows • At 6 weeks precautions come off and the device progresses — after my office confirms it, not before • Expect the full course to run longer than a primary. Do not compress the timeline.	• Precautions lift at 6 weeks on my confirmation • Walker to cane at that point for most

Functional milestones. Revision hips progress slower than primaries. Device progression and precaution release come from my office, not a calendar.

END OF WEEK 1	END OF WEEK 2	WEEK 4	WEEK 6
Safe transfers within precautions	**Household walking, even step length**	**Community distance with walker**	**Precautions off, walker to cane**

High-yield do and do not

What I want from therapy

- Reinforce precautions every single visit. Many of these patients had a Direct Superior primary with no precautions and assume the same rules apply now. They do not.
- Verify the weight-bearing order before session one and keep to it exactly.
- Teach the environment, not just the exercise — chair and toilet height, car transfer, bed mobility.
- Expect abductor weakness. A limp at six weeks may be structural, not an effort problem.
- Know what a dislocation looks like and act immediately. Call me with anything that does not fit — I would rather field an unnecessary call.

What I do not want in the first 6 weeks

- No flexion past 90°, no adduction past midline, no internal rotation — actively or passively, in any position, including on the mat.
- No PROM into the restricted planes, no end-range stretching, no hip mobilization.
- No advancing weight-bearing status or dropping a precaution on your own judgment. That call is mine.
- No active or resisted abduction if there was a trochanteric osteotomy or abductor repair, until I clear it.
- No low or soft seating, no floor transfers, no deep squats. No applying primary THA timelines — revision recovery is simply slower.

Milestone triggers — when to call me

CHECKPOINT	IF THE PATIENT IS NOT MEETING THIS	DO THIS
Any session	The patient cannot reliably maintain precautions, or the home setup does not support them	Call my office. A patient who cannot comply with precautions needs a different plan, not more repetitions.
Week 2	Unsafe or dependent transfers, or swelling not trending down	Notify my office. Reassess the home setup and add edema control.
Week 4	No progression in walking distance, or abductor weakness with no measurable change	Call my office before advancing anything.
Any time	New or increasing groin or thigh pain with weight bearing, a sense of the hip giving way, or a new limb-length difference	Stop, keep the patient non-weight-bearing on that limb, and contact my office the same day.

Send to the emergency department — do not wait for a callback

Suspected dislocation: sudden severe hip or groin pain, inability to bear weight, and a limb that appears shortened and internally rotated. Do not attempt to reduce it, do not ambulate the patient, and do not send them home to call in the morning. **This is the complication this protocol exists to prevent.**

Also same-day: clunk with weight bearing • calf that is hard, tense, or asymmetrically swollen with pain • fever above 101.5°F over 24 hours or shaking chills • drainage soaking a dressing or wound dehiscence • spreading erythema • sudden shortness of breath or pleuritic chest pain (call 911)

Logistics

Driving and return to work

- Driving: my call, not the therapist's, for revision patients. The patient must be off narcotics entirely, out of precautions, and able to enter and exit a car safely. Expect this to be later than a primary.
- Return to work: case by case and generally later than a primary. Seated work is limited by the 90° precaution and car transfers, not just by pain. Do not clear anyone without calling me.

Communication with my office

- Send progress notes with weight-bearing status observed, precaution compliance, assistive device, gait findings, hip AROM within limits, and abductor strength.
- Notes are due before the 2-week and 6-week visits.
- Call 574-247-9441 with any milestone concern — I would rather hear from you early than at week 10.
- The patient-facing hip Recovery Guide is written for primary Direct Superior patients. Do not give it to a revision patient as their plan.

Where this protocol comes from. Where a case-specific order in the operative note conflicts with this sheet, the operative note governs — call my office if the two disagree.

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