Outpatient Rehabilitation Protocol Following DIRECT ANTERIOR TOTAL HIP ARTHROPLASTY

This muscle-sparing, direct anterior approach (DAA) preserves the posterior hip capsule and short external rotators, and does not require standard hip dislocation precautions. Patients may move and bear weight as tolerated within pain limits and physician-specified weight-bearing status. This protocol is intended for the outpatient physical therapy course, typically beginning within the first 1-2 weeks after surgery and progressing through week 12.

REFERRAL TO OUTPATIENT THERAPY

Patients are typically referred to outpatient physical therapy within the first 1-2 weeks following surgery. The initial outpatient evaluation should include:

- Review of surgical approach, weight-bearing status, and any physician-specified deviations from standard protocol
- Assessment of incision, edema, gait, and current assistive device use
- Baseline hip/knee/ankle ROM, strength, and functional mobility
- Review of home exercise program compliance since discharge

Phase I – Early Outpatient (Weeks 0-2):

Goals:

- Diminish pain, swelling, and post-surgical inflammation
- Restore normal gait pattern with appropriate assistive device
- Regain hip and lower extremity active ROM in all planes
- Reactivate gluteal and quadriceps musculature
- Independent with home exercise program and activities of daily living

Weight Bearing:

- Weight bearing as tolerated (WBAT) unless otherwise specified by physician
- Progress from assistive device (walker/cane) to unassisted ambulation as strength, balance, and gait mechanics allow

No hip precautions are required with this direct anterior approach – the patient may move, sit, stand, bend, and rotate the hip freely as pain and weight-bearing status allow.

Weeks 0-2:

- Cryotherapy and edema management as needed
- Active and active-assisted hip ROM in all planes – flexion, extension, abduction, adduction, internal/external rotation
- Ankle pumps and quad sets
- Gluteal sets and submaximal isometrics (abduction, extension)
- Heel slides / supine active-assisted hip and knee flexion

- Supine and standing hip abduction/extension as tolerated
- Gait training – progress assistive device as appropriate
- Stationary bike (no resistance) for ROM once comfortable
- Scar mobility once incision is clean, dry, and healed

Phase II – Progressive Strengthening (Weeks 2-6):

Goals:

- Normalize gait without assistive device
- Restore full active and passive hip ROM
- Progress hip abductor, extensor, and quadriceps strength
- Improve single-leg balance and postural control
- Return to most activities of daily living without limitation

Weeks 2-4:

- Discontinue assistive device once gait is safe and symmetrical
- Closed kinetic chain exercises – mini-squats, sit-to-stand, step-ups (low height)
- Hip strengthening with resistance bands – abduction, extension, external rotation
- Standing hip flexion/extension/abduction with light resistance as tolerated
- Balance training – double-leg progressing to single-leg stance
- Stationary bike with light resistance
- Continue stretching for hip flexor, hamstring, and IT band flexibility

Weeks 4-6:

- Progress closed kinetic chain strengthening through fuller range
- Standing hip abduction/extension with increasing resistance
- Step-ups/step-downs progressing in height
- Multi-planar balance and proprioceptive training
- Nustep or elliptical for conditioning as tolerated
- Initiate light functional activities – stairs, uneven surfaces – as strength and confidence allow

Phase III – Advanced Strengthening and Functional Return (Weeks 6-12):

Goals:

- Achieve strength and ROM symmetry with the uninvolved limb
- Restore normal gait mechanics on level and uneven surfaces, and on stairs
- Improve muscular endurance, balance, and dynamic stability
- Return to prior level of function, work, and recreational activities per physician clearance

Weeks 6-8:

- Progressive resistance training – squats, lunges, leg press, hip abduction/extension machines as available
- Single-leg balance and dynamic stability drills

- Core and trunk stabilization exercises
- Treadmill or overground walking program for endurance
- Functional training – floor-to-stand transitions, carrying tasks, stair negotiation without rail

Weeks 8-12:

- Advance strengthening intensity and resistance as tolerated
- Introduce light impact/conditioning activities (walking program progression, stationary bike intervals, elliptical) as appropriate for patient goals
- Continue single-leg strength and balance progression toward symmetry with uninvolved side
- Discharge planning – transition to independent home/gym-based maintenance program
- Progress toward return to recreational activity, work duties, or sport-specific training as directed by physician

This protocol is designed to be administered by a licensed physical therapist and/or certified athletic trainer in the outpatient setting.

Please do not hesitate to contact our office should you have any questions concerning the rehabilitation process.