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SPORTS MEDICINE | JOINT REPLACEMENT

# Abductor Repair

*Core Rehabilitation Guidelines*

- Foot-flat weight bearing 20%, with assistive devices for 2-4 weeks
- Hip brace for 6 weeks
    - No active hip abduction or internal rotation the first 6 weeks
    - No passive hip adduction or external rotation the first 6 weeks
- Gait training first 6 weeks, then formal rehabilitation to start after 6 week mark with progressive weight bearing around 8-10 weeks
- Post-op appointments with Dr. Ramkumar: 2 weeks, 6 weeks, 12 weeks, 6 months, 1 year
- Everyone will progress through the guidelines at their own pace.
- You may need a cane for prolonged walking even after discharge from physical therapy

*Specific Timeline: Weeks 0-6*

- Precautions:
    - Foot flat weight bearing, 20 pounds, with assistive device (crutches or walker)
    - NO active hip abduction or internal rotation
    - NO passive hip adduction or external rotation
    - Monitor for hip flexor tendonitis, trochanteric bursitis and anterior knee pain
- Wound care
- Assessment:
    - Precaution awareness, as listed above
    - Gait pattern with assistive device
- Bed mobility and transfers
    - Understanding of continuous passive motion machine
    - Activity modification inside and outside of the home
    - Patient and family education
- Treatment Recommendations:
    - No formal physical therapy until after 6 week follow up
    - Gait training
    - FFWB, 20 pounds, with assistive device (crutches or walker)
- Can break up the sessions into 1 hour increments
- Home Exercise Program
    - Ankle pumps
    - Quadriceps sets
    - Pelvic tilts
- Patient Education
    - Rehabilitation timeline
- Activity modification
    - Icing, frequently during the day in 20-30minute increments
- Advancement Criteria:
    - 6 week follow up with Dr. Ramkumar
    - Progress weight bearing, with assistive device, after clearance from Dr. Ramkumar

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- Initiate formal outpatient physical therapy

*Specific Timeline: Weeks 6-12*

- Precautions:
  - Avoid premature progression of weight bearing status and activity level
  - Gait deviations
  - Perform gentle passive hip external rotation, internal rotation and abduction
  - Avoid hip adduction past neutral
  - No increase in symptoms with progressions
- Assessment:
  - Gait pattern with weight bearing progressions and assistive device
  - Scar and soft tissue mobility
  - Range of motion in lower extremity
  - Strength in lower extremity
  - Bed mobility and transfers
  - Functional movement patterns – control, quality, alignment
    - Bilateral leg squat
    - Single leg stance
  - Activity modification and tolerance inside and outside of the home
- Treatment Recommendations:
  - Gait training, with assistive device (crutches or walker)
  - Progress weight bearing from FFWB to WBAT over post-op weeks 8-10
  - Assistive device weaning as tolerated
  - May use cane after crutches or walker are discharged
  - Manual therapy
    - Scar massage
    - Soft tissue to hip flexors and glutes as needed and tolerated
    - Passive range of motion to hip flexion
    - Gentle hip external and internal rotation, abduction
    - Stretching of hip flexors
  - Stretching
    - Self-stretching to hip flexors and calf
    - Quad rocking - gentle
  - Balance
    - Weight shifting
    - Double leg to single leg
    - Floor, foam, board, etc
  - Functional movements
    - Mini squats for sit to stand
    - Transfers
    - Stair navigation
    - Ergonomics
  - Strengthening
    - Isometric hip adduction, hip extension and external rotation

  - Quadriceps sets to short arc quads
  - Prone gluteal squeezes and progress to bridges
  - Standing strengthening for lower extremity as tolerated
  - Calf raises, mini squats, hip extension
  - Core strengthening
    - Pelvic tilts
    - Hooklying marches/taps
    - Hooklying with upper extremity movements
    - Standing strengthening as tolerated
  - Stationary bicycle
  - Isometric hip abduction progression (approximately 8-10 weeks post-op)
  - Isometric bent knee fall-out
  - Supine hip abduction isometric
  - Aquatic therapy, if available
  - Home Exercise Program - dictated by your physical therapist
  - Icing – daily as needed and tolerated
- Advancement Criteria:
  - Compliance with self-care, activities of daily living and activity modification
  - Gait pattern normalized (may need cane for prolonged ambulation)
  - Range of motion within normal limits (except adduction)
  - No increased pain with increased activity
  - Single leg stance for 10 seconds with no trunk or hip deviations
  - Perform sit to stand with minimal upper extremity support
  - Follow up appointment at approximately 12 weeks with Dr. Ramkumar

*Specific Timeline: Weeks 13-Week 24*

- Precautions:
  - Avoid premature progression of activity level and gym program (as directed)
  - Gait deviations
  - Monitor for hip flexor tendonitis and/or trochanteric bursitis
  - No increase in symptoms with progressions
  - No sports specific or impact activity
  - Assessment:
- Gait pattern
- Scar and soft tissue mobility
- Range of motion in lower extremity
- Strength in lower extremity
- Bed mobility and transfers
- Activity modification and tolerance inside and outside of the home
- Functional movement patterns – control, quality, alignment
  - Bilateral and single leg squat
  - Single leg stance
- Treatment Recommendations:
  - Continue previous treatment recommendations as needed
  - Manual therapy

- Stretching to lower extremity as needed
- Scar massage
- Soft tissue to hip flexors, adductors, abductors, glutes, as needed and tolerated
- Passive range of motion to hip
- Stretching
  - Self stretching to hip flexors, adductors, glutes, piriformis and hamstrings
  - Foam rolling
  - Balance and proprioception
  - Double leg to single leg
  - Floor, foam, board, etc
  - Progress to include dynamic activities
- Functional movements
  - Squats for sit to stand
  - Transfers
  - Stair navigation
  - Ergonomics
- Strengthening
  - Bridges: Double leg and single leg
  - Leg press: Double leg and single leg
    - Concentric and eccentric strength
  - Standing strengthening for lower extremity as tolerated
    - Open chain and closed chain (hip abduction, hip extension)
    - Side stepping: no resistance and progress to include resistance
      - Progress resistance from short lever to long lever
  - Step up
    - 4” to 6” to 8”: watch for compensations
  - Step down
    - 4” to 6” to 8”: watch for compensations
  - Core strengthening
    - Cable column rotations and presses (pallof press)
    - bilateral LE → single LE (watch for stability and form)
    - Planks – front and side
      - Progress from modified to full, as appropriate and tolerated
  - Stationary bicycle
  - Elliptical (when patient can demonstrate good mechanics with 6” step up)
  - Aquatic therapy, if available
- Patient education – may need cane for prolonged ambulation
- Home Exercise Program - dictated by your physical therapist
- Icing – daily as needed and tolerated

- Advancement Criteria:
  - Compliance with self-care, activities of daily living and activity modification
  - Pain free or manageable discomfort with ADLs and activity progression
  - Full active and passive range of motion
  - Perform squat with good symmetry

- Ascend and descend 6”-8” step with good quality and control
- Single leg stance > 20 seconds without trunk or hip deviations
- Independent floor transfers
- Follow up appointment at approximately 24 weeks with Dr. Ramkumar

*Specific Timeline: Weeks 25 and Beyond*

- Precautions:
  - Avoid premature progression of activity level, gym program and recreational activities
  - Gait deviations
  - Monitor for hip flexor tendonitis and/or trochanteric bursitis
  - No increase in symptoms with progressions
- Assessment:
  - Gait pattern
  - Scar and soft tissue mobility
  - Range of motion in lower extremity
  - Strength in lower extremity
  - Activity modification and tolerance inside and outside of the home
  - Functional movement patterns – control, quality, alignment
    - Bilateral and single leg squat
    - Single leg stance
  - Return to Sport testing, if applicable
  - Precaution awareness, as listed above
- Treatment Recommendations:
  - Continue previous treatment recommendations as needed
  - Manual therapy
    - To hip as needed
    - Scar and soft tissue massage
  - Stretching
    - Continue from previous phase
  - Balance and proprioception
    - Progress to include dynamic activities
  - Functional movements
  - Strengthening
    - Continue previous strengthening as needed
    - Advanced core and hip strength and endurance exercises
    - Static lunges, as appropriate
  - Lower extremity and Core strengthening
    - Dynamic strengthening and progressive strengthening as tolerated
  - Sports specific activity, as appropriate
  - Stationary bicycle or elliptical for cross training
  - Home Exercise Program - dictated by your physical therapist
  - Icing – daily as needed
- Advancement and Discharge Criteria:
  - Compliance with self-care, activities of daily living and activity modification

- Pain free or manageable discomfort with ADLs and activity progression
- MMT WFL
- Full active and passive range of motion
- Normalized functional movement patterns – control, quality, alignment
  - Bilateral and single leg squat
  - Single leg stance
- Sport specific testing (If applicable)