

TOTAL HIP REPLACEMENT

Physical Therapy Protocol · Anterior Approach

PATIENT

SURGEON

Andrew L. Merritt, MD

DATE OF SURGERY

PT START DATE

For the patient

Dr. Merritt does hip replacement only through the **anterior approach**: no muscles are cut or detached. This **greatly lowers the risk of dislocation (well under 1%)** and removes the movement restrictions of the older posterior approach. **You have no restrictions on bending, sitting in low chairs, or crossing your legs.** Your two restrictions are **no bridging and no leg lifts against resistance for 6 weeks** (bridging is lying on your back and lifting your hips), because they strain the front of the hip while it heals.

PROTOCOL AT A GLANCE

WEIGHT BEARING	Full weight as tolerated from day 1
WALKER · CANE	Walker for the first 1 to 2 weeks , then a cane (usually around week 2), and no device by 4 to 6 weeks
MOTION GOALS	No motion restrictions. Bending, sitting in low chairs, bending forward, and crossing your legs are all allowed from day 1
PHYSICAL THERAPY	Home exercise program first. Formal PT only if Dr. Merritt orders it, or after your PA visit at 2 weeks; then usually 2 times a week
KEY PRECAUTIONS	No bridging for 6 weeks. No leg lifts against resistance until cleared. The Quiet Hip: ice 20 minutes on, 20 minutes off and keep activity modest for 2 weeks
RETURN TO ACTIVITY	Most people reach their activity goals by about 3 months . Running is generally not recommended ; discuss it with Dr. Merritt

Recovery Timeline

Phase	When	PT visits	Focus
1	Weeks 0–2	Home program first; formal PT if ordered or after the PA visit	The Quiet Hip: walker, ice the front of the hip, no bridging
2	Weeks 2–6	If ordered, about 2× a week	Walker → cane → no device; hip abductor and gluteal strength; walking program
3	Weeks 6–12	If ordered, 1× a week, then as needed	Bridging allowed; full strengthening; walking, cycling, swimming, golf, pickleball

For the Therapist

Check the surgeon notes first. They override anything else in this protocol. Questions or setbacks: call (425) 656-5060.

Surgeon notes and special instructions

General principles

- **Direct anterior approach (DAA).** This internervous, intermuscular approach does not detach any muscle insertions and avoids the posterior capsule entirely, removing the posterior dislocation risk that defines traditional posterior precautions. It works between the tensor fasciae latae and the sartorius, close to the hip flexors.
- **No posterior precautions.** There are no restrictions on hip flexion, sitting, bending forward, or low chairs. The anterior approach greatly lowers the dislocation risk (well under 1%); tell patients this explicitly. The sitting and bending restrictions of posterior-approach surgery do not apply.
- **The Quiet Hip, first two weeks.** The anterior dissection creates local inflammation next to the hip flexors. Patients who feel good and become overly active often develop hip flexor tendinopathy in the first 2–4 weeks. Ice the anterior hip 20 min on, 20 min off while awake, keep activity modest, and avoid any exercise that loads the hip flexors against resistance.
- **Two restrictions: no bridging for 6 weeks and no resisted hip flexion until cleared (usually 6 weeks).** Bridging combines hip extension and loading that stresses the anterior capsular repair. All other functional activities (walking, sitting, bending forward, stairs) are unrestricted from day 1.
- **Weight bearing as tolerated from day 1.** A walker is used for the first 1–2 weeks for balance and confidence, then a cane (usually around week 2), weaned as soon as gait is safe and pain-free.
- **Home program first.** Patients start with a home exercise program; formal PT begins only if ordered by Dr. Merritt or after the first post-op (PA) visit at 2 weeks, usually about 2× a week. If the patient does formal PT, it is usually complete by 3 months; after that, patients keep advancing on their own.

PHASE

1

The Quiet Hip

Weeks 0–2

For the patient: what to expect

You had an anterior-approach hip replacement, so there are **no restrictions on sitting, bending, or walking**. You do not have the usual hip replacement precautions: no limits on chair height, and no worry about bending to tie your shoes. **Your two restrictions are no bridging** (lifting your hips off the bed) **and no leg lifts against resistance** for 6 weeks. The most important thing in the first two weeks is **not to overdo it**. You will likely feel better than expected, so resist the urge to be too active. Ice the front of your hip 20 minutes on, 20 minutes off while you are awake. This prevents a painful hip flexor problem that comes from doing too much too soon.

WEIGHT BEARING	As tolerated immediately. Walker for the first 1–2 weeks for safety and gait support; then a cane, usually around week 2. Goal: normal walking pattern by weeks 2–3
MOTION	No restrictions. Hip flexion, extension, rotation, and abduction are unrestricted from day 1; gentle active motion starts immediately. No chair-height, toilet-height, or bend-forward restrictions
BRACE	None. No hip precautions apply to this approach

Goals

- Safe, independent walking with a walker on level surfaces
- Manage pain and anterior hip soft-tissue inflammation
- Quad activation, ankle pumps, and gentle hip exercises
- Patient education: anterior approach, no sitting, flexion, or bending restrictions
- Stair training with a handrail

Move on when

- ☐ Safe, confident walking on level surfaces
- ☐ Stairs with a handrail, step over step by week 2
- ☐ Pain and anterior hip inflammation controlled
- ☐ Understands the anterior approach: no sitting or flexion restrictions

Exercises

Exercise	How
Ankle pumps	Every hour while awake (DVT prophylaxis)
Quad sets	3 × 15
Heel slides	Supine hip flexion and extension: 3 × 10
Supine hip abduction	3 × 10
Hip rotation	Supine gentle IR/ER (log rolls): 3 × 10
Seated knee extension	3 × 15
Standing hip abduction	Support at a counter: 3 × 10
Gait training	Normal heel-toe pattern, symmetrical step length
Stair training	Up with the good leg first, down with the operated leg first
Ice	Anterior hip, 20 min on, 20 min off while awake; do not skip
Walks	Short, flat walks 2–3× a day; stop before fatigue and build gradually

Precautions

- No bridging for 6 weeks and no resisted hip flexion until cleared (usually 6 weeks); no other motion restrictions. Bridging loads the anterior capsule and hip flexors in extension
- No resisted hip flexion (straight-leg raises against resistance, hip flexor machine); avoid loading the inflamed anterior soft tissues
- No prolonged walking or standing beyond tolerance in the first 1–2 weeks; the anterior soft tissues are easily irritated even when pain is minimal
- Ice the anterior hip 20 min on, 20 min off while awake, regardless of pain level; it prevents hip flexor tendinopathy
- No posterior-approach precautions apply: sitting low, bending forward, and hip flexion are all permitted

Why: The direct anterior approach is performed next to the hip flexors and rectus femoris. Although no muscle is detached, dissection and retraction inflame this region. Patients who are overly active or start hip flexor exercises too early often develop anterior hip flexor tendinopathy in the first 2–4 weeks. This is preventable with modest activity, frequent icing, and no loaded hip flexion in Phase 1.

PHASE

2

Progressive Hip Strengthening

Weeks 2–6

For the patient: what to expect

Your walking improves and you wean off the cane during this phase. Hip strengthening progresses: **strong hip abductor and extensor muscles are what give you a normal, pain-free walk.** Keep icing after exercise. **Still no bridging until week 6.** If Dr. Merritt has ordered formal PT, it is usually about 2 times a week.

WEIGHT BEARING	Full. Walker to cane around week 2; cane in the opposite hand for community walking as needed. Goal: no assistive device on level surfaces by weeks 4–6
MOTION	Full, unrestricted. Continue motion exercises as needed for flexibility
BRACE	None

Goals

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

Move on when

- ☐ Walking without an assistive device on level surfaces
- ☐ Hip abduction and extension strength 4/5 (MMT)
- ☐ 20 min of flat walking without pain
- ☐ Driving cleared by the surgeon

Exercises

Exercise	How
Side-lying hip abduction	3 × 15; add a band at week 3
Prone hip extension	3 × 15; add a band at week 3
Standing hip abduction	With a band: 3 × 15
Standing hip extension	With a band: 3 × 15
Mini squats	0–60°: 3 × 15
Step-ups	4–6-inch step: 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	Both legs → single leg: 3 × 15
Walking program	Progressive distance on flat and uneven surfaces
Ice	Anterior hip after exercise, 20 min on, 20 min off as needed

Precautions

- No bridging until week 6; the restriction continues through the end of this phase
- No resisted hip flexion (machine or band) until anterior hip discomfort has fully resolved, typically cleared at the 6-week surgeon visit
- No running, jumping, or high-impact activity in Phase 2

Why: Anterior soft-tissue healing continues through weeks 4–6. Loading the hip flexors before then risks persistent tendinopathy. The bridging restriction continues through week 6 to allow anterior capsular healing.

PHASE

3

Full Strengthening and Return to Activity

Weeks 6–12

For the patient: what to expect

At week 6 the bridging restriction is lifted and full hip strengthening begins. This is the most productive phase: strength comes back quickly once the full program is underway. **If you are doing formal PT, most people finish by about 3 months** and continue on their own. The goal is to leave PT with a program you can keep up yourself.

WEIGHT BEARING	Full, unrestricted
MOTION	Full, unrestricted
BRACE	None

Goals

- Bridging and a full hip strengthening program established
- Hip and quad strength ≥ 75 –80% of the other side
- Stairs without a handrail
- Return to low-impact recreation: cycling, swimming, golf
- Independent with a home maintenance program by month 3

Move on when

- ☐ Bridging allowed; full hip strengthening program underway
- ☐ Hip and quad strength ≥ 75 –80% of the other side
- ☐ Stairs step over step without a handrail
- ☐ Low-impact recreation (cycling, golf, swimming) without pain
- ☐ Independent home maintenance program by month 3

Exercises

Exercise	How
Glute bridges	Both legs: 3 × 15, starting week 6
Single-leg glute bridge	Progress at weeks 8–10
Squats	3 × 15; progress depth and load through month 3
Leg press	Both legs → single leg: 3 × 12; progress resistance
Step-ups • step-downs	8-inch step-ups and eccentric step-downs: 3 × 10
Lateral band walks	3 × 15 each direction
Romanian deadlift	3 × 12
Resisted hip flexion	With a band, from week 6: 3 × 15
Stationary bike	Moderate resistance: 20–30 min
Elliptical	20–30 min
Swimming	Once the incision has healed; all strokes
Single-leg squat • balance	Progression: 3 × 10–12
Hip flexor stretching	Stretching program
Golf	Putting and chipping at weeks 6–8; full swing at month 3
Hiking	Flat and moderate terrain from month 2

Precautions

- No running or high-impact activity. Running is generally not recommended after hip replacement; discuss it with Dr. Merritt
- Watch the anterior hip for tendinopathy with new exercises; if it appears, reduce resistance and ice after activity
- No pivoting sports or lateral cutting in this phase

Why: Anterior capsular and hip flexor healing is complete by weeks 6–8, so full progressive loading is now appropriate. Patients who do formal PT usually finish by month 3 with enough strength and function to keep advancing on their own.

After 3 Months

Instructions for patients once formal PT is finished.

KEEP EXERCISING	If you did formal PT, it is usually complete by 3 months. You don't need to keep going to PT, but keep exercising on your own. Your hip keeps getting stronger for up to a year after surgery, and the work you do at home makes a real difference
STRENGTH PROGRAM	At home or at a gym 2–3× a week. Focus on squats, step-ups, hip abduction with a band, and bridges. These protect your new hip long term
WALKING · LOW-IMPACT CARDIO	Walking, cycling, swimming, and the elliptical are excellent long-term activities. Aim for 30 min most days of the week
GOLF	Full swing is usually cleared at month 3. If your hip is sore after a round, take a day off and play less
HIKING	Flat and moderate trails are fine from months 2–3. Use trekking poles on steep or uneven ground to reduce the load on your hip
RUNNING	Running is generally not recommended after hip replacement. Discuss it with Dr. Merritt
WHEN TO CALL	New groin pain, a clicking or clunking feeling in the hip, significant swelling, or any sense that something has changed. These are uncommon but should be checked promptly

Clinical note

There are no long-term restrictions on sitting, bending, or hip flexion with the anterior approach. Your new hip is very stable; dislocation is rare. Keep advancing your activities as your strength and comfort allow.

GREAT ACTIVITIES	Walking, cycling, swimming, elliptical, hiking, golf, and pickleball
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Questions about PT progress? Patients can call our office or bring them to their next appointment. We are always glad to coordinate with the therapist.