EDWARDS ORTHOPEDICS
Advanced Orthopedic Surgery, Close to Home.
Dr. Chad Edwards, Orthopedic Surgeon

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POST-OPERATIVE REHABILITATION PROTOCOL

Posterior Total Hip Arthroplasty

Early mobility with posterior dislocation precautions and progressive hip strengthening

PATIENT	SURGERY DATE	SIDE / PROCEDURE NOTES
_____	_____	_____

HOW TO USE THIS PROTOCOL Time frames are guides, not deadlines. Progress only when the phase criteria are met and the knee/arm is not reacting with increased pain or swelling. Dr. Edwards' written instructions always take priority.

SCOPE Use for primary posterior-approach total hip arthroplasty/hemiarthroplasty. Revision, bone grafting, trochanteric repair, or a different approach requires different precautions.

STOP AND CALL: fever/chills, increasing redness or drainage, uncontrolled pain, new or worsening numbness/weakness, calf pain/swelling, chest pain, or shortness of breath. Call 911 for an emergency.

KEY RESTRICTIONS AT A GLANCE

TIME	PROTECTION / WEIGHT BEARING	MOTION / LOADING
0-6 weeks	WBAT unless ordered otherwise; walker/cane as needed	No hip flexion over 90, adduction past neutral, or internal rotation
6-12 weeks	Wean device with normal gait	Progress hip/core strength, balance, and endurance
12-16 weeks	Return to most daily activity	Advance strength and low-impact recreation
4+ months	High impact generally discouraged	Activity-specific return after clearance

PHASE-BY-PHASE PLAN

Phase 1 | Mobility and precautions (day 0-2 weeks)

- **Priorities:** Protect the hip; control pain/swelling; achieve safe transfers, walking, stairs, and home exercise.
- **Protection:** Posterior precautions: no hip flexion beyond 90 degrees, no adduction across midline, no internal rotation, and do not combine these motions. Avoid twisting on the operated leg.
- **Protection:** Weight bearing is commonly as tolerated, but the discharge order controls. Use the prescribed walker/crutches.

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- **Therapy focus:** Ankle pumps, quad/glute/hamstring sets, heel slides within precautions, long-arc quads, standing hip abduction as allowed, sit-to-stand, gait, and stair training.

Phase 2 | Gait and strength (2-6 weeks)

- **Priorities:** Reduce swelling; improve ROM within precautions; normalize gait and daily function.
- **Protection:** Continue posterior precautions until Dr. Edwards lifts them, commonly around 6 weeks. Do not abandon the cane if a limp persists.
- **Therapy focus:** Progress hip abductor/extensor and core strength, weight shifts, step work, balance, walking endurance, and bike around weeks 3-4 if comfortable.
- **Therapy focus:** Wean the device only when gait is pain-free, balanced, and without Trendelenburg compensation.

Phase 3 | Functional strengthening (6-12 weeks)

- **Priorities:** Restore lower-extremity strength, balance, endurance, and most daily activities.
- **Protection:** Even after formal precautions are lifted, avoid forceful end-range combinations and sudden pivots.
- **Therapy focus:** Progress resistance, step-up/down, squat/hinge pattern, side stepping, uneven-surface walking, bike/elliptical, pool, and age-appropriate balance.

Phase 4 | Return to activity (12-16+ weeks)

- **Priorities:** Return to appropriate recreation, work, and independent exercise.
- **Protection:** Lower-impact activities are preferred for implant longevity; jogging and contact/high-impact sport are generally discouraged unless specifically approved.
- **Therapy focus:** Progress carrying, pushing/pulling, endurance, and activity-specific tasks.
- **Therapy focus:** Discharge criteria: pain-free functional ROM, normal independent gait and stairs, at least 4+/5 hip strength, safe balance, and independent home program.

GENERAL PROGRESSION RULE A mild exercise ache that resolves is acceptable. Back down and contact the care team if pain is sharp, swelling increases, motion is lost, gait/mechanics worsen, or symptoms remain elevated the next day.