

Direct Anterior Total Hip Replacement

Physical therapy protocol - rapid recovery primary THA

Patient: _____ Surgery / procedure date: _____

This is the full Pacific Bone & Joint postoperative protocol. Patient-specific operative and discharge orders take precedence over this default pathway.

Protection and early recovery

This protocol is for an uncomplicated primary direct anterior total hip arthroplasty. Most PBJ anterior primary hips do not require traditional hip precautions. The goal is early safe walking, normal stride and progressive strength without forcing the healing anterior soft tissues.

Item: Default plan

Weight bearing: Weight bearing as tolerated with walker or cane as needed for balance and gait quality.

Brace / pillow: No routine brace or abduction pillow.

Hip precautions: No routine posterior precautions. Do not force end-range passive hip extension or external rotation, and avoid aggressive combined extension plus external rotation or twisting during the first 6 weeks.

Therapy focus: Walking, transfers, gait symmetry, gluteal and thigh activation, then progressive endurance and strength.

First 2 weeks

- Use short, frequent walks rather than one long walk that produces a limp or marked fatigue.
- Encourage a normal step-through gait and gradual return of hip extension during walking; do not force a long stride.
- Ankle pumps, quadriceps sets, gluteal sets, heel slides, gentle supine hip abduction and sit-to-stand are appropriate as tolerated.
- Avoid repeated straight-leg raises or resisted hip flexion if they provoke groin pain. Early hip-flexor irritation is common and usually responds to reducing that load.
- Avoid twisting on the planted leg and high-impact activity.

Incision and safety

Protect the incision and follow the separate wound instructions. New motor weakness, progressive numbness, inability to bear weight, a sudden change in leg position, or a painful pop requires prompt surgical review.

Therapy and exercise progression

Weeks 0-2

- Gait and transfer training; walker to cane progression based on balance and limp, not the calendar.
- Gluteal and quadriceps isometrics, heel slides, comfortable hip abduction, calf raises and supported standing weight shifts.
- Gentle bridges may begin when comfortable and the patient can perform them without anterior groin pain or lumbar compensation.
- Stairs as needed for home access. Use the rail and an assistive device until control is reliable.

Weeks 2-6

- Wean the cane when gait is symmetrical without a trunk lean.
- Progress bridge, standing hip abduction/extension, sit-to-stand, step-ups, heel raises and balance training.
- Stationary bicycle with low resistance when mounting and pedaling are comfortable; pool after the incision is fully healed.
- Increase walking duration gradually. Avoid sudden hills, long strides, sprinting and forceful passive anterior hip stretching.

Weeks 6-12

- Progress hip abductor, extensor and external-rotator strength; add controlled single-leg tasks, lateral stepping, step-downs and carries.
- Advance endurance with cycling, elliptical, swimming, walking and hiking progression.
- Restore functional hip motion rather than chasing extreme range. Strength and gait quality are higher priorities than end-range stretching.

Progression and return to activity

Progress when

- The patient walks without a meaningful limp or Trendelenburg pattern and no longer needs an assistive device for safety.
- Sit-to-stand, stairs and single-leg stance are controlled without a large increase in pain the next day.
- Hip strength and endurance are steadily improving and there is no progressive groin pain.

Return to recreation

Most low-impact activities can be built back between 6 and 12 weeks as strength and endurance permit. More demanding hiking, golf and gym work should be reintroduced progressively. Repetitive impact activity is individualized and requires surgeon discussion.

Driving and work

Driving requires discontinuation of sedating medication and the ability to enter/exit the vehicle and perform an emergency braking response safely. Work timing depends on commute, standing, lifting and travel demands rather than a fixed date.

When to call

Call (808) 439-6201 for wound drainage, spreading redness, fever, a sudden inability to bear weight, new marked leg shortening/rotation, a painful pop, new progressive weakness, calf swelling or worsening pain. Chest pain or shortness of breath requires emergency evaluation.

Clinical references: Morton PN. Hip Replacement Rehabilitation Protocol, 2021.

JointReplacementHawaii.com, Total Hip Replacement / current direct-anterior recovery information, reviewed 2026. Mass General Brigham, Rehabilitation Protocol for Total Hip Arthroplasty, 2025. AAHKS, Hip Replacement Home Therapy Exercises. Christensen et al. Clin Orthop Relat Res. 2015;473:1001-1007.