

Revision Total Hip Replacement - Posterior Approach

Physical therapy protocol - protected revision pathway

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.

Confirm the operative restrictions before therapy

Revision hip rehabilitation cannot be safely reduced to one universal weight-bearing schedule. Bone loss, stem or cup fixation, osteotomy, abductor repair and the reason for revision may each change the plan. The written operative order takes precedence over every default below.

Operative item: Write the order

Weight bearing: ☐ WBAT ☐ 50% ☐ 20-lb flat-foot ☐ toe-touch ☐ non-weight bearing Duration: _____

Posterior precautions: ☐ 6 weeks ☐ 12 weeks ☐ other: _____

Trochanter / abductor: ☐ none ☐ no active abduction ☐ no resisted abduction ☐ other: _____

Brace / special fixation: _____

Default posterior precautions if no different order is written

- For the first 6 weeks: do not flex the hip beyond 90 degrees, do not adduct past midline, and do not internally rotate beyond neutral. Avoid the combined position of flexion, adduction and internal rotation.
- Do not cross the legs or twist on the planted operative leg. Use a raised sitting surface if needed to remain inside the motion limits.
- If an abductor or greater-trochanter repair was performed, avoid active or resisted abduction and avoid passive adduction stress until the surgeon clears it.
- If weight-bearing status is not documented, contact the surgical team before advancing loading. Do not assume WBAT in a revision.

Exercise progression

Weeks 0-6 - protection phase

- Gait and transfer training with the prescribed weight-bearing limit and assistive device. Fall prevention is a major goal.
- Ankle pumps, quadriceps sets, gluteal sets and gentle knee motion. Hip motion only within written precautions.
- Gentle heel slides or active-assisted hip flexion may be used within the flexion ceiling. Do not force rotation.
- Avoid straight-leg raise or active abduction when restricted by pain, abductor repair, trochanteric fixation or the operative order.

- Maintain trunk, upper-extremity and contralateral-leg strength needed for safe protected gait.

Weeks 6-12 - only after surgical review

- Advance weight bearing only when the surgeon confirms fixation/bone healing allows it. A revision may remain protected beyond 6 weeks.
- Gradually restore functional hip motion. Continue posterior precautions longer if instability risk or soft-tissue repair warrants it.
- Begin or progress gluteal strengthening only if any trochanteric/abductor restriction has been released.
- Progress sit-to-stand, step-ups, balance and endurance with strict attention to gait symmetry.

After 12 weeks

- Progress toward symmetrical gait, functional ROM, hip strength and endurance.
- Advance closed-chain strengthening, stairs and low-impact aerobic training. Avoid sudden impact and torque until bone/soft-tissue healing is confirmed.
- Use cane longer when needed for abductor weakness or balance rather than accepting a persistent trunk lean.

Progression and return to activity

Criteria to advance

- Radiographs and clinical exam support advancement of weight bearing and motion.
- No wound problem, new instability event or progressive pain.
- Patient can maintain precautions during transfers, stairs and activities of daily living.
- Gait is safe at the current load before the next load increase is attempted.

Higher-risk revision features

Major acetabular reconstruction, bone graft, extended trochanteric osteotomy, periprosthetic fracture, abductor repair, recurrent instability, infection reconstruction and poor bone quality may require a substantially slower pathway. When any of these is present, the therapist should use the operative order rather than a generic primary-hip timeline.

When to call

Call (808) 439-6201 for a painful pop or dislocation sensation, sudden inability to bear weight, new shortening/rotation, increasing drainage, fever, progressive neurologic symptoms, a fall, or pain that is worsening instead of improving. Chest pain or shortness of breath requires emergency evaluation.

Clinical references: JointReplacementHawaii.com, Revision Hip Replacement, medically reviewed September 2026. Morton PN. Hip Replacement Rehabilitation Protocol, 2021. Mass General Brigham, Rehabilitation Protocol for Total Hip Arthroplasty, 2025. Van der Weegen et al. Hip Int. 2016;26:486-492 (approach/precaution concepts).