REHABILITATION AFTER TOTAL HIP REPLACEMENT: ANTERIOR APPROACH

Anterior hip replacement recovery: no routine hip precautions, crutches often 3–10 days, driving typically 2–4 weeks.

PATIENT NAME _____

DATE OF SURGERY _____

WHAT IS INSIDE

23 minutes to read. Reviews: Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks. Then reviews with X-rays at 6 months and 12 months. A 3-month review is added only if you are not progressing as expected.

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This is a general guide. Your operation record and the instructions you are given always take precedence over anything written here. Last reviewed 5 August 2026.

Which approach did I have? Your discharge summary and operation record state the approach. If you are unsure, call the rooms. The precautions are different. This guide is for the anterior (direct anterior) approach, where the surgeon works from the front of the hip. If your operation was from behind the hip, use our posterior approach guide instead, its precautions are close to the opposite of the advice here.

This guide walks you through recovery after an anterior-approach total hip replacement, week by week, what to do, what to expect, and when to call us. Two headlines: you can stand and walk on the new hip from day one, and you do not need the traditional hip precautions, no raised toilet seat, no ban on bending or crossing your legs. There is one position to respect for six weeks, and it is explained below.

Every timeframe in this guide is typical, not a rule. Your hip, your health and your operation are your own, and Dr Broadhead’s instructions for you always override the general figures here.

AT A GLANCE

WEIGHT BEARING
Full weight bearing as tolerated from day one

WALKING AIDS
Frame or crutches typically 3–10 days, then a stick as needed to about 2–4 weeks

BRACE
No brace

PRECAUTIONS
No routine posterior precautions, instead, avoid the leg stretched out behind you and turned outward, for 6 weeks

DRIVING
Typically 2–4 weeks, individually assessed

DESK WORK
Typically 1–3 weeks

PHYSICAL WORK
Typically 8–12 weeks

SPORT & ACTIVITY
Low-impact activity from around 6–12 weeks; most activities by 3–6 months

REVIEWS
Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks. Then reviews with X-rays at 6 months and 12 months. A 3-month review is added only if you are not progressing as expected

WHAT WAS DONE IN YOUR OPERATION

The hip joint is a ball and socket. The worn ball (femoral head) is removed and replaced with a metal or ceramic ball on a stem that sits inside the thigh bone; the socket is resurfaced with a metal shell and a plastic or ceramic liner: the same implant used through any approach.

Through the anterior approach, the surgeon reaches the joint from the front of the hip through a natural plane between muscles, rather than through or off

them, no muscle is divided or detached. The joint capsule (the sleeve of tissue enclosing the joint) is opened at the front and usually repaired. Because the capsule and the small rotator muscles at the back of the hip are left completely intact, the hip's stability behind is preserved, which is why the traditional posterior precautions do not apply.

THE IDEAS THAT MAKE EVERYTHING ELSE MAKE SENSE

1. Different approach, different at-risk position

The back of your hip was not opened, so deep bending and crossing your legs are not the concern they are for a posterior approach. The front of the hip is where the repair is, so the position to respect is the opposite one: the leg extended behind you and turned outward.

2. Early function is genuinely faster. The end result is the same

Pooled trial evidence shows a modest but real advantage in the first weeks: less pain on days 1–2, better hip function at 2 and 6 weeks, walking aids discarded around 11 days sooner, and a hospital stay shorter by about a third of a day. Beyond about three to six months there is no meaningful difference in hip function or patient-reported outcomes. Overall revision rates are very similar; the Australian registry shows a difference in the kind of problem leading to revision: anterior somewhat more femoral loosening and fracture around the implant, posterior more dislocation. And the ERAS Society consensus is worth quoting: there is insufficient evidence that any one surgical approach or technique independently changes how quickly a patient meets discharge criteria.

3. Numbness at the front and outside of the thigh is expected

The lateral femoral cutaneous nerve. A skin-sensation nerve crossing the front of the hip, is often stretched or irritated, leaving a patch of numbness, tingling or hypersensitivity over the front and outer thigh. Honest numbers: about 1–2% of patients complain of it spontaneously, but when every patient is asked, 20–35% describe some altered sensation. It affects skin sensation only: strength, walking and hip function scores are unaffected. About 96% improve without treatment, most within three to six months, with numbers continuing to fall out to two years; a minority are left with a permanent patch. It is not a sign anything has gone wrong.

4. What you ARE allowed to do

Patients often arrive assuming the traditional restrictions apply. They do not. You may bend past 90 degrees, sit in a normal chair, use a normal toilet, bend to tie a shoe within comfort, cross your legs, and sleep on your side. No raised toilet seat, sock aid or reacher is needed, though they can be convenient in the first fortnight. Deep squatting and low seats are limited by comfort, not by rule.

5. Walking is the main exercise

Frequent short walks beat occasional long ones. Build the habit of getting up and moving at least hourly while you are awake.

WEIGHT BEARING AND WALKING AIDS

WEIGHT BEARING

FULL WEIGHT BEARING AS TOLERATED FROM DAY ONE

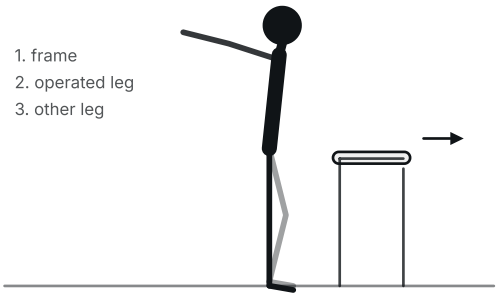
You will stand and walk on the new hip, taking as much weight as comfort allows, from the day of surgery, whether the implant was cemented or uncemented. The implant is fixed and stable immediately.

The walking-aid progression is typically quicker than after a posterior approach, in pooled trial data, anterior-approach patients discarded their aids around 11 days sooner. Progress by the criteria below, not by the calendar.

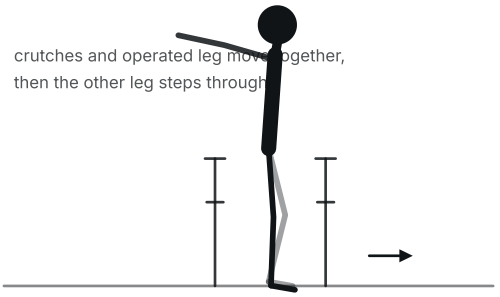
The frame or crutches are for balance and confidence, not to keep weight off the leg. Keep a stick for crowds, uneven ground and long distances for as long as it is useful.

STAGE	TYPICAL TIMING	MOVE ON WHEN
Wheeled frame or two crutches	Day 0 to about day 3–10	Safe balance; walking without a lurch

STAGE	TYPICAL TIMING	MOVE ON WHEN
One crutch or a single stick (opposite hand)	About 1–3 weeks	Level walking without a limp; able to stand on the operated leg with control
No aid	About 2–4 weeks	Confident indoors and outdoors; no lurch; able to manage a kerb



Frame first, then the operated leg, then the other leg



Crutches and operated leg together, then step through

ANTERIOR APPROACH: SENSIBLE ANATOMICAL CAUTION FOR SIX WEEKS, NOT AN ESTABLISHED PROTOCOL

SIX WEEKS

Be clear about what this is: there is no established, validated set of “anterior approach precautions”, and this list should not be read as a recognised protocol. Large published anterior series ran with no formal restrictions at all: one series of over 2,600 hips reported a 0.15% dislocation rate with no raised seats, no abduction pillows and no driving restrictions. What supports the list is anatomy: the joint capsule was opened and repaired at the front, and cadaveric work shows the ligament divided during the anterior approach provides most of the hip’s resistance to rotating outwards, especially with the hip extended, while the repair restores only a fraction of that resistance. So the theoretically vulnerable position is the hip extended and externally rotated: the leg back behind the body and turned out. One counterpoint you should hear: most dislocations after an anterior-approach hip are still backwards, not forwards. Treat the rules below as sensible anatomical caution for six weeks, not rules carved in stone.

RULE	WHY	HOW TO MANAGE
No large steps backward: avoid lunging or striding the operated leg behind you	Extension (the leg stretched behind the body) stresses the front-of-hip repair	Turn by stepping around in small forward steps.
Do not let the operated foot turn markedly outward, particularly while the leg is behind you	External rotation combined with extension is the at-risk combination	Keep the toes pointing forward when standing and walking; log-roll rather than twist.
Do not sleep face down, and do not lie with the operated leg trailing behind you	Prolonged, unguarded extension while you are asleep	Sleep on your back, or on either side with a pillow between the knees.
Avoid aggressive hip flexor stretching, bridging with the operated leg extended back, and prone-lying (face-down) hip extension exercises	These load the front-of-hip repair directly	These exercises return after 6 weeks.
Do not force the last few degrees of anything, no forced stretching in any	With an intact posterior capsule,	Move freely within comfort; let range

RULE	WHY	HOW TO MANAGE
direction	comfort is a good guide	return on its own.

EVERYDAY SITUATIONS

What you ARE allowed to do. Bend past 90 degrees. Sit in a normal chair. Use a normal toilet. Bend to tie a shoe within comfort. Cross your legs. Sleep on your side. No raised toilet seat, sock aid or reacher is needed, though they can be convenient in the first fortnight. Deep squatting and low seats are limited by comfort, not by rule.

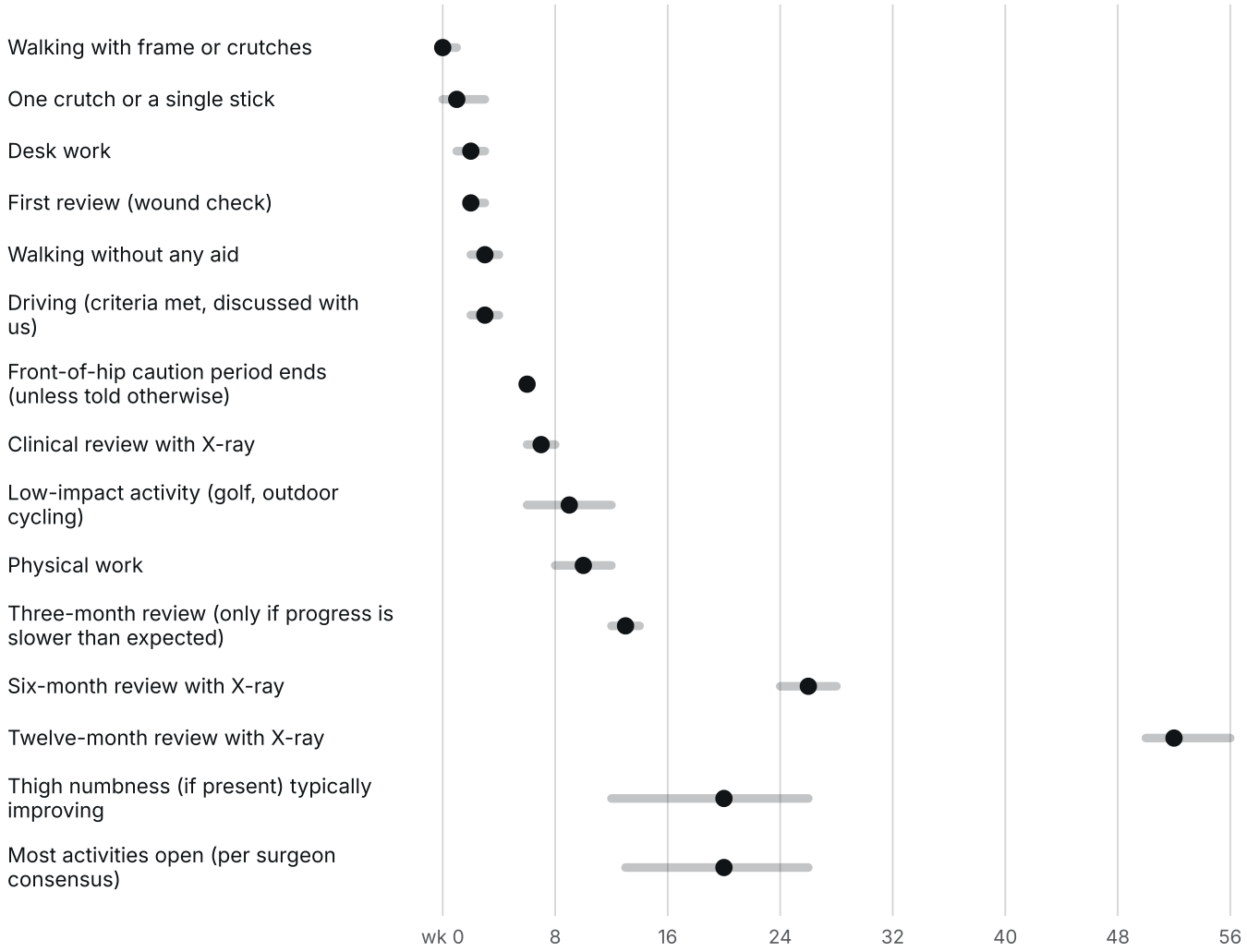
Car. Still sit down first and swing both legs in together: mainly for comfort rather than safety.

Bed. In and out without twisting: log-roll. Avoid lying with the operated leg trailing behind you.

Stairs. Up with the good leg first, down with the operated leg first at the start, progressing to normal step-over-step quickly.

Turning. Small forward steps to turn, no pivoting with the leg stretched out behind you and the foot turned out.

YOUR RECOVERY TIMELINE



Bars show the earliest-to-latest normal window; the dot is typical. Your own dates are set with us, not by this chart.

THE PHASES, ONE BY ONE

You move to the next phase by meeting its exit criteria, not by the calendar. The week numbers are typical, nothing more.

PHASE 1: WALK EARLY, RESPECT THE FRONT

WEEKS 0–2

Walk little and often, settle the swelling, wake the hip muscles up, and learn the one position to respect.

GOALS: TICK THEM OFF

- [ ] Walking short distances hourly, weaning off the frame or crutches as balance allows (often within 3–10 days)
- [ ] Toes-forward walking with no large steps backward: automatic by the end of the fortnight
- [ ] Buttock and thigh muscles switching on (static holds without the leg trembling)
- [ ] Swelling settling rather than building
- [ ] Wound clean, dry and settled

DO THIS

- Short, frequent walks: hourly while awake beats one long outing.
- Ankle pumps every waking hour, plus the Phase 1 exercises below.
- Ice 15–20 minutes, 4–6 times a day, and elevate properly several times a day.
- Sit in normal chairs, use a normal toilet, and bend within comfort. The traditional restrictions do not apply to you.

AVOID THIS

- Large steps backward, lunges, or striding the operated leg behind you.
- Letting the operated foot turn markedly outward, especially with the leg behind you.
- Sleeping face down, or lying with the operated leg trailing behind.
- Forcing end-of-range stretch in any direction.

READY FOR THE NEXT PHASE WHEN…

- Walking with one crutch or a stick, or no aid, with balance and no lurch
- Independent with stairs, car and bed transfers
- Swelling stable or falling

PHASE 2: STRENGTH WITHOUT FORCING

WEEKS 2–6

Wean off any remaining aid, build outer-hip (abductor) strength, and hold off on extension work until the front of the hip has healed.

GOALS: TICK THEM OFF

- [ ] Walking without a limp and without an aid (typically by 2–4 weeks)
- [ ] Standing on the operated leg with a level pelvis, briefly and with control
- [ ] Walking distance building day on day
- [ ] Stationary cycling once the wound is fully healed

DO THIS

- Keep walking as the main exercise: a little further each few days.
- Add the straight leg raises, standing abductor work, sit-to-stands, heel raises and mini squats below.
- Start the stationary bike once the wound is fully healed: saddle at a comfortable height.
- Start scar massage from about 3 weeks, once the wound is fully healed and dry.

AVOID THIS

- Hip flexor stretches, bridging with the leg extended back, and face-down extension exercises. These return after 6 weeks.
- Forcing the last few degrees of any movement: move freely within comfort instead.
- Comparing yourself to anyone else’s week number.

READY FOR THE NEXT PHASE WHEN…

- Walking unaided without a limp on level ground
- Single-leg stand on the operated side with the pelvis level, briefly
- Six weeks done: the front-of-hip caution finishes unless you are told otherwise

PHASE 3: FULL MOVEMENT, REAL STRENGTH

WEEKS 6–12

With the front of the hip healed, reintroduce extension work, bridging included, and build the strength, balance and endurance for real life.

GOALS: TICK THEM OFF

- [ ] Bridging and gentle hip-extension work reintroduced
- [ ] Single-leg balance 30 seconds
- [ ] Stairs step-over-step both directions
- [ ] Low-impact activity (golf, outdoor cycling) starting in this window as comfort and confidence allow

DO THIS

- Add bridging and progress step-ups and balance work.
- Walk and cycle for endurance: distance and hills.
- Move freely: the six-week caution period is over unless you have been told otherwise.

AVOID THIS

- Impact work: running and jumping are not part of hip replacement rehabilitation.
- Sudden aggressive stretching: build range progressively rather than forcing it.

READY FOR THE NEXT PHASE WHEN…

- Confident daily function: shopping, stairs, car, garden
- Strength near-symmetrical on sit-to-stand and step-up
- Walking distance building week on week

PHASE 4: RETURN TO LIVING

MONTHS 3–12

Back to the activities that matter, at the right pace, with realistic expectations of what is recommended long term.

GOALS: TICK THEM OFF

- [ ] Return-to-activity list progressing (see the table below)
- [ ] Physical work resumed where relevant, typically from 8–12 weeks
- [ ] Thigh numbness, if present, typically improving over these months
- [ ] The hip gradually “disappearing” from daily thought

DO THIS

- Keep a twice-weekly strength habit. It protects the result for years.
- Progress through the activity table. Most activities are open by six months.
- Raise anything that worries you, including persisting thigh numbness, at your next review, or sooner by contacting the rooms.

AVOID THIS

- Handball, soccer and other football codes, basketball, full-contact sport and martial arts, not recommended at any stage after hip replacement.

READY FOR THE NEXT PHASE WHEN…

- Activity goals agreed at review and progressing

YOUR EXERCISES

Little and often beats one heroic session. Each exercise lists what you should feel, sharp pain that lingers afterwards means ease off and, if it persists, call.

ANKLE PUMPS

PHASE 1

Pull up and point away, from the ankle only

Keep blood moving in the calf: your main clot-prevention exercise.

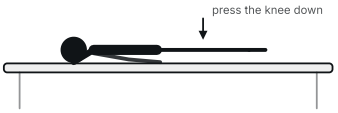
10 firm pumps, every waking hour, for the first 2 weeks

1. Lie or sit with the leg supported.
2. Pull your foot up towards you as far as it goes.
3. Point it away as far as it goes.
4. Repeat briskly.

Feel: You should feel the calf muscles working. Move through the full range each time.

STATIC QUADRICEPS SETS

PHASE 1



Tighten the front of the thigh and hold 5 seconds

Keep the thigh muscle switched on. It supports every step you take.

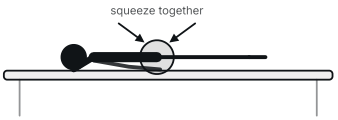
10 holds of 5 seconds, 3–4 times daily

1. Lie with the leg straight.
2. Push the back of the knee down into the bed by tightening the front of the thigh.
3. Hold, then fully relax.

Feel: You should feel this in the front of the thigh. Keep breathing: do not hold your breath.

STATIC GLUTEAL SQUEEZES

PHASE 1



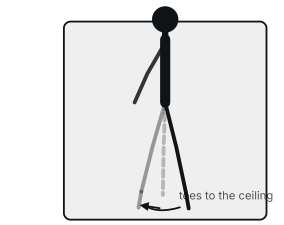
Squeeze the buttocks together and hold 5 seconds

Wake the buttock muscles: the hip's engine, untouched by this approach and ready to work.

10 holds of 5 seconds, 3–4 times daily

1. Lie on your back with the legs straight and slightly apart.
2. Squeeze the buttocks firmly together.
3. Hold, then fully relax.

Feel: You should feel the buttocks firm under you. No movement of the hip is needed. This is a squeeze, not a lift.



Slide out to the side and back, keep the toes up

HIP ABDUCTION (LYING)

PHASE 1

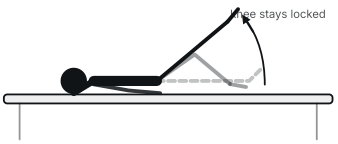
Start strengthening the outer-hip (abductor) muscles that keep your pelvis level when you walk.

10 slow reps, 3–4 times daily

1. Lie on your back with both legs straight.
2. Keeping the knee straight and the toes pointing at the ceiling, slide the operated leg out to the side about 30 cm.
3. Slide it back to the middle with control.

Feel: Toes to the ceiling the whole time. You should feel the outer hip working.

Easier: A smooth board or a plastic bag under the heel makes the slide easier.



Lock the knee straight, lift, lower slowly

STRAIGHT LEG RAISE

PHASE 2

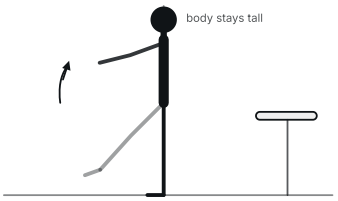
Thigh and hip strength with the knee locked straight.

10 lifts, hold 3 seconds, 3 times daily

1. Lie on your back, other knee bent, operated leg straight.
2. Tighten the thigh first, locking the knee straight.
3. Lift the whole leg about 30 cm.
4. Lower slowly with control.

Feel: A working ache at the front of the hip is common after this approach, ease off if it is sharp or lingers.

Easier: Shorten the hold, or start with smaller lifts.



Leg out to the side, body stays tall

HIP ABDUCTION (STANDING)

PHASE 2

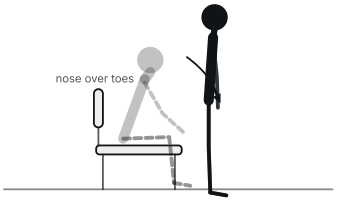
The abductor strength that abolishes the limp: the key hip exercise of Phase 2.

2–3 sets of 10 each side, once or twice daily

1. Stand tall holding the bench or a rail.
2. Keeping the knee straight and the toes pointing forward, lift the operated leg out to the side.
3. Lower slowly with control.

Feel: Stay upright: do not lean away to cheat the lift. Lift to the side, not behind you, keep the leg in line with your body.

Harder: Slow the lowering phase, then add a light ankle weight if advised.



Nose over toes, push up evenly through both legs

SIT-TO-STAND

PHASE 2

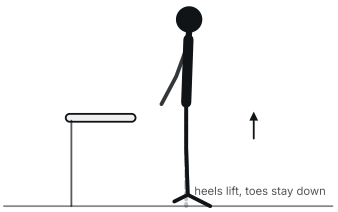
Real-world leg strength: the movement you will do more than any other.

2–3 sets of 8–10, once or twice daily

1. Sit on a firm chair: a normal-height chair is fine after this approach.
2. Feet back, lean forward, push up through both legs, use the arms only as needed.
3. Lower back down slowly with control.

Feel: Share the load evenly between the legs, no swinging or flopping.

Harder: Lower the chair height, then progress to no hands.



Up onto the balls of the feet, lower slowly

HEEL RAISES

PHASE 2

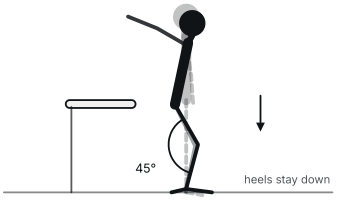
Calf strength for a normal push-off when walking.

2–3 sets of 10, once or twice daily

1. Stand tall holding the bench or rail.
2. Rise up onto the balls of both feet.
3. Lower slowly.

Feel: Even weight through both feet. Toes pointing forward.

Harder: More weight onto the operated side over time.



Bend to about 45 degrees, knees over toes, heels down

MINI SQUAT

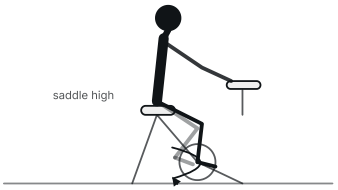
PHASE 2

Thigh and hip strength through a small, comfortable range.

2–3 sets of 10 to about 45 degrees, once or twice daily

1. Stand holding the bench, feet hip-width apart, toes forward.
2. Bend both knees to about 45 degrees, as if starting to sit.
3. Keep the chest up and push back up.

Feel: You should feel the thighs and buttocks working. Depth is limited by comfort, not by rule.



Saddle high at first, build time before resistance

STATIONARY CYCLING

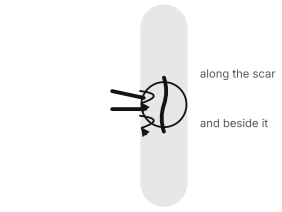
PHASE 2

Endurance and circulation with almost no joint load.

10–20 minutes, most days, once the wound is fully healed

1. Set the saddle at a comfortable height.
2. Mount carefully, swinging the leg over without twisting.
3. Progress time before resistance.

Feel: Comfort is the guide: bending the hip on the bike is not restricted after this approach.



Firm small circles, 2 to 3 minutes twice daily

SCAR MASSAGE

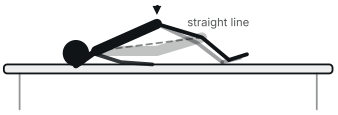
PHASE 2

Soften and desensitise the scar once fully healed: useful for the sensitive skin at the front of the thigh too.

2–3 minutes, twice daily, from about 3 weeks once healed and dry

1. Use a bland moisturiser.
2. Firm, small circles along and beside the scar.
3. Include the skin around it, which is often more sensitive than the scar itself.

Feel: Firm enough to blanch the skin slightly; it should not be painful. Numb or tingly skin nearby can be gently included. It helps desensitise it.



Lift the hips to a straight line from shoulder to knee

BRIDGING

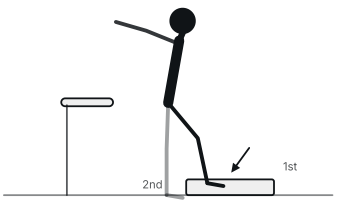
PHASE 3

Gluteal and core strength: reintroduced now that the front-of-hip repair has healed.

2–3 sets of 10, hold 3–5 seconds, once or twice daily, from 6 weeks

1. Lie on your back with both knees bent, feet flat and hip-width apart.
2. Squeeze the buttocks and lift the hips until the body is straight from shoulders to knees.
3. Hold, then lower slowly.

Feel: Push through the heels. This exercise is deliberately held back until after six weeks, because the finishing position extends the hip and loads the front of the joint.



Operated leg goes up first, the other foot joins it

STEP-UPS

PHASE 3

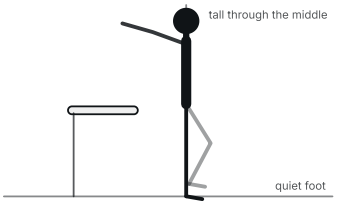
Single-leg strength for stairs and slopes.

2–3 sets of 8 each leg, once daily

1. Stand facing a low step, hand on the rail.
2. Step up with the operated leg, bringing the other foot up to join it.
3. Step down leading with the non-operated leg.

Feel: Push through the whole foot. Keep the pelvis level: do not let it drop to one side.

Harder: Raise the step height, then reduce hand support.



Quiet foot, tall posture, build to 30 seconds

SINGLE-LEG BALANCE

PHASE 3

Steadiness, abductor endurance and confidence: protects you from trips and falls.

Build to 3 holds of 30 seconds each leg, daily

1. Stand near the bench, fingertips hovering.
2. Lift the other foot and balance on the operated leg.
3. Progress: eyes tracking side to side, then a gentle head turn, then no hands.

Feel: Keep the pelvis level: do not sag onto the hip. Quiet foot, tall posture.

SWELLING, ICE AND ELEVATION

WHAT IS NORMAL

- Swelling is the single biggest brake on progress. It peaks about 6–8 days after surgery, then settles gradually.
- Most of the swelling resolves over the first two to three months, but it is normal for the limb to puff up after a long day or a burst of activity for some months after that, measurable swelling is still present at 7 weeks in most knee replacement patients.
- A limb that is bigger the morning after activity means you did too much the day before, not that something is wrong.

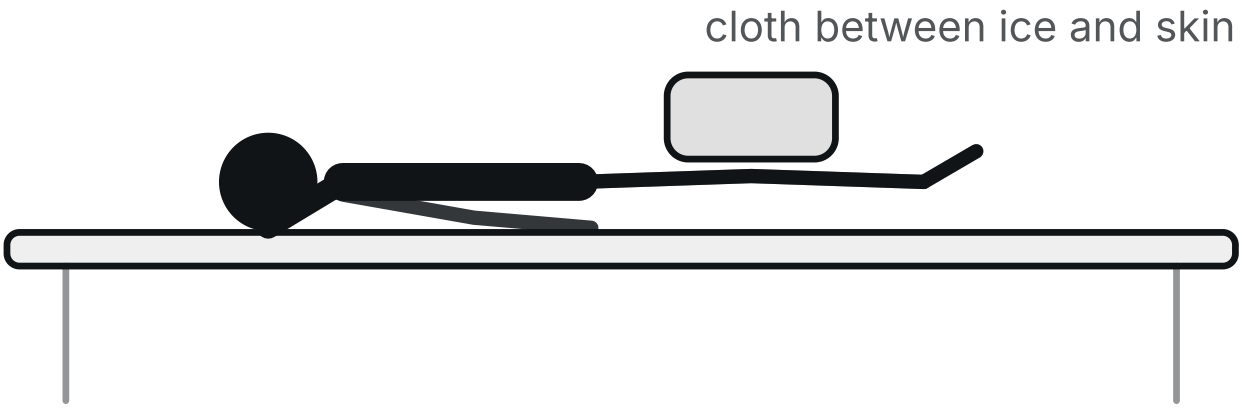
- Warmth and mild redness around the wound settle over weeks.
- After a hip replacement in particular, bruising travels with gravity: bruising down the thigh and into the knee, and even the ankle, is expected and not a complication.

ICE

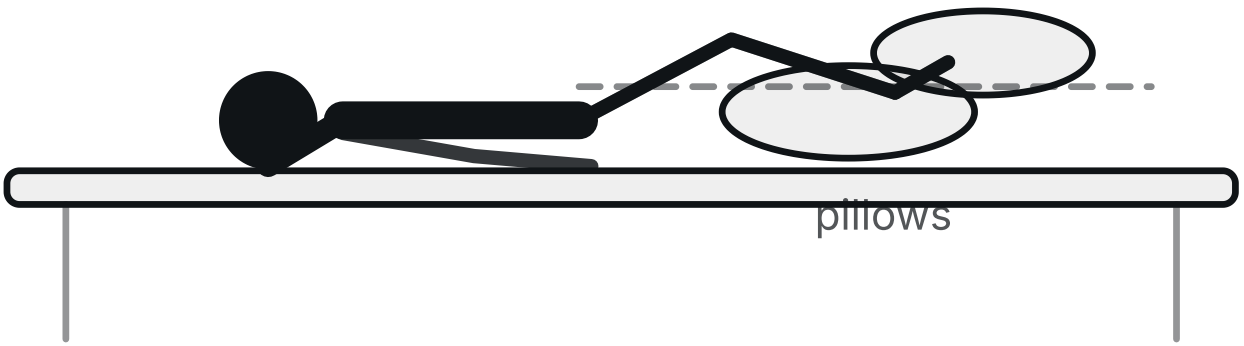
- Ice is safe, cheap and comfortable, and probably gives a small benefit for pain and swelling in the first few days.
- Use it for 15–20 minutes at a time, 4–6 times a day for the first 2 weeks, then as needed after activity and physiotherapy. It is particularly useful in the hour after exercise.
- Always place a thin cloth between the ice and your skin. Never sleep with ice on. Never ice over numb skin or a fresh wound dressing without checking with the rooms first.
- Stop and call the rooms if the skin becomes white, mottled or numb.
- An honest note about the evidence: the 2025 Cochrane review of icing after knee replacement (22 trials, 1,839 patients) found small improvements: pain at 48 hours better by 1.6 points out of 10, about 8 degrees more bend at discharge, and less blood loss: all on low-certainty evidence. The reviewers concluded the benefits may be too small to justify routine use. Use ice because it is harmless and makes you more comfortable, not because it changes the final result.
- There is no good evidence that expensive cold-compression machines work better than a bag of ice or a gel pack. The trials have never been analysed in a way that answers that question. Please do not spend money on one on our recommendation.

ELEVATION & COMPRESSION

- Elevate the limb above heart level for 20–30 minutes several times a day: foot higher than the knee, knee higher than the hip, hip higher than the heart.
- Lie down to do this: a recliner does not raise the leg above your heart.
- Avoid sitting with the leg hanging down for long periods.
- A graduated compression stocking or sleeve helps control swelling, wear it as advised.



15 to 20 minutes, 4 to 6 times daily



Foot above knee, knee above hip, lying flat

WOUND AND SCAR CARE

- Keep the dressing dry and intact until it is reviewed. Most modern waterproof dressings allow showering, but do not soak, scrub, or put soap directly on the wound.
- No baths, spas, pools or ocean swimming until the wound is fully healed and has been reviewed, usually 2–3 weeks at a minimum.
- Do not apply creams, powders or antiseptics unless you have been told to.
- Clips or stitches are removed or checked at your first appointment.
- Tell the rooms about any dressing that becomes soaked, loose or soiled.
- From about 3 weeks, once the wound is fully healed and dry: massage the scar with a bland moisturiser for 2–3 minutes, twice a day, using firm circular pressure. This softens the scar and desensitises the skin around it.
- Silicone gel or sheeting can improve the appearance of prominent scars.
- Protect the scar from the sun for 12 months. It burns easily and can darken permanently.
- Scars take a full 12–18 months to fade and flatten.
- Numbness in the skin around and below the scar is normal and often permanent, small skin nerves are unavoidably divided during surgery.

SLEEP AND POSITIONING

Sleep on your back, or on either side, including the operated side, with a pillow between the knees for comfort. Side sleeping is allowed from the start after an anterior approach.

For the first six weeks, do not sleep face down, and do not lie with the operated leg trailing behind you: both put the hip into prolonged, unguarded extension.

Get in and out of bed without twisting: log-roll.

Disturbed sleep is common in the first weeks and improves as things settle: ice before bed and timing pain relief for the night both help.

PAIN, MEDICATION AND WHAT TO EXPECT

Expect real pain needing regular pain relief in the early weeks, settling steadily, pooled trial evidence shows anterior-approach patients have somewhat less pain in the first two days than posterior-approach patients, but this is still major surgery.

Take pain medication as prescribed and ahead of exercise sessions rather than chasing pain afterwards. Wean the strongest medications first as things settle.

You will usually be on a blood thinner for some weeks: take it exactly as directed.

Bruising tracking down the thigh, aches, warmth and tightness continue for weeks and are normal. Pain that is increasing week on week is not, call the rooms.

A patch of numbness, tingling or hypersensitivity over the front and outer thigh is expected after this approach and is not a sign anything has gone wrong: see the FAQ below.

PREVENTING BLOOD CLOTS

- Get up and move at least hourly while you are awake.
- Do ankle pumps: 10 firm up-and-down pumps of the ankles: every waking hour for the first 2 weeks.
- Stay well hydrated.
- Take any prescribed blood thinner exactly as directed, and wear stockings as advised.
- Avoid long-haul flights for 6 weeks after joint replacement: discuss any earlier travel with the rooms.

DRIVING: THE CRITERIA THAT ACTUALLY MATTER

You may drive when **all** of the following are true:

- You are off opioid painkillers and any other sedating medication.

- You can sit comfortably in the driver's seat.
- You can perform an emergency stop at full force, without hesitation and without pain.
- You are not using a walking aid in the car, and not wearing a brace that limits the movement needed to work the pedals.
- You have practised the movements in a stationary car first.

What the driving research does and doesn't show

What the research actually measures is braking reaction time on a simulator. Those studies show braking performance returns to its pre-operative level at about 2 weeks after a right hip replacement and about 4 weeks after a right knee replacement, with movement time back to normal by 6 weeks. After knee arthroscopy the simulator evidence is more conservative than common practice: in the one study that measured it directly, braking was still slower one week after surgery than before it, and had recovered by four weeks, and a 2021 review of eight studies put the average return at about six weeks. Most people having a simple arthroscopy are driving well before that, which is why the criteria above matter more than the date. But these are averages, in one study, about one in three right-hip patients still could not meet an emergency-stop benchmark at six weeks. Treat the timeframes in this guide as targets for discussion with us, not as permissions.

No published study has compared automatic and manual cars. The logical point is simply that a manual needs the left leg for the clutch, so left-sided surgery is the relevant caution in a manual. Advice about driving earlier with a left-leg operation in an automatic is clinical judgement, not trial evidence.

In Australia, your treating doctor's advice governs: under the Austroads "Assessing Fitness to Drive" standards, temporary post-operative impairment is a matter of clinical judgement, and commercial drivers are held to a higher standard. Driving while impaired may invalidate your

insurance, check your insurer's position. Do not drive for at least 24 hours after any general anaesthetic or sedation.

GETTING BACK TO WHAT YOU DO

ACTIVITY	TYPICAL	WHEN IT'S RIGHT	NOTES
Walking for exercise	From the outset	Comfort and steadiness	Frequent short walks first; build distance gradually. It is the core of the programme
Swimming and hydrotherapy	2–3 weeks	Wound fully healed and reviewed	No baths, spas or pools before the wound is checked
Stationary cycling	2–3 weeks	Wound fully healed	Saddle at a comfortable height; mount without twisting
Driving	2–4 weeks	All the driving criteria below, discussed with us	Individually assessed: the criteria matter more than the date
Desk work	1–3 weeks	Comfortable sitting; travel sorted	Normal chairs are fine after this approach
Golf and outdoor cycling	Generally 6–12 weeks	Confident balance; walking without a limp	Per European surgeon consensus (expert opinion, not trial data)
Physical work	8–12 weeks	Strength and endurance for the actual duties	Modified duties in between where available

ACTIVITY	TYPICAL	WHEN IT'S RIGHT	NOTES
Doubles tennis	Usually 3–6 months	Strength, balance and confidence built in Phases 3–4	Per surgeon consensus guidance
Most other activities	By 6 months	Progressing through the phases without setbacks	European surgeon survey: about 5 activities permitted within 6 weeks, 10 at 6–12 weeks, 26 at 3–6 months, and 37 of 47 by 6 months: expert consensus, not trial data
Handball, soccer and football codes, basketball, full-contact sport, martial arts	Not recommended	—	Not recommended at any stage in the surgeon consensus

Flying after joint replacement: an honest note

You will often hear "no flying for six weeks" after joint replacement. Be aware that this is a convention, not a proven rule: a 2025 review found limited data and no demonstrated difference in clot risk between people who did and did not fly after hip or knee replacement: mostly within the first week.

The six-week convention reflects practical realities rather than trial evidence: managing airports and cramped seating, being past the highest-risk clot window while still on prevention, the higher baseline clot risk of long-haul flights over four hours, and individual airline and travel-insurance rules, check both, as some airlines impose their own restrictions.

If you need to travel long-haul in the first six weeks, talk to the rooms first so clot prevention, an aisle seat, stockings and on-board movement can be planned.

WARNING SIGNS: ACT, DON’T WATCH

None of these should be watched overnight to see how they go. Early treatment of a problem is simple; late treatment is not.

EMERGENCY: 000 Emergency department / call 000

- Sudden shortness of breath
- Chest pain
- Coughing blood, or feeling faint
- Sudden severe hip pain with the leg looking shorter or turned, or being suddenly unable to take weight: possible dislocation

GP TODAY See your GP today

- New, one-sided calf pain, tenderness or firmness
- Calf or whole-leg swelling out of proportion to the rest of your recovery

CALL THE ROOMS Call the rooms: same day

- Pain that is increasing rather than decreasing after the first week
- New redness spreading out from the wound
- Wound discharge, particularly cloudy, thick or offensive fluid, or wound edges opening
- Fever of 38°C or higher, or shaking chills, or feeling generally unwell
- A fall onto the hip, or a sudden change in what the leg can do

For joint replacement patients, a wound problem is never something to "wait and see". Early treatment of an infected joint replacement is vastly more successful than late treatment, call the rooms the same day.

ARRANGING PHYSIOTHERAPY IN AUSTRALIA

- Most privately insured patients self-fund private physiotherapy or use extras cover. A GP Chronic Disease Management plan subsidises only five allied-health visits per calendar

year, not enough for a major reconstruction, so plan for this.

- Compensable patients (workers compensation, CTP) follow an insurer-approved plan.
- Tele-rehabilitation and app-supported home programmes are reasonable additions, but a sports knee reconstruction still needs periodic in-person objective strength testing.

COMMON QUESTIONS

Which approach did I have: anterior or posterior?

Your discharge summary and operation record state the approach. If you are unsure, call the rooms. The precautions are different. This guide covers the anterior approach, where the surgeon works from the front of the hip. If your operation was from behind the hip, use our posterior approach guide instead: its rules on bending, crossing the legs and sleeping positions are close to the opposite of the advice here.

What are the hip precautions after an anterior hip replacement?

There is no established, validated set of anterior precautions: large published series ran with no restrictions at all, with very low dislocation rates. What we ask instead is sensible anatomical caution for six weeks: avoid the operated leg stretched out behind you and turned outward, do not sleep face down, and do not force end-of-range stretches. You may sit in normal chairs, bend past 90 degrees and cross your legs from the start.

How long will I be on crutches after an anterior hip replacement?

Typically a frame or two crutches for about 3–10 days, often shorter than after a posterior approach, then one crutch or a stick for about 1–3 weeks, and nothing from about 2–4 weeks. In pooled trial data, anterior-approach patients discarded their walking aids around 11 days sooner. You progress when you can walk without a limp, not on a set date.

Can I put weight on my leg after an anterior hip replacement?

Yes: full weight from day one, whether the implant was cemented or uncemented. The implant is fixed and stable from the moment of surgery, so you will stand and walk on it

the same day, using a frame or crutches for balance rather than to keep weight off. Walking little and often is the main exercise of the whole programme.

Why is the front of my thigh numb after an anterior hip replacement?

A patch of numbness, tingling or hypersensitivity over the front and outer thigh is expected after this approach. The lateral femoral cutaneous nerve. A skin-sensation nerve that crosses the front of the hip, is stretched or irritated during surgery. It affects skin feeling only: your strength, walking and hip function are unaffected, and hip function scores are identical with or without it. It is not a sign anything has gone wrong.

Will the thigh numbness go away?

Usually. About 96% of patients improve without any treatment: most within three to six months, with numbers continuing to fall out to two years. A minority are left with a permanent patch. The honest numbers: only about 1–2% of patients complain of it spontaneously, but when every patient is asked directly, 20–35% describe some altered sensation. Mention it at your reviews so we can track it with you.

Can I sleep on my side after an anterior hip replacement?

Yes, from the start, on either side, including the operated side, with a pillow between the knees for comfort. Side sleeping is one of the things this approach frees up. The two positions to avoid for the first six weeks are sleeping face down and lying with the operated leg trailing out behind you: both put the hip into prolonged, unguarded extension.

Do I need a raised toilet seat, sock aid or reacher?

No. After an anterior approach you may use a normal toilet, sit in a normal chair, bend past 90 degrees and reach down to your feet within comfort. The traditional equipment is not needed. That said, a sock aid or reacher can be convenient in the first fortnight while things are sore and swollen; convenience, not rule, is the reason to use them.

Can I bend past 90 degrees or cross my legs?

Yes to both. The back of your hip: the side those traditional rules protect, was not opened during an anterior approach, so deep bending, crossing your legs and low chairs are matters of comfort, not safety rules. The position to respect for six weeks is the opposite one: the leg stretched out behind you and turned outward. Deep squatting is limited by comfort, not by rule.

When can I drive after an anterior hip replacement?

Typically 2–4 weeks, individually assessed. The date matters less than the criteria: off strong painkillers, comfortable in the driver's seat, able to perform an emergency stop at full force without hesitation, and practised in a stationary car first. Confirm your own timing with us at review. Your insurer's position is worth checking too.

When can I go back to work after an anterior hip replacement?

Desk work typically at 1–3 weeks, once you are comfortable sitting and have transport sorted, normal chairs are fine after this approach. Physical work typically takes 8–12 weeks, sometimes with modified duties in between. Your own job's demands set the real date, raise it at the two-week review so a plan is in place early.

Can an anterior hip replacement still dislocate?

Yes, though it is uncommon: one series of over 2,600 anterior-approach hips managed with no formal restrictions reported a 0.15% dislocation rate. Worth knowing: most dislocations after an anterior-approach hip still occur backwards, not forwards. That is part of why the sensible advice is simply to move freely within comfort and avoid forcing the extremes of any movement for six weeks.

What is the difference between anterior and posterior hip replacement recovery?

Early on the anterior approach is modestly faster: less pain on days 1–2, better hip function at two and six weeks, walking aids discarded around 11 days sooner, and a slightly shorter hospital stay. Beyond about three to six months there is no meaningful difference in hip function or patient-reported outcomes. Overall revision rates are very

similar. The Australian registry shows anterior hips have somewhat more femoral loosening and fracture around the implant, and posterior hips more dislocation.

Why is my thigh bruised down to my knee?

Bruising travels with gravity. Blood from around the hip tracks down the thigh, into the knee and sometimes the ankle over the first couple of weeks. It can look dramatic and is expected: a consistent clinical observation rather than something formally studied. Bruising alongside a calf that is newly painful, firm or swollen is different: see your GP the same day.

THE EVIDENCE BEHIND THIS GUIDE 19 sourced statements

CLAIM	SOURCE
Immediate unrestricted weight bearing on an uncemented stem does not compromise subsidence or bone ingrowth	Hol et al., Arch Orthop Trauma Surg 2010 (PMID 20012073); Woolson & Adler, J Arthroplasty 2002 (PMID 12375238)
Anterior/anterolateral approach with no formal restrictions: 0.15% dislocation in 2,612 hips	Restrepo et al., Clin Orthop Relat Res 2011 (PMID 21076896)
Medial iliofemoral ligament provides 68–80% of the hip's resistance to external rotation; repair restores 17–25%	Bido et al., J Arthroplasty 2024 (PMID 38537838)
58.8% of anterior-approach dislocations occur posteriorly	Christensen et al., J Arthroplasty 2023 (PMID 37236286)
Anterior approach, less pain days 1–2, better function at 2 and 6 weeks, no difference at 6–12 months	Nassar et al., Orthop Rev 2025 (PMID 40416593)
Anterior approach: shorter hospital stay (about a third of a day) and better Harris Hip Score at 6 weeks (24 RCTs)	Ang et al., Eur J Orthop Surg Traumatol 2023 (PMID 37010580)

CLAIM	SOURCE
Walking aids discarded about 11 days earlier after the anterior approach; lateral femoral cutaneous nerve injury RR 38.97 vs posterior	Yang et al., Orthop Surg 2020 (PMID 32558261)
AOANJRR, no overall difference in revision between approaches; anterior more femoral complications, posterior more dislocation	Hoskins et al., J Bone Joint Surg Am 2020 (PMID 32769807); Hoskins et al., Hip Int 2024 (PMID 38529902)
Insufficient evidence that any surgical approach or technique independently changes time to meeting discharge criteria	Wainwright et al., Acta Orthop 2020: ERAS Society consensus (PMID 31663402)
Lateral femoral cutaneous nerve numbness spontaneously reported by about 1% of patients	Gorur et al., Arthroplast Today 2024 (PMID 39100423)
Lateral femoral cutaneous nerve altered sensation in 21–36% of patients when specifically sought	Vasantharao et al., Hip Int 2022 (PMID 32787466); Sang et al., J Arthroplasty 2021 (PMID 34074541); Homma et al., Int Orthop 2016 (PMID 26224618)
96% spontaneous improvement of thigh numbness; prevalence falling from 31.9% to 11.2% between 13 and 26 months	Ozaki et al., J Orthop Surg 2017 (PMID 28118808)
Lateral femoral cutaneous nerve injury does not affect hip function scores	Homma et al., Int Orthop 2016 (PMID 26224618)
Braking returns to baseline about 2 weeks after right hip replacement	van der Velden et al., Bone Joint J 2017 (PMID 28455464)
Pooled driving recommendation 4.5 weeks; individualise by side and transmission	Patel et al., Hip Int 2023 (PMID 33736494)
Return to sport, about 5 activities permitted by 6 weeks and 37 of 47 by 6 months; contact sport not permitted (expert consensus survey)	Thaler et al., J Arthroplasty 2021 (PMID 33277143)

CLAIM	SOURCE
Surgeons steadily more permissive about activity after hip replacement; perceived risk minimal	Vu-Han et al., Arch Orthop Trauma Surg 2021 (PMID 33258998)
Air travel, no demonstrated difference in clot risk after joint replacement; long-haul flights over 4 hours carry a higher baseline risk	Elmenawi et al., JBJS Rev 2025 (PMID 40259452)
Bruising tracking down the thigh after hip replacement	No primary literature identified: presented as a consistent clinical observation, not a studied finding

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This guide is general information for patients of Dr Matthew Broadhead (Harbour Orthopaedics & Sports Medicine) and is not a substitute for the specific advice given to you by Dr Broadhead, your physiotherapist or your hospital team.

Surgical findings vary, and your protocol may differ from what is written here: your operation record and your surgeon’s instructions always take precedence.

If in doubt, call the rooms on (02) 9052 1883. In an emergency, call 000.

Last reviewed: 2026-08-05 by Dr Matthew Broadhead, FRACS (Orth).

YOUR PROGRESS TRACKER

Fill this in once a week: it shows your trend at a glance and makes reviews far more useful. Bring it to every appointment.

Week	1	2	3	4	5	6	7	8	9	10	11	12
Exercises done (sessions)												
Walking distance / time												
Pain score (0–10)												
Swelling (less / same / more)												

QUESTIONS FOR DR BROADHEAD