REHABILITATION AFTER TOTAL HIP REPLACEMENT: POSTERIOR APPROACH

Posterior hip replacement recovery: full weight bearing day one, hip precautions for 6 weeks, driving typically 4–6 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 posterior approach, where the surgeon works from behind the hip. If your operation was through the front of the hip, use our anterior approach guide instead, its advice is close to the opposite of this one.

This guide walks you through recovery after a posterior-approach total hip replacement, week by week, what to do, what to expect, and when to call us. The headline is simple: you can stand and walk on the new hip from day one, and walking is the main exercise. What needs protecting for the first six weeks is not the implant but the repaired soft tissues at the back of the hip, and one specific combination of movements.

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 for balance, typically 1–2 weeks, then a single stick as needed to about 3–6 weeks

BRACE
No brace

PRECAUTIONS
Posterior precautions for 6 weeks, no bending past 90°, no crossing the midline, no turning the leg inward

DRIVING
Typically 4–6 weeks, individually assessed; often earlier for a left hip in an automatic

DESK WORK
Typically 2–4 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.

Through the posterior approach, the surgeon works from behind the hip, splitting the gluteal muscle fibres and dividing the small rotator muscles at the

back of the hip, which are then repaired. The joint capsule (the sleeve of tissue enclosing the joint) at the back is also repaired. This is the most widely used and most versatile approach worldwide. It gives excellent access, and it does not disturb the main hip abductor mechanism. The outer-hip muscles that keep your pelvis level when you walk.

THE IDEAS THAT MAKE EVERYTHING ELSE MAKE SENSE

1. The implant is stable immediately. The soft tissues are what need protecting

The metal is fixed to bone from the moment you wake up, which is why you may put full weight through it straight away. The repaired muscles and capsule at the back of the hip take about six weeks to heal, which is why there are movement restrictions for six weeks, and not longer.

2. The precautions target one specific combination of movements

Everything you are asked to avoid is a version of the same risk: deep bending combined with turning the leg inward. Understanding the pattern is easier than memorising a list.

3. 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.

4. Swelling and bruising travel with gravity

Bruising down the thigh and into the knee, and even the ankle, is expected and not a complication. It tracks downward from the hip over the first weeks and then fades.

5. An honest word about the precautions

Careful studies show that relaxing these restrictions has not been shown to increase dislocation, and dropping them has not been shown to be harmful, but nor has dropping them been shown to make hips safer. This guide takes a moderate position: full six-week precautions, because they are cheap, temporary and easily explained. Your surgeon may relax these for you, and that is a reasonable, evidence-supported decision.

WEIGHT BEARING AND WALKING AIDS

WEIGHT BEARING

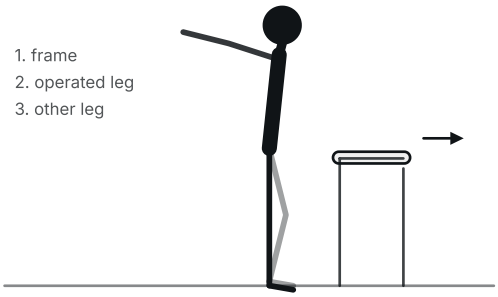
FULL WEIGHT BEARING AS TOLERATED FROM DAY ONE

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 press-fit (uncemented). The one exception: if something found during your operation means weight needs restricting, such as a crack in the bone, extra bone work or a fixation that needs protecting, Dr Broadhead will tell you before you first get up.

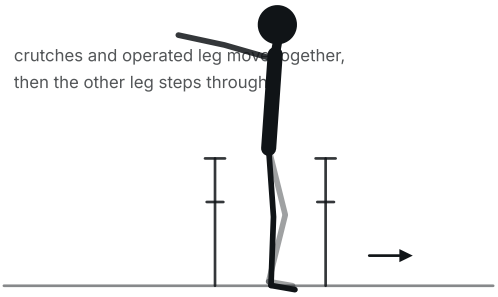
This is backed by evidence, not just habit. Systematic review evidence shows that immediate unrestricted weight bearing on an uncemented stem does not compromise the stem settling into position (subsidence) or the bone growing onto it; cement achieves immediate mechanical fixation.

The frame or crutches are for balance and confidence, not to keep weight off the leg. And keep a stick for crowds, uneven ground and long distances for longer than you think you need it.

STAGE	TYPICAL TIMING	MOVE ON WHEN
Wheeled frame or two crutches	Day 0 to about 1–2 weeks	Safe balance; walking without a lurch
One crutch or a single stick (opposite hand)	About 2–4 weeks	Level walking without a limp; able to stand on the operated leg with control
No aid	About 3–6 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

POSTERIOR HIP PRECAUTIONS

SIX WEEKS

The repaired posterior capsule and short external rotators are the hip's guard against the ball levering out of the socket backwards. The unsafe pattern is deep hip bending, the legs crossing the midline, and the operated leg turning inward, especially any two of these together. The usual formulation is: keep hip bending under 90 degrees, do not cross the midline, and do not turn the leg inward, for six weeks, but be aware that units vary (some use 12 weeks, some limit rotation in both directions, and one UK survey found advice ranging from six weeks to lifelong). The honest evidence summary: these restrictions do not appear to buy a safety benefit, dislocation rates are about the same with or without them, and dropping them has not been shown to be harmful. We ask you to follow the full six weeks because the rules are cheap, temporary and easily explained. Your surgeon may relax these for you, and that is a reasonable, evidence-supported decision.

RULE	WHY	HOW TO MANAGE
Do not bend the hip more than 90 degrees, keep the knee below hip height, and do not lean forward past your knees when seated	Deep flexion (bending) levers the ball toward the back of the socket	Use high chairs with arms; raise a low bed; use a toilet seat raiser and a shower chair for 6 weeks. No low sofas, beanbags, camping chairs or car seats reclined low.
Do not cross the operated leg over the midline: legs, ankles or knees	Adduction (the leg crossing the middle of the body) narrows the safety margin	Sleep with a pillow between the knees; sit with feet apart; do not cross your legs even briefly.
Do not turn the operated foot or knee inward	Internal rotation is the third component of the dislocating position	Pivot on your feet by taking small steps, not by twisting the hip; move the whole body to turn.
Do not combine bending with reaching down or twisting	The combination is the real risk, not any single movement	Use a long-handled reacher, sock aid, long-handled shoehorn and long sponge for 6 weeks.

RULE	WHY	HOW TO MANAGE
Do not lie on the operated side without a pillow, and do not sleep face down	Your position is uncontrolled while you are asleep	Sleep on your back with a pillow between or under the knees, or on the non-operated side with a firm pillow between the knees.

EVERYDAY SITUATIONS

Car. Reverse in: sit down first with the seat slid fully back and reclined slightly, then swing both legs in together, keeping the knees apart. Do not twist.

Toilet. Use the raised seat, hands on rails or thighs, operated leg slightly forward.

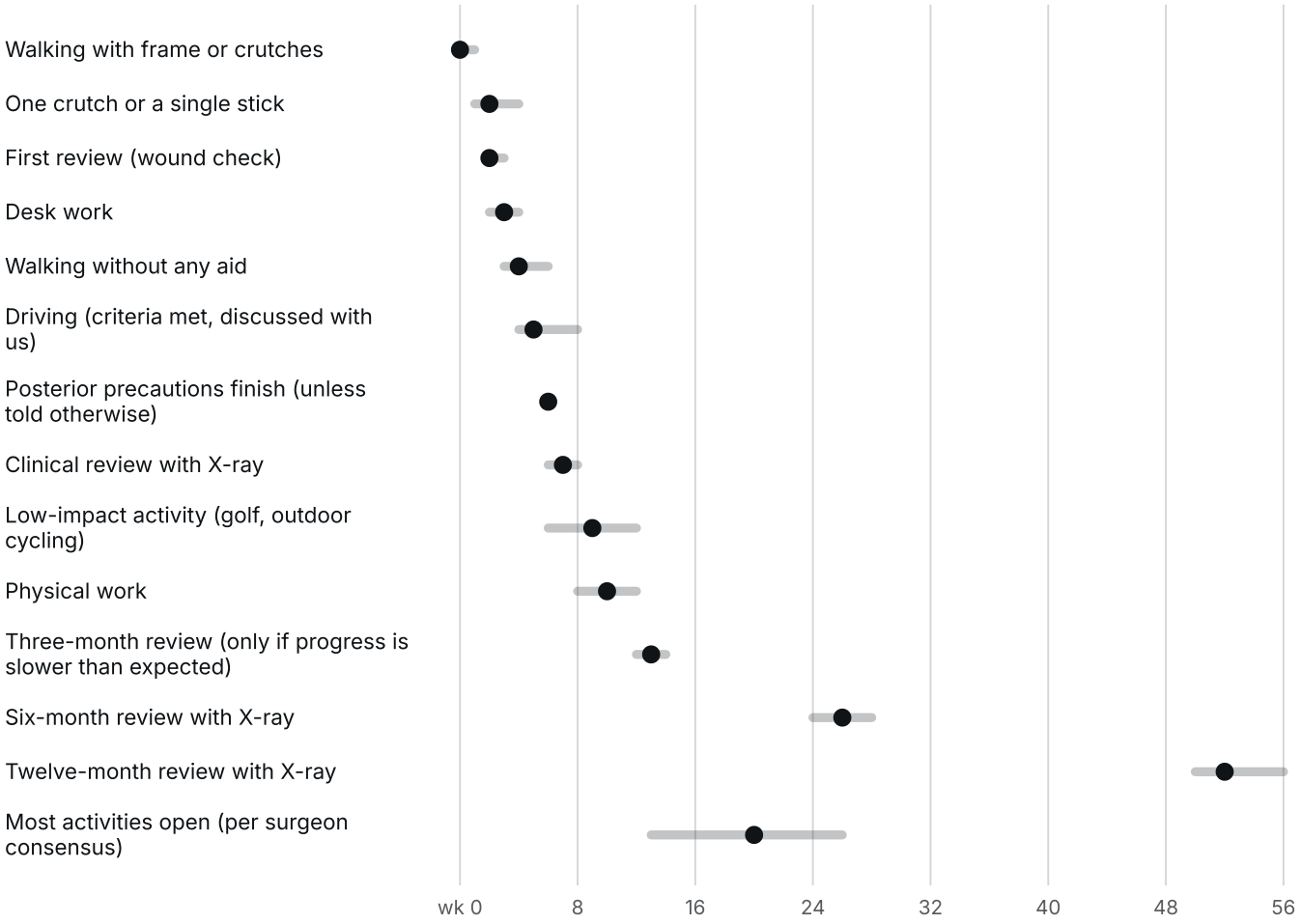
Bed. Sit at the edge, slide back, then lift the legs up together with a pillow between the knees.

Shower. Use a shower chair, a long sponge and a non-slip mat. Do not bend to wash your feet.

Dressing. Dress the operated leg first and undress it last. Use the sock aid and reacher, no bending to floor level.

Stairs. Up with the good leg first, down with the operated leg first: “up with the good, down with the bad”.

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: PROTECT AND SETTLE

WEEKS 0–2

Walk little and often, settle the swelling, wake the hip muscles up, and make the precautions automatic.

GOALS: TICK THEM OFF

- [ ] Walking short distances hourly with the frame or crutches
- [ ] Precautions automatic: chair, toilet, bed and car all set up and rehearsed
- [ ] 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.
- Set the house up before you tire: high chair with arms, raised toilet seat, raised bed, reacher and sock aid within arm's length.

AVOID THIS

- Low sofas, beanbags, camping chairs and any seat that puts your knee above your hip.
- Crossing the legs, even briefly, even at the ankles.
- Twisting on the planted leg; turn with small steps instead.
- Bending to floor level: use the reacher.

READY FOR THE NEXT PHASE WHEN…

- Safe, independent transfers: bed, chair, toilet, car, with the precautions intact
- Walking with the aid, balanced and without a lurch
- Swelling stable or falling

PHASE 2: WALK TALLER

WEEKS 2–6

Wean off the aids, build the outer-hip (abductor) strength that abolishes the limp, and keep the precautions automatic.

GOALS: TICK THEM OFF

- [ ] Walking without a limp; wean from crutches to a stick, then to nothing as confidence allows
- [ ] Standing on the operated leg with a level pelvis, briefly and with control
- [ ] Walking distance building day on day
- [ ] Precautions still automatic: they run to the six-week mark

DO THIS

- Keep walking as the main exercise: distance a little further each few days.
- Add the standing abductor work, bridging, sit-to-stands, heel raises and mini squats below.
- Start scar massage from about 3 weeks, once the wound is fully healed and dry.
- Ice after exercise sessions.

AVOID THIS

- Dropping the precautions early because the hip feels good. The soft tissues heal on their own schedule, not on how the hip feels.
- Stretching the hip into deep bending, range returns by itself after six weeks.
- 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: precautions finish unless you are told otherwise

PHASE 3: STRENGTH AND FREEDOM

WEEKS 6–12

With the precautions finished, gradually return to normal movement and build the strength, balance and endurance for real life.

GOALS: TICK THEM OFF

- [ ] Normal seating, bending and movement returning gradually, within comfort
- [ ] 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

- Reintroduce normal chairs, normal toilets and bending, gradually and within comfort, unless you have been told to continue the precautions.
- Progress step-ups, balance work and the stationary bike.
- Walk for endurance: distance and hills.

AVOID THIS

- Impact work: running and jumping are not part of hip replacement rehabilitation.
- Forcing range that is not ready: firm stretch is fine, lingering pain is not.

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
- [ ] 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 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.

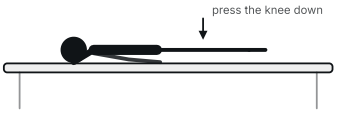
10 firm pumps, every waking hour, for the first 2 weeks

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.

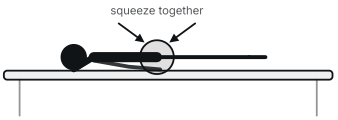
10 holds of 5 seconds, 3–4 times daily

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



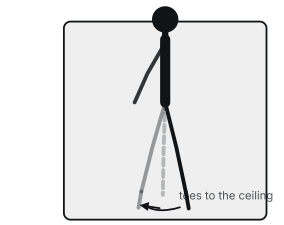
Squeeze the buttocks together and hold 5 seconds

Wake the buttock muscles: the muscles the surgeon worked through, and the hip's engine.

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. Mild pulling near the wound is normal; sharp pain is not.



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

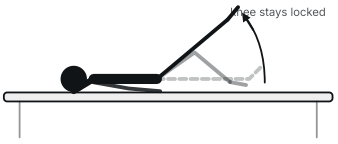
1. Lie on your back with both legs straight.
2. Keeping the knee straight and the toes pointing at the ceiling, slide the operated leg out to the side about 30 cm.
3. Slide it back to the middle, and stop there. Do not cross the midline.

Feel: Toes to the ceiling the whole time. This stops the leg rotating. You should feel the outer hip working.

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

STRAIGHT LEG RAISE

PHASE 1



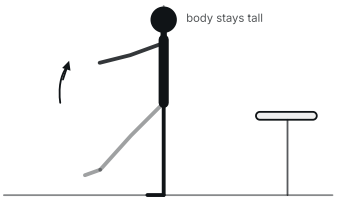
Lock the knee straight, lift, lower slowly

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: Keep the toes pointing at the ceiling. Ease off if you feel sharp pain in the groin. A dull working ache is fine.



Leg out to the side, body stays tall

HIP ABDUCTION (STANDING)

PHASE 2

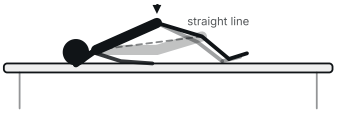
The abductor strength that abolishes the limp: the key hip exercise of Phase 2.

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, and stop at the midline, do not swing the leg across.

Feel: Stay upright: do not lean away to cheat the lift. Keep the pelvis level; the movement is small and controlled.

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



Lift the hips to a straight line from shoulder to knee

BRIDGING

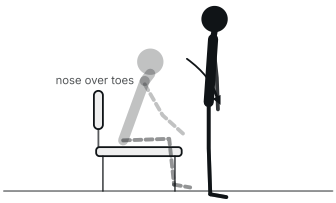
PHASE 2

Gluteal and core strength for standing up, stairs and a stable pelvis.

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

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. Keep the knees hip-width apart: do not let them fall together.



Nose over toes, push up evenly through both legs

SIT-TO-STAND

PHASE 2

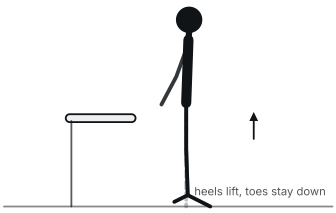
Real-world leg strength: the movement you will do more than any other.

2–3 sets of 8–10, once or twice daily

1. Use a firm, high chair with arms, never a low one while the precautions apply.
2. Slide to the front edge with the operated leg slightly forward.
3. Push up through the arms and legs together, rising tall rather than folding your chest over your knees.
4. Lower back down slowly with control.

Feel: Operated leg slightly forward on the way down as well. Share the load evenly, no flopping into the seat.

Harder: Use the arms less over time; keep the seat high until the six-week mark.



Up onto the balls of the feet, lower slowly

HEEL RAISES

PHASE 2

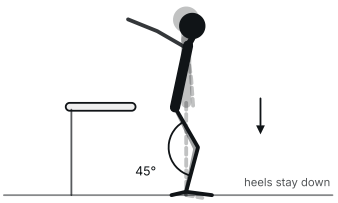
Calf strength for a normal push-off when walking.

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

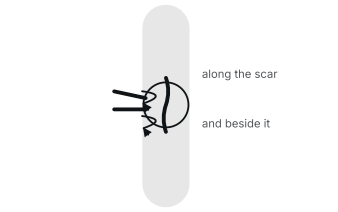
PHASE 2

Thigh and hip strength through a small, safe range: well short of the 90-degree limit.

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. Small range: this is not a deep squat.



Firm small circles, 2 to 3 minutes twice daily

SCAR MASSAGE

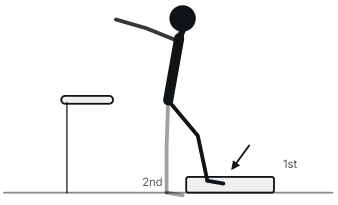
PHASE 2

Soften and desensitise the scar once fully healed.

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.



Operated leg goes up first, the other foot joins it

STEP-UPS

PHASE 3

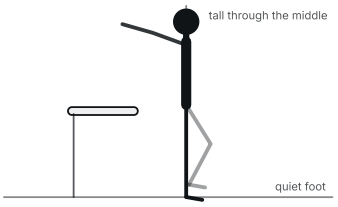
Single-leg strength for stairs and slopes.

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

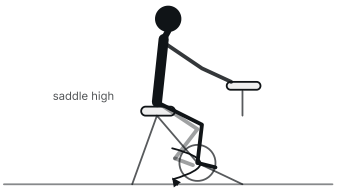
PHASE 3

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.



Saddle high at first, build time before resistance

STATIONARY CYCLING

PHASE 3

Endurance and circulation with almost no joint load.

10–20 minutes, most days, from about 6 weeks

1. Set the saddle high: a higher seat keeps the hip bend comfortable.
2. Mount carefully, swinging the leg over without twisting.
3. Progress time before resistance.

Feel: Comfort is the guide; lower the saddle gradually over the following weeks.

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.

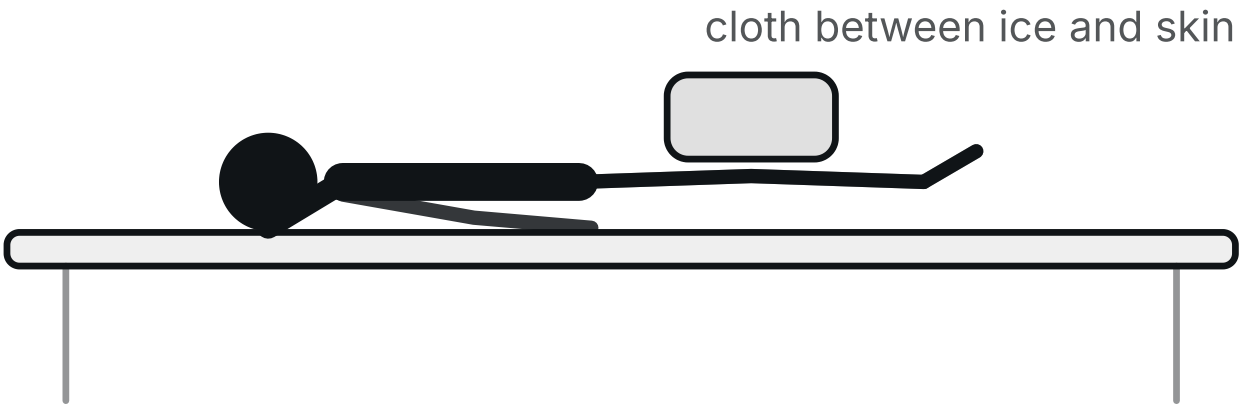
- After a hip replacement in particular, bruising travels with gravity: bruising down the thigh and into the knee, and even the ankle, is expected and not a complication.

ICE

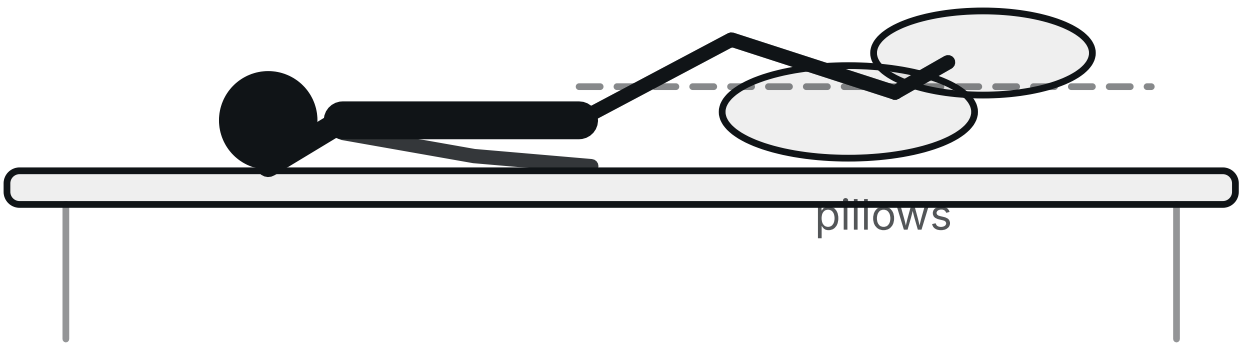
- Ice is safe, cheap and comfortable, and probably gives a small benefit for pain and swelling in the first few days.
- Use it for 15–20 minutes at a time, 4–6 times a day for the first 2 weeks, then as needed after activity and physiotherapy. It is particularly useful in the hour after exercise.
- Always 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

For the first six weeks: sleep on your back with a pillow between or under the knees, or on the non-operated side with a firm pillow between the knees.

Do not lie on the operated side without a pillow, and do not sleep face down. Your position is uncontrolled while you are asleep, which is exactly why these two rules exist.

Getting into bed: sit at the edge, slide back, then lift the legs up together with a pillow between the knees. Raise a low bed for the first six weeks.

After six weeks, unless you are told otherwise, sleep in whatever position is comfortable.

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, hip replacements generally hurt less early on than knee replacements, 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.

Numbness over the buttock or the outer thigh is not typical of the posterior approach: if you notice it, mention it at your review.

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	From about 6 weeks	Wound fully healed; precautions finished or saddle set high	Saddle high; mount without twisting
Driving	4–6 weeks	All the driving criteria below, discussed with us	Often earlier for a left hip in an automatic: clinical judgement, not trial evidence
Desk work	2–4 weeks	Comfortable sitting in a suitably high chair; travel sorted	Set the workstation up to respect the 90-degree rule for the first six weeks
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: posterior or anterior?

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

How long will I be on crutches after a posterior hip replacement?

Typically a frame or two crutches for the first 1–2 weeks, then one crutch or a stick in the opposite hand from about 2–4 weeks, and nothing from about 3–6 weeks. You progress when you can walk without a limp, not on a set date. Keep a stick for crowds, uneven ground and long distances longer than you think you need it. That is sensible, not slow.

Can I put weight on my leg after a hip replacement?

Yes: full weight from day one, whether the implant was cemented or press-fit. The implant is fixed to bone from the moment you wake up. The only exception is if something found during your operation means weight needs restricting, in that case Dr Broadhead will tell you before you first get up. The frame or crutches are for balance, not to keep weight off.

What are the hip precautions after a posterior hip replacement?

The usual formulation is: do not bend the hip past 90 degrees, do not cross the operated leg over the midline, and do not turn the operated foot or knee inward, for six weeks. All of it is a version of one risk: deep bending combined with the leg turning inward,

especially together. Units vary in how long and how strictly they apply these, so follow the version you were given.

Do I really need to follow the hip precautions?

Follow the version you were given. The honest evidence: across about 6,900 patients, dislocation was 2.2% with precautions and 2.0% without, so the restrictions do not appear to buy a safety benefit, and dropping them has not been shown to be harmful. We ask for the full six weeks because the rules are cheap, temporary and easily explained. Your surgeon may relax these for you, and that is a reasonable, evidence-supported decision.

When can I sleep on my side after a hip replacement?

From the start you can sleep on the non-operated side with a firm pillow between the knees, or on your back with a pillow between or under the knees. For the first six weeks, do not lie on the operated side without a pillow, and do not sleep face down. After six weeks, unless you are told otherwise, sleep in whatever position is comfortable.

When can I drive after a hip replacement?

Typically 4–6 weeks after a posterior hip replacement, individually assessed, often earlier for a left hip in an automatic, which is clinical judgement rather than trial evidence. The date matters less than the criteria: off strong painkillers, comfortable in the driver’s seat, and able to perform an emergency stop at full force without hesitation. Confirm your own timing with us at review.

When can I go back to work after a hip replacement?

Desk work typically at 2–4 weeks, once you are comfortable sitting in a suitably high chair and have transport sorted. 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.

How long do I need the raised toilet seat and high chair?

For the six weeks the posterior precautions apply. The raised toilet seat, shower chair and high chairs with arms all serve the same purpose: keeping the hip from bending past 90 degrees. After six weeks, unless you are told otherwise, the equipment can be returned and you can go back to normal seating gradually, within comfort.

What is the risk of the hip dislocating?

About 1–2% in the first year, and up to about 3.5% within two years when every dislocation, including those put back without further surgery, is counted. Larger femoral heads reduce the risk, and dual-mobility bearings reduce it substantially further in higher-risk patients. The highest-risk position is deep bending combined with the leg turning inward: exactly the pattern the six-week precautions target.

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

Pooled trial evidence gives the anterior approach a modest early advantage: slightly less pain in the first two days, better hip function scores at two and six weeks, and walking aids discarded around 11 days sooner. 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 the approaches differ mainly in the kind of problem that leads to revision.

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.

When can I bend down to put on socks and shoes?

Not in the first six weeks: bending to floor level takes the hip well past 90 degrees, and combining bending with reaching is the exact pattern to avoid. Use a sock aid, a long-

handled shoehorn and a reacher; dress the operated leg first and undress it last. From six weeks, once the precautions finish, return to bending gradually within comfort.

THE EVIDENCE BEHIND THIS GUIDE 21 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)
Dislocation 2.2% with precautions vs 2.0% without (systematic review, 7 studies, 6,900 patients)	Crompton et al., Acta Orthop 2020 (PMID 32718213)
No influence of precautions on early recovery; low-to-very-low certainty evidence	Korfitsen et al., Acta Orthop 2023 (PMID 37039064)
No need for precautions; better HOOS-JR and earlier walking-aid discontinuation without them	Guo et al., Medicine 2024 (PMID 39686472)
RCT, less difficulty with daily activities, earlier driving and side-sleeping when unrestricted	Tetreault et al., J Arthroplasty 2020 (PMID 32146109)
Counterpoint RCT, no benefit from removing restrictions; slightly lower HOOS-JR at 2 weeks in the unrestricted group	Dietz et al., J Arthroplasty 2019 (PMID 30975478)
Uncertain evidence for precautions and equipment provision	Smith et al., Cochrane Database Syst Rev 2016;7:CD010815 (PMID 27374001)
Danish registry, no significant increase in dislocation after dropping precautions, in the context of a simultaneous move to 36 mm heads	Iljazi et al., Acta Orthop 2024 (PMID 39023400)
True 2-year dislocation incidence 3.5% when every dislocation is counted	Hermansen et al., J Bone Joint Surg Am 2021 (PMID 33347013)
Larger femoral heads reduce dislocation risk	Hermansen et al., J Bone Joint Surg Am 2021 (PMID 33347013); Cnudde et al., Acta Orthop Belg 2025 (PMID 41928745)

CLAIM	SOURCE
Dual mobility, around 80% reduction in dislocation within 2 years in a large matched study	Hussein et al., Bone Joint J 2025 (PMID 39740683)
AOANJRR: dual mobility no advantage over heads ≥36 mm except in sockets <58 mm	Hoskins et al., J Arthroplasty 2021 (PMID 34088570)
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)
35% of right-hip and 15% of left-hip patients failed the 600 ms braking threshold at 6 weeks	Jordan et al., Arch Phys Med Rehabil 2014 (PMID 24685390)
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)
Surgeons steadily more permissive about activity after hip replacement; perceived risk minimal	Vu-Han et al., Arch Orthop Trauma Surg 2021 (PMID 33258998)
Anterior approach, less pain days 1–2, better function at 2 and 6 weeks, no difference at 6–12 months; walking aids discarded ~11 days earlier	Nassar et al., Orthop Rev 2025 (PMID 40416593); 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)
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

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