



Rapid Recovery After Anterior Total Hip Replacement

*What You Should Expect From
Surgery & Return-to-Work*

2026 Workers' Compensation Conference
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Learning Objectives

1

Describe rapid recovery anterior THA

Muscle-sparing concepts, multimodal pain control, and same-day discharge protocols — and how they affect outcomes.

2

Outline recovery milestones

Expected postoperative benchmarks after anterior hip replacement, from surgery day through functional recovery.

3

Apply return-to-work timelines

Evidence-based RTW planning by job demand level for Workers' Compensation case management.

Why Case Managers Need a Hip Replacement Roadmap



- THA is highly successful, but recovery expectations vary widely.
- Working-age patients increasingly expect faster recovery & earlier return to function.
- Case managers influence outcomes by coordinating approvals, therapy, transportation, home support, job modification, & timely RTW communication.
- RTW should be planned around **functional ability and job demand**, not a single universal date.

Cost of Hip Replacement



Summary Cost Projections by Dataset			
	Best Practice	Claim Typical	Claim Max
Indemnity	\$3,926.56	\$10,887.28	\$14,099.92
Medical	\$33,631.35	\$43,524.39	\$62,535.04
Expense & Admin	\$3,599.85	\$3,243.98	\$4,285.48
Total	\$41,157.76	\$57,655.65	\$80,920.44

Hip Arthritis & Work Disability

- **Common patient symptoms**

- Groin or anterior thigh pain
- Stiffness with shoes, socks, stairs, and vehicles
- Limp, gait compensation, and reduced endurance
- Sleep disturbance and difficulty with prolonged sitting or standing

- **Work tasks affected**

- Walking distance and uneven terrain
- Stairs, ladders, kneeling, squatting, crawling
- Pushing, pulling, lifting, carrying
- Commercial driving or safety-sensitive work



Goal of Hip Replacement

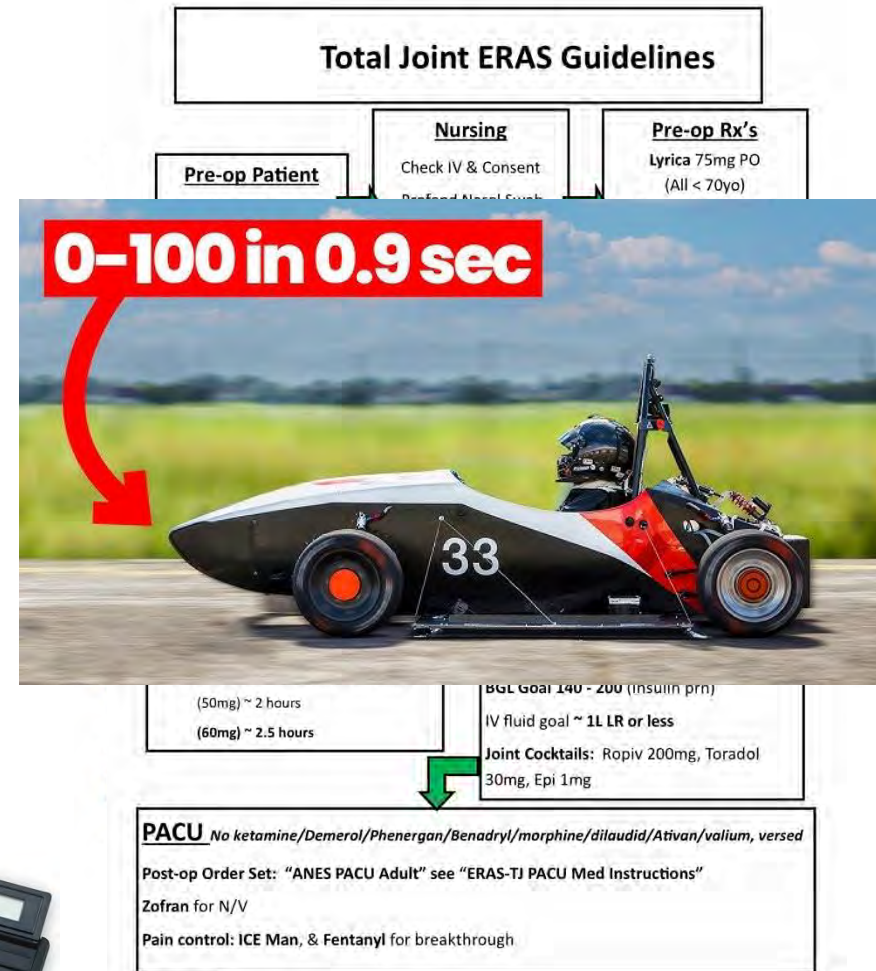
- Natural feeling hip
- Painless
- Durable
- Quicker recovery
- Fast return to work

So how do we get there??



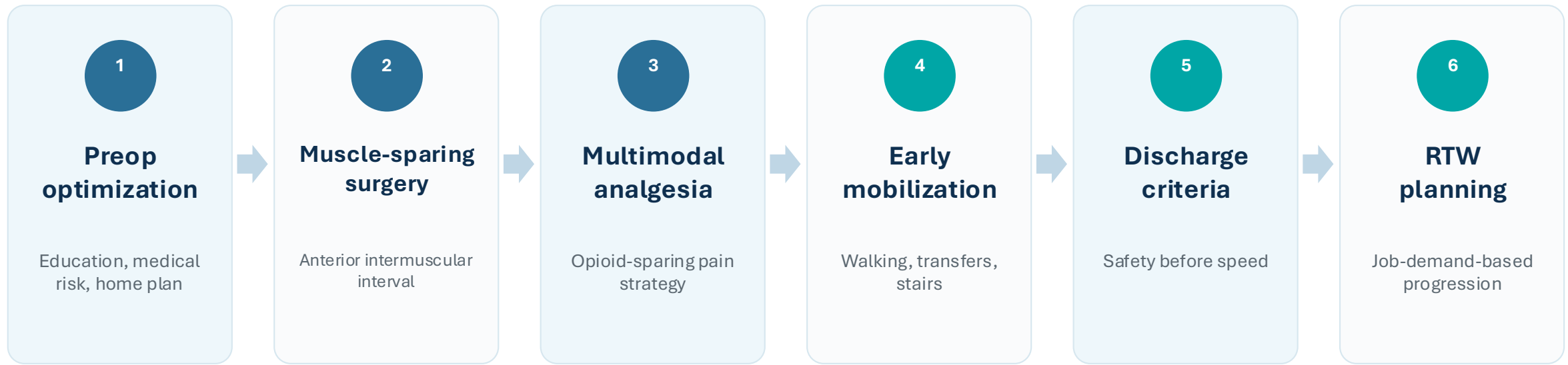
Rapid Recovery Joint Replacement

- RRJR – aims to minimize postoperative pain & restore function in the shortest time possible.
- Keys to Success:
 - Patient Selection
 - Risk factor assessment
 - Social support
 - Pre-operative optimization
 - *Come in healthy & leave healthy*
 - Enhanced Recovery After Surgery protocols
 - Frequent patient communication



Rapid Recovery Joint Replacement is a pathway

Not “just a smaller incision” - a coordinated sequence of decisions before, during, & after surgery.



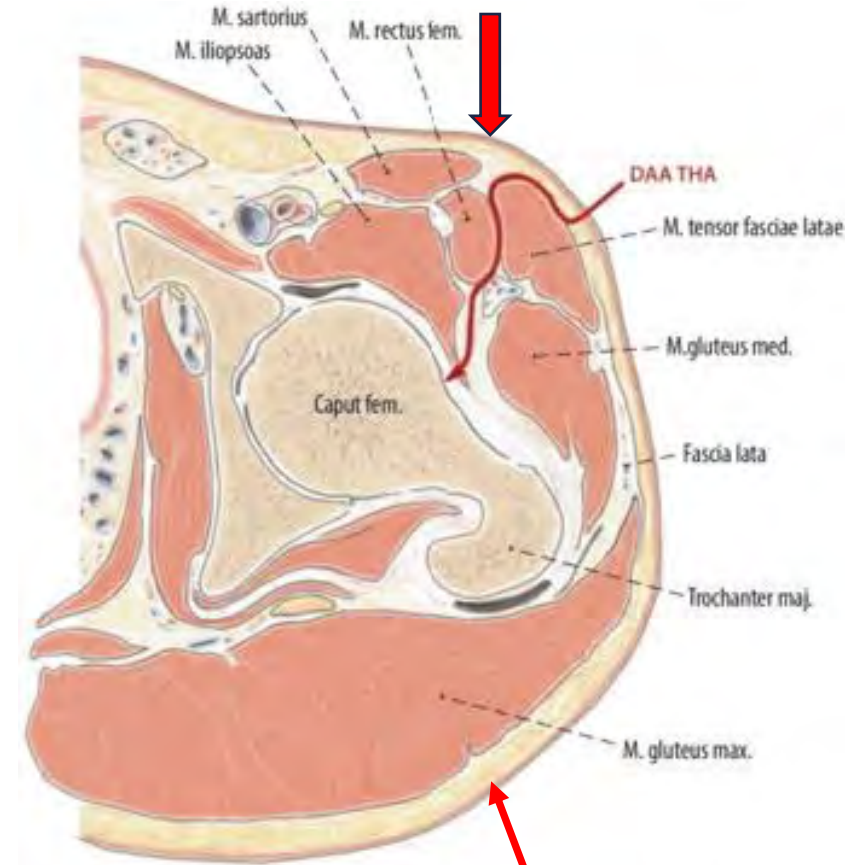
Case manager takeaway: rapid recovery succeeds when predictable barriers are removed before surgery.

Muscle Sparing Joint Replacement

- Aims to reduce muscle & soft tissue damage while restoring function as expeditious as possible



Direct Anterior v/s Mini-Posterior Approach



PA

Direct Anterior v/s Mini-Posterior

Clin Orthop Relat Res (2018) 476:216-229
DOI 10.1007/s11999-000000000000112

Clinical Orthopaedics
and Related Research®
A Publication of The Association of Bone and Joint Surgeons®

2017 Hip Society Proceedings

Lin et al.
Journal of Orthopaedic Surgery and Research (2023) 18:119
<https://doi.org/10.1186/s13018-023-03603-0>

Journal of Orthopaedic
Surgery and Research

RESEARCH ARTICLE

Open Access

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Research Article

Direct Anterior Approach to Total Hip Arthroplasty Improves the Likelihood of Return to Previous Recreational Activities Compared with Posterior Approach

Paul A. Mead, MD
William D. Bugbee, MD 

ABSTRACT

Journal of the AAOS Global Research & Reviews® | January 2022, Vol 6, No 1 | © American Academy of Orthopaedic Surgeons

- DA 6 wk improved function, quicker no cane, no diff at 8 wks
- DA LOS 1day shorter & 6 wk improved function, no diff at >6 months
- At 1 yr DA 73% v/s PA 54% return to previous level sport

Multimodal Pain Strategies



Preoperative case manager checklist

Home & transport

- Responsible adult 24–72 hrs
- Stairs/bathroom/fall hazards
- Ride home and first visit

DME & meds

- Walker/cane, toilet equipment if needed
- Pain meds, antiemetic, bowel regimen
- DVT prophylaxis authorization

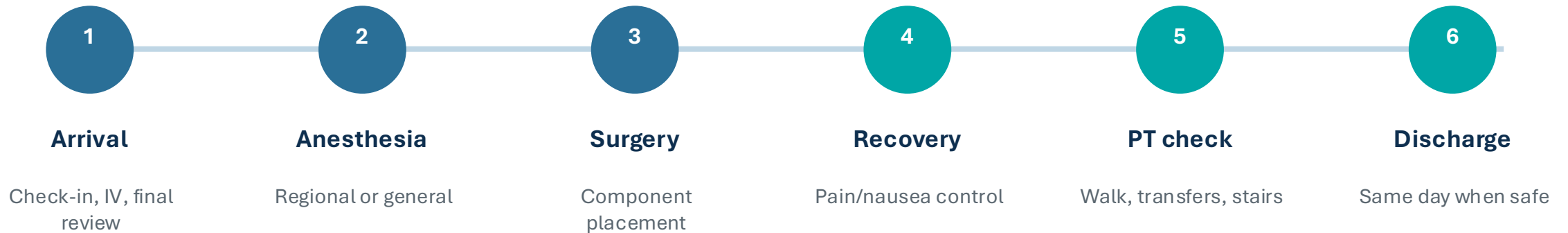
Care pathway

- PT or home exercise plan
- Wound care instructions
- Red-flag escalation route

Work planning

- Actual job description
- Modified duty availability
- Remote work or reduced hours

What the patient should expect on surgery day



Same-day discharge is the norm and not the exception in the working-age individual

Same-day discharge criteria



Medical stability

Vitals stable; bleeding and nausea controlled



Oral pain plan

Pain controlled with oral regimen



Safe mobility

Transfers, ambulation, stairs when needed



Home support

Responsible adult, safe home setup, transport



Patient education

Meds, wound care, DVT prevention, red flags



Follow-up plan

Clear contact path and visit schedule

Physical Therapy After Joint Replacement

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Formal Physical Therapy After Total Hip Arthroplasty Is Not Required

A Randomized Controlled Trial

Matthew S. Austin, MD, Brian T. Urbani, BS, MS, Andrew N. Fleischman, MD, Navin D. Fernando, MD, FRCSC, James J. Purtill, MD, William J. Hozack, MD, Javad Parvizi, MD, FRCS, and Richard H. Rothman, MD, PhD

Investigation performed at The Rothman Institute, Department of Orthopaedic Surgery, Thomas Jefferson University, Philadelphia, Pennsylvania

Background: The value of formal physical therapy after total hip arthroplasty is unknown. With substantial changes that have occurred in surgical and anesthesia techniques, self-directed therapy may be efficacious in restoring function to patients undergoing total hip arthroplasty.

Methods: We conducted a single-center, randomized trial of 120 patients undergoing primary, unilateral total hip arthroplasty who were eligible for direct home discharge. The experimental group followed a self-directed home exercise program for 10 weeks. The control group received the standard protocol for physical therapy that included in-home visits with a physical therapist for the first 2 weeks followed by formal outpatient physical therapy for 8 weeks. Functional outcomes were measured using validated instruments including the Harris hip score (HHS), the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC), and the Short Form-36 Health Survey (SF-36) preoperatively, at 1 month postoperatively, and at 6 to 12 months postoperatively.

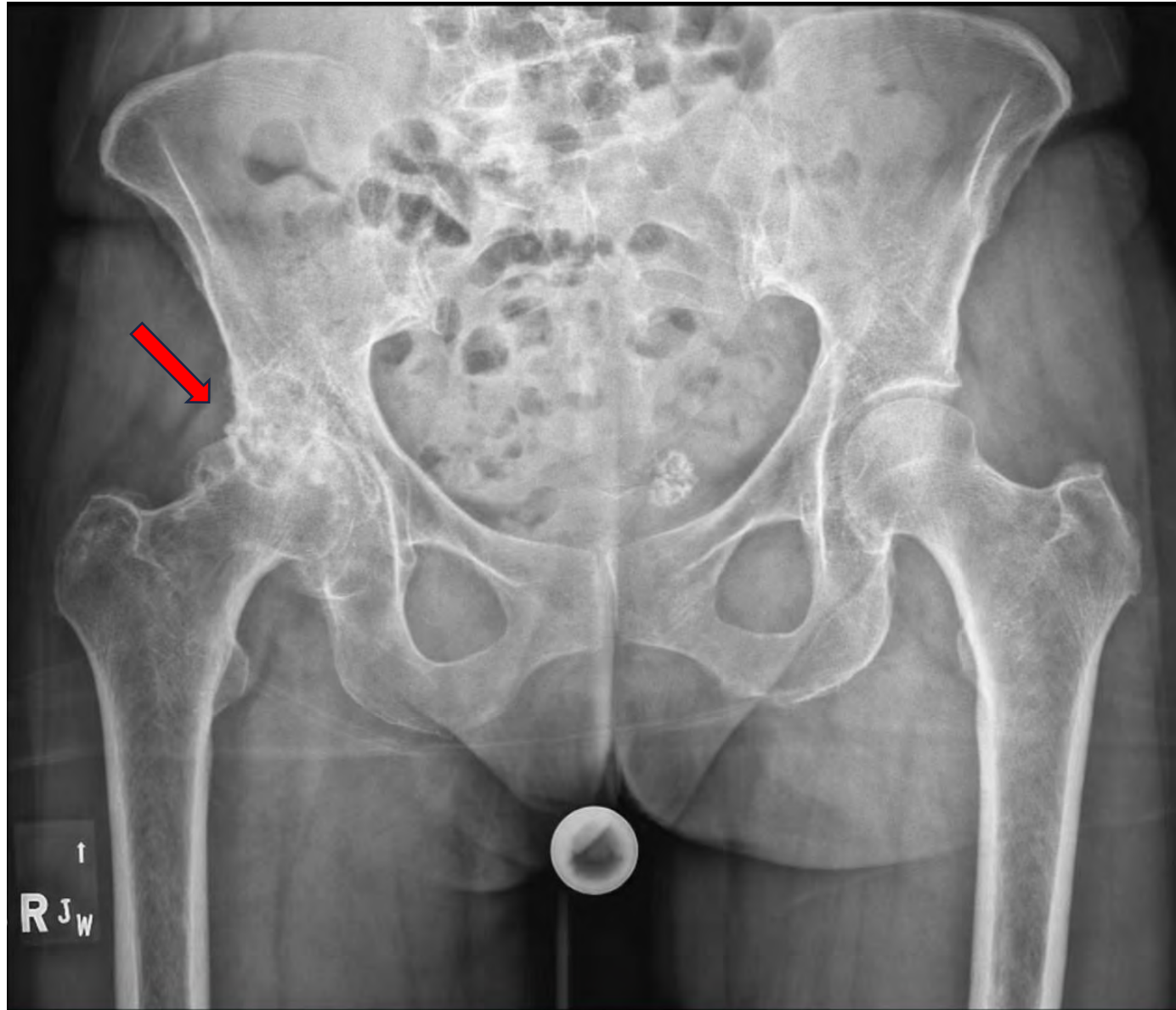
Results: Of 120 randomized patients, 108 were included in the final analysis. Ten patients (19%) were randomized to unsupervised home exercise and 20 patients (37%) were randomized to formal outpatient therapy crossed over between groups. There was no significant difference in any of the measured functional outcomes between patients receiving formal therapy ($n = 54$) and those participating in unsupervised home exercise ($n = 54$) at any time point (HHS, $p = 0.82$; WOMAC, $p = 0.80$; and SF-36 physical health, $p = 0.90$).

Conclusions: This randomized trial suggests that unsupervised home exercise is both safe and efficacious for a majority of patients undergoing total hip arthroplasty, and formal physical therapy may not be required.

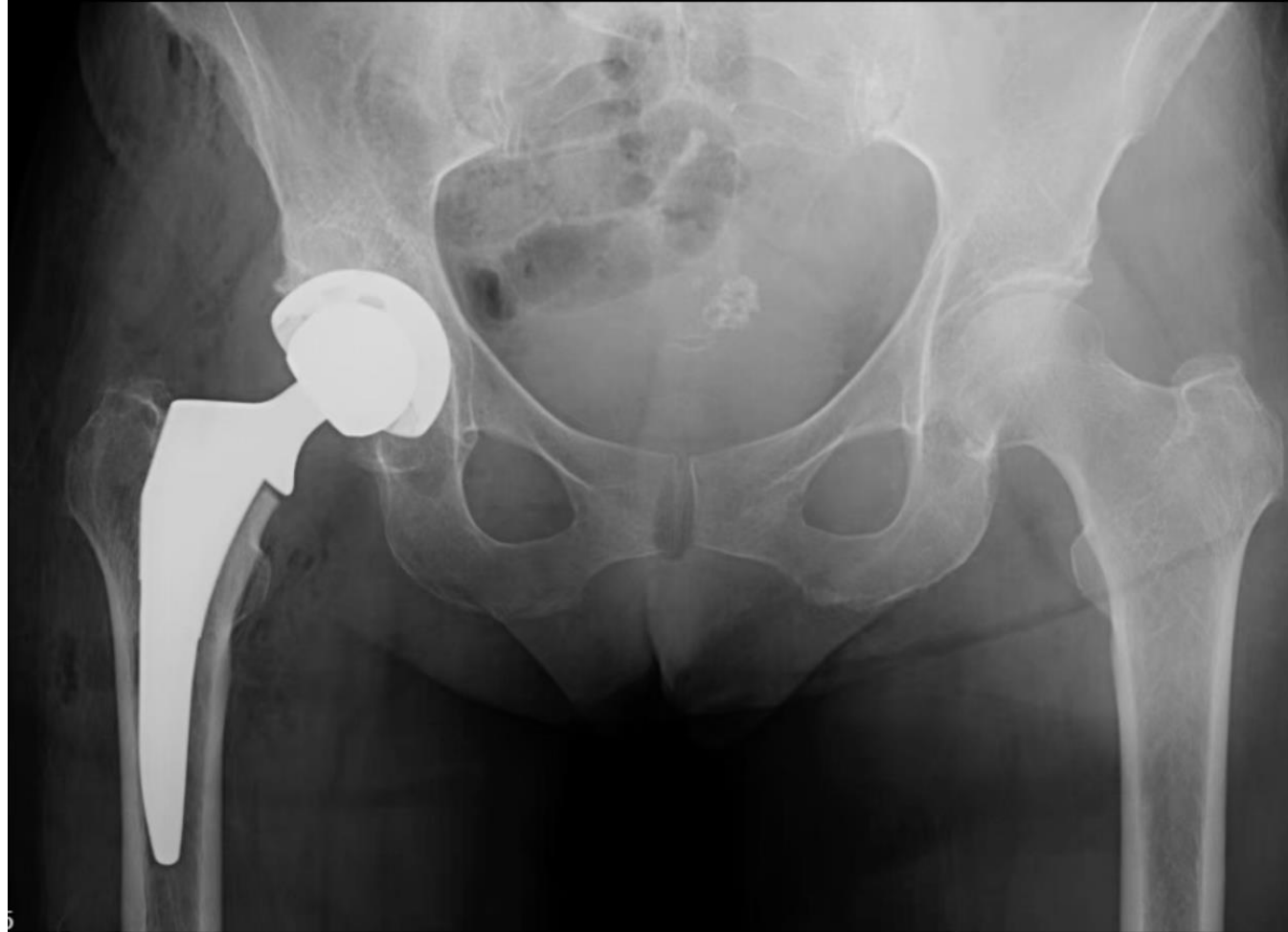
Level of Evidence: Therapeutic Level I. See Instructions for Authors for a complete description of levels of evidence.

- Literature Take Home Point:
 - Most THAs could safely perform un-supervised program
 - A sub-set would benefit from supervised PT
 - Usually recommended in the injured worker to minimize time to RTW

Case Example

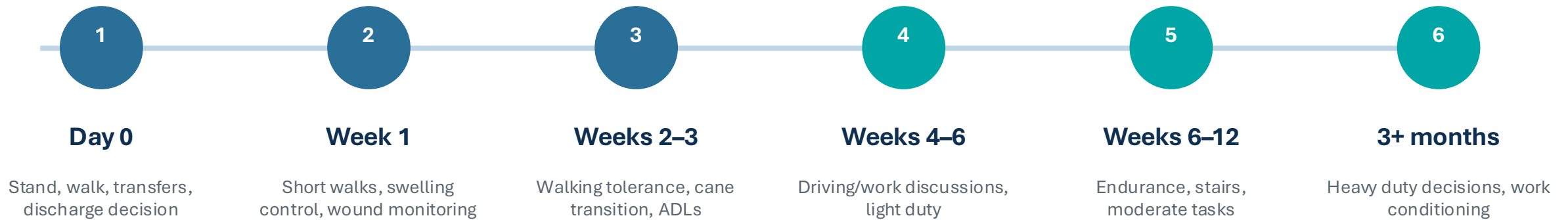


Case Example





Recovery timeline overview



Every patient progresses differently — advance activity when functional benchmarks are met.

Evidence-based RTW expectations

70.7%

Patients working after primary
THA in a 2023 systematic
review/meta-analysis

87.9%

RTW among patients who
worked before surgery

2–3 mo

Majority return-to-work window
in the same review

Slower

Physically demanding work
predicts later and less frequent
RTW

Summary for case managers

- **Desk/low-intensity** roles **may return earlier** when remote work, reduced commute, and sit/stand flexibility are available.
- **Moderate and heavy** jobs should be planned as **staged progression** with restrictions and reassessment.
- **Full duty for heavy** labor often requires more than pain relief — it requires **endurance, balance, strength, and task simulation**.

Recovery After Joint Replacement

RETURN TO SPORTS AND RETURN TO WORK AFTER TOTAL KNEE ARTHROPLASTY

A Systematic Review and Meta-Analysis

JBJS REVIEWS 2023;11(7):e22.00250 • <http://dx.doi.org/10.2106/JBJS.RVW.22.00250>



Return to Daily Activities, Work, and Sports at 3 Months After Total Hip Arthroplasty

Maud C.W.M. Peters, MSc, Yvette Pronk, MSc, and Justus-Martijn Brinkman, MD, PhD

Investigation performed at Kliniek ViaSana, Mill, The Netherlands

When Is It Safe for Patients to Drive after Right Total Hip Arthroplasty?

Victor H. Hernandez, MD, MS, Alvin Ong, MD, Fabio Orozco, MD, Anne M. Madden, Zachary Post, MD

Rothman Institute, Egg Harbor Township, New Jersey



The Journal of Arthroplasty 30 (2015) 627–630

- Literature Take Home Points:
 - 3 months 8:10 back to most activities
 - 6-12 months for full recovery
 - 6 months RTS:
 - THA 82%,
- Back to driving
 - 2 weeks for THA

Return to Work After Joint Replacement



■ ARTHROPLASTY

Time to return to work by occupational class after total hip or knee arthroplasty

Cite this article: *Bone Joint J* 2023;105-B(9):977-984.

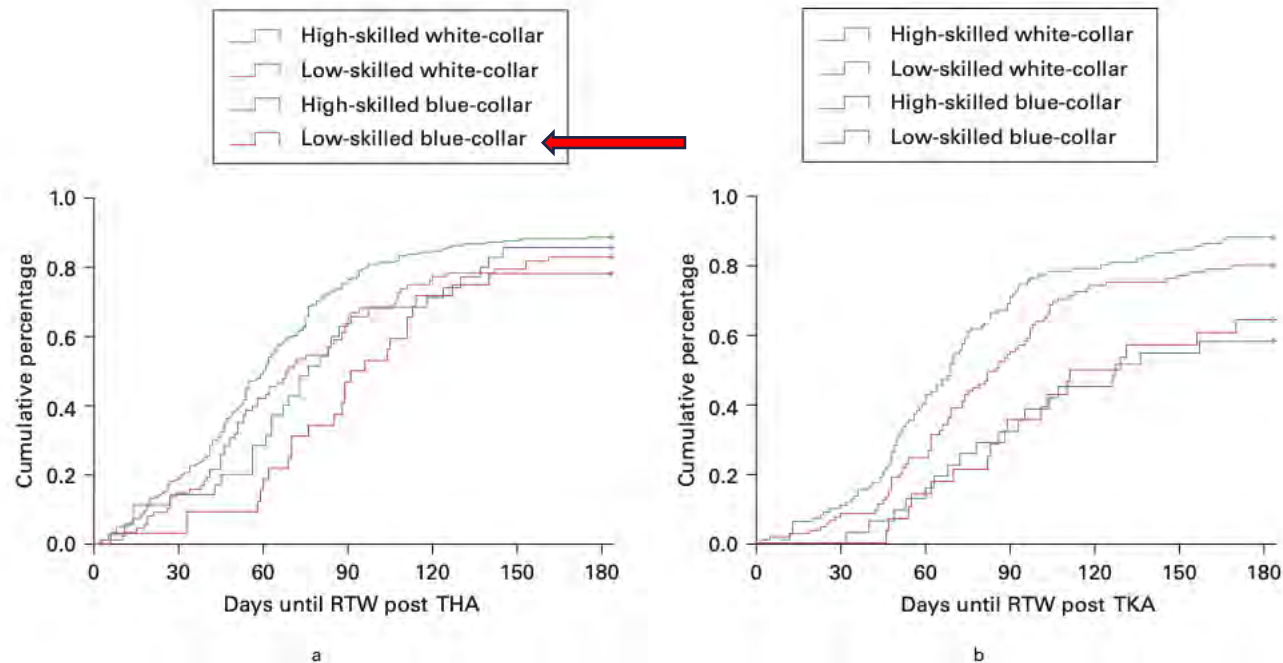


Fig. 2

Kaplan-Meier curves showing a) cumulative percentage of return to work (RTW) within the first six months after total hip arthroplasty (THA) and b) cumulative percentage of RTW within the first six months after total knee arthroplasty (TKA).

- 6 months RTW
- 78% THA

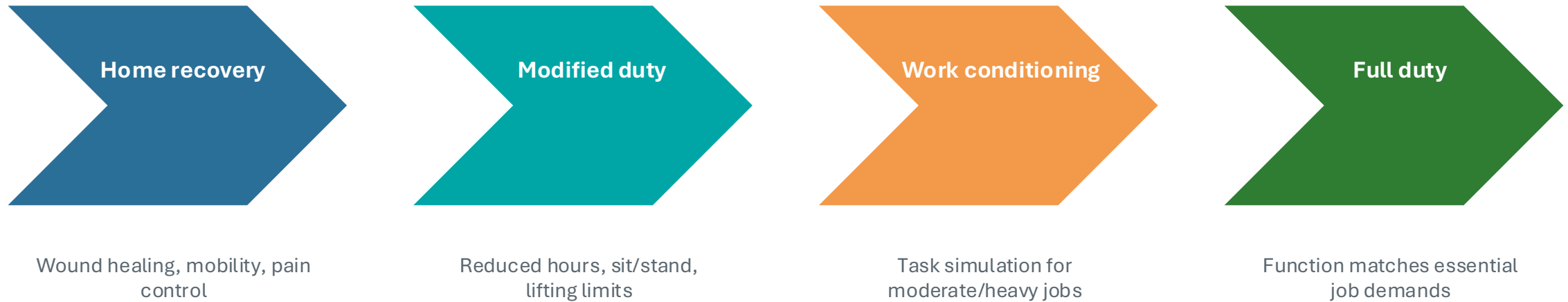
What the surgeon needs from case managers

- Accurate job description: lifting, carrying, stairs, ladders, kneeling, crawling, walking distance, uneven surfaces, driving, safety-sensitive tasks
- Modified duty availability and exact restrictions employer can accommodate
- Remote work, reduced hours, sit/stand options, assistive-device policy
- Prompt communication if milestones are delayed or job demands exceed current function



**The more specific the job data,
the safer and faster the RTW
plan.**

Modified duty is a bridge, not a destination



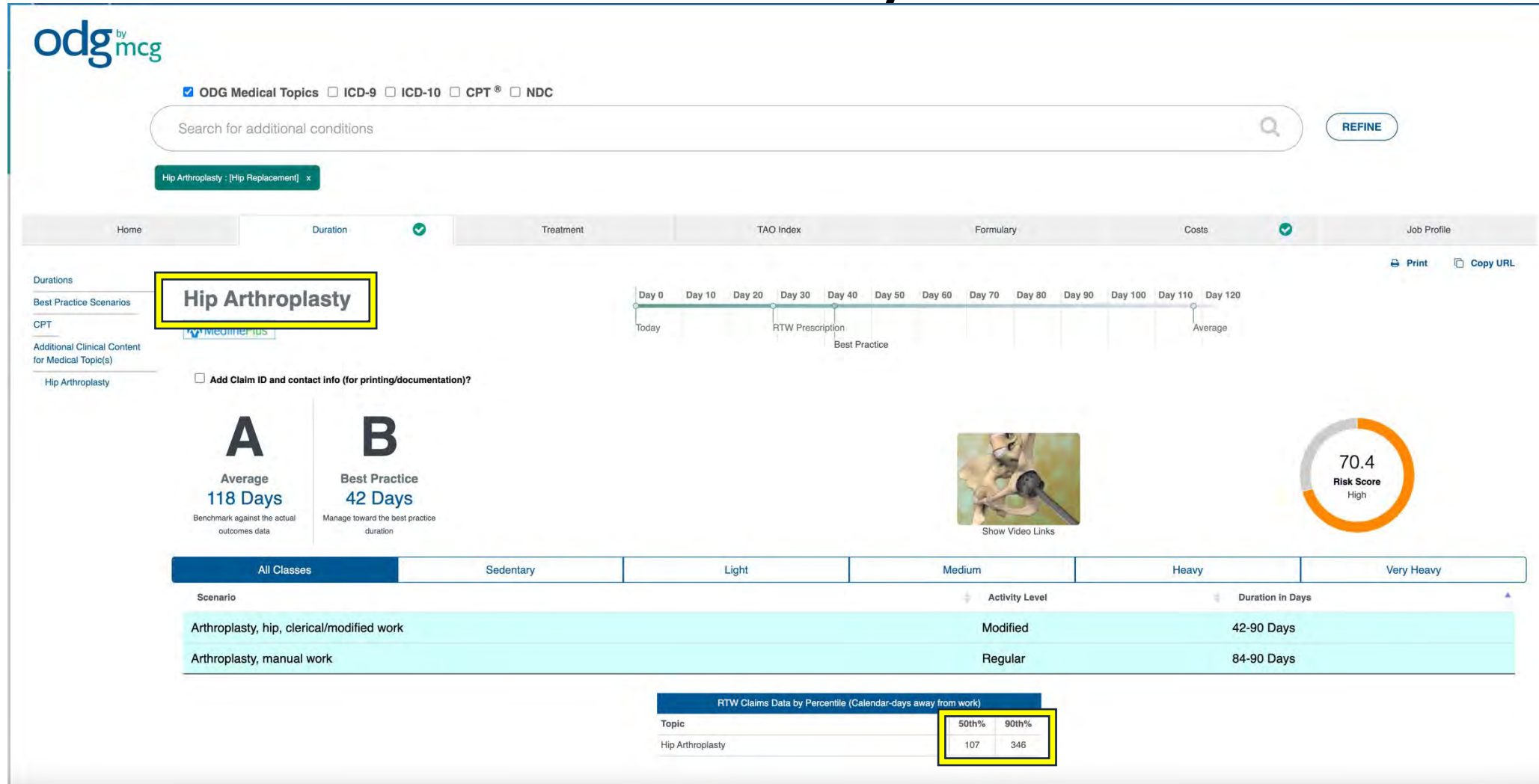
Flexible work conditions can shorten disability without rushing unsafe full-duty demands.

Practical best case RTW planning guide

Demand	Examples	Planning window	Common modifications
Sedentary	Desk, computer, phone, remote work	2–4 weeks	Sit/stand option; limited commute; no opioids if driving; breaks for swelling
Light duty	Mostly standing/walking, light carrying	4–6 weeks	Limit prolonged standing/walking; no heavy lifting; avoid uneven terrain
Moderate duty	Frequent walking, stairs, pushing/pulling/lifting	6–10 weeks	Graduated hours; lifting limits; avoid repetitive squatting/kneeling/ladders
Heavy duty	Construction, warehouse, law enforcement, climbing	10–12+ weeks; often 3+ months	Work conditioning; task simulation; progressive lifting; ladder/heights restrictions
Safety-sensitive	Commercial driving, machinery, heights, emergency response	Individualized	Off opioids; safe reaction time; surgeon clearance; emergency movement capacity

Use as a planning guide — final clearance is individualized by clinical course and essential job tasks.

Official Disability Guidelines



Three take-home messages

1

Rapid recovery is a coordinated pathway

Anterior muscle-sparing technique, multimodal opioid-sparing pain control, early mobilization, discharge criteria, and education.

2

Recovery is milestone-based

Transfers, walking, stairs, wound healing, pain control, medication safety, gait, endurance, and job-specific capacity.

3

Return to work is job-demand based

Sedentary roles may resume in weeks; moderate/heavy jobs need phased restrictions, reassessment, and often work conditioning.

Best RTW plans are specific, staged, and aligned to essential job functions.

Case application 1: sedentary worker

Scenario

- 58-year-old office administrator
- Anterior THA, same-day discharge
- Walking with cane at 2 weeks
- Off opioids; wound healed

Planning answer

- Remote or office-based work may be reasonable at 2–4 weeks if symptoms and commute allow
- Restrictions: sit/stand option, short breaks, avoid prolonged commute initially
- Watch fatigue, swelling, sleep disruption, and opioid use before driving

Desk work is often limited by fatigue, commute, and medication safety — not the implant.

Case application 2: delivery driver

Scenario

- 52-year-old delivery driver
- Frequent vehicle entry/exit
- Lifts/carries 25–50 lb
- Walking, stairs, route time pressure

Planning answer

- Driving a personal car ≠ full route delivery readiness
- Modified duty may begin around 6–8 weeks if off opioids and transfers are safe
- Full lifting/route demands may require 10–12+ weeks and progressive work simulation

**The essential job is driving + transfers +
lifting + stairs + time pressure.**

Case application 3: construction laborer

Scenario

- 48-year-old construction laborer
- Ladders, uneven terrain, carrying materials
- Kneeling/squatting/crawling
- Limited transitional duty available

Planning answer

- Full duty often 3+ months; avoid ladders/heights until balance and gait normalize
- Use work conditioning and task simulation for progressive lifting, stairs, kneeling demands
- Consider FCE if recovery and job demands remain mismatched

Heavy-duty RTW is a functional clearance decision, not a calendar event.



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