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Week-by-Week Recovery

Your guide after total knee replacement

From Adam J. Cien, DO
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A note from Dr. Cien

Hip replacement recovery looks a little different from what most people picture. The surgery itself is short. The recovery is long, but most of it is quiet — ice, elevation, short walks, sleep. Your job in the first weeks is not to push hard. It is to heal well.

I use a muscle-sparing approach called Direct Superior for almost every primary hip. That means no hip precautions — you can sit, sleep, bend, and cross your legs the way you always have. The one restriction I do ask for is no resisted hip rotation against weight for the first four to six weeks. I'll explain why on page two.

This guide walks you through what your body is doing each week and what I want you to be doing along with it. Read it once before surgery. Then read each section as you get to it. If something doesn't feel right at any point, call my office. We'd rather hear from you twice than miss a real concern.

— Dr. Cien

How recovery actually works

Most patients picture recovery as a steady climb — a little better every day until they're back to normal. The real shape is bumpier than that. There are good days and bad days, plateaus that last a week, and predictable pain spikes around days three through five and again around days six through nine. None of that means anything has gone wrong. It means you're recovering on the timeline a hip actually takes.

Three pillars hold the whole plan up. If you understand them, the rest of this guide will make sense.

1. Direct Superior means you don't need hip precautions.

My approach goes in from above the hip and works between the muscles instead of cutting through them. The soft-tissue envelope that holds the new ball inside the new socket stays intact. That envelope is what prevents dislocation, so the old rules — don't bend past 90, don't cross your legs, don't sleep on your side — don't apply to you.

2. Swelling drives pain. Control swelling first.

Hip swelling is less visible than knee swelling, but it's still the main reason you hurt in the first two weeks. Ice, elevation, and short frequent walks are the active treatment. Exercises come second.

3. Slow early weeks let you ramp faster later.

Patients who push hard in week one almost always pay for it in week three. Patients who rest, ice, and walk gently in the first two weeks usually catch up and then pass the people who tried to sprint. Slow is not behind.

Why I trust the slow approach

The slow-rehab philosophy I use is grounded in Dr. Andrew Wickline's research, especially his book *Less Swelling, Less Pain*. His work focuses on knee recovery, so the specific step counts and exercise reps don't map one-for-one onto hips — but the principles do: control swelling first, ramp slowly, and trust that controlled early weeks pay off later.

Before surgery: the long ramp

The four to six weeks before surgery are an underrated part of recovery. Patients who arrive in good shape — nutritionally, physically, mentally — recover faster and with fewer complications than patients who don't. Most of this work is small and steady. None of it has to be heroic.

Things to start working on now

- **Pick a recovery coach.** Someone who can be at your house for at least the first three or four days. Not a nurse — just a person. Their job is meals, reminders, walks with you, and noticing things you might miss.
- **Walk daily.** Twenty to thirty minutes a day. Walking is the closest thing we have to a single magic exercise before surgery.
- **Eat for healing.** Protein at every meal, vegetables, water. Cut back on alcohol. If you smoke, this is the moment to stop — even a few weeks off cigarettes meaningfully lowers infection risk.
- **Set up your recovery space.** A comfortable chair with armrests, a small table within reach, your charger, your ice machine, water, and the things you read or watch.
- **Pick up your prescriptions early.** Don't wait for the week before surgery. The pharmacy can be slow, and you don't want to be hunting down medications the day you get home.

Three handouts I want you to use before surgery

- **Preparing Your Skin Before Surgery** — the three-step nose, mouth, and body wash routine.
- **Your Medications** — what each medication does, when to start, when to stop.
- **Pre-Surgery Shopping Checklist** — ice machine, compression, snacks, the things that actually matter.

Each one lives on dradamcien.com. You don't have to memorize anything in those handouts — just keep them near your recovery chair.

Your recovery team

You are the most important person on this team, but you shouldn't do this alone. The two roles I want you to fill before surgery are a recovery coach and a recovery diary. Both sound small. Both make a measurable difference.

The coach

Your coach is someone who lives with you or can be at your house frequently for the first week. A spouse, an adult child, a sister, a close friend. Their job is not medical. It is to make sure you're icing when you should be, walking when you should be, taking medication on time, and resting when you should be. They're also the second pair of eyes on your incision and your mood.

Pick this person early and tell them you're picking them. Don't assume — ask.

The diary

A short daily diary is the single most useful tool I can give you. It's how you track whether things are getting better or worse. It's how my team knows what's going on between visits. And it's how you catch a problem early, before it becomes the kind of problem that lands you back in the office or the ER.

What to track each day

- **Pain score.** Best and worst, 0 to 10.
- **Steps.** Approximate — a phone counter is fine.
- **Sleep.** Hours, and where you slept.
- **Pain medication.** How many narcotic pills you took today.
- **Ice and elevation.** How many sessions, roughly how long.
- **One sentence.** Best part of the day and worst part. That's it.

★ Bring the diary to every follow-up

Take a picture of it on your phone or bring the paper copy. At your two-week and six-week visits, this is the first thing I want to see. It tells me more in thirty seconds than I can learn from any single exam.

A sample day in your diary

Here's what a Day 5 entry might look like for a typical Direct Superior hip patient. Yours won't match this exactly. The point is the shape of the day and the kinds of numbers we look at, not whether you hit these specific marks.

Postop Day 5

- **Pain score:** 5/10 worst (mid-afternoon after the long walk), 2/10 best (after the second ice session).
- **Steps:** about 700. More than yesterday. Took it in small chunks, not one long walk.
- **Sleep:** 6 hours total, in my own bed. Woke up twice. Felt rested.
- **Pain meds:** 2 narcotic pills today. Yesterday I took 3. Tylenol and Celebrex every dose on schedule.
- **Ice and elevation:** 4 sessions, about 30 minutes each. Did one before bed.
- **Walker:** yes, all day. Comfortable on it.
- **Best part:** walked to the mailbox and back without stopping.
- **Worst part:** stiff and sore after lunch — sat too long in one position.

Day 3 to Day 5 is the swelling peak

Pain often gets a little worse around now even though you're further from surgery. That's the swelling catching up, not anything going wrong. Ice harder, walk shorter, elevate longer. By Day 7 most patients are starting to feel the curve turn.

The first 72 hours after surgery

You'll likely go home the same day or the next morning. Most patients are walking with a walker before they leave the hospital. The first three days at home are the most uncomfortable stretch you'll have — and they're the most important to handle well.

Your job, hour by hour

- **Ice and elevate.** Every one to two hours while awake. Foot above heart level. Ice over the hip and front of the thigh.
- **Walk a little, often.** Five or ten steps every hour or two, around the house with the walker. Not long walks.
- **Stay ahead of pain.** Take Tylenol and Celebrex on schedule, not as needed. Narcotic on top of that when you need it.
- **Drink water and eat.** Small meals are fine. Constipation from pain medication is the most common avoidable problem this week — stay ahead of it.
- **Sleep where you sleep.** Your own bed is fine. No abductor pillows, no special positioning. Lie however is comfortable.

Things you don't need to do yet

- **No formal exercises.** The walking is the exercise.
- **No outpatient PT yet.** That starts somewhere between Day 5 and Day 10.
- **No driving.** Not yet, and not while taking narcotic pain medication at all.

★ Call my office today if

- **You have a fever above 101.5°F** that lasts more than 24 hours.
- **The dressing is soaking through** or has fresh red blood spreading.
- **Your calf becomes hard, tight, hot, or markedly more swollen than the other side** — we want to rule out a clot.
- **You haven't had a bowel movement** by Day 5.

Week 1 — Heal

Week 1 is for healing, not for exercising. Your hip is still angry. Swelling is climbing toward its peak around Day 3 to Day 5, and pain follows swelling. The best thing you can do this week is the simplest thing: ice, elevate, walk a little, sleep, repeat.

What your week should look like

- **Walker, all the time.** Even short trips to the bathroom. Get comfortable using it well.
- **Short walks, often.** Around the house, several times a day. Not around the block.
- **Ice and elevation.** Several sessions a day, at least 30 to 40 minutes each.
- **Outpatient PT starts.** Somewhere between Day 5 and Day 10, three times a week for four weeks. If that's a stretch the first week, that's fine — we'd rather you start a few days later than push through swelling.
- **Pain medication on schedule.** Tylenol and Celebrex regularly, narcotics as needed.
- **Diary every night.** Even if it's only three lines.

The one restriction I do ask for

No resisted hip rotation — against weight, against a band, or against someone's hand — for the first four to six weeks. Why: the muscles I worked between need that long to seal back together at full strength. Resisting rotation puts a focused stretch right on that healing seam. Everything else — walking, sitting, bending, sleeping however you like — is fine.

If your surgery was a revision through the posterior approach

Revision hips done through the back are different. For those patients, traditional hip precautions do apply for the first six weeks: don't bend the hip more than 90 degrees, don't cross your operated leg past the midline of your body, and don't rotate the foot inward. Use an abductor pillow at night. If this applies to you, your discharge papers say so and your PT will reinforce it. If you're unsure which approach you had, call my office.

Living at home that first week

Most of what makes home recovery hard is logistics, not medicine. Where you sit. How you get up. Where you keep your phone. Whether the stairs are between you and the bathroom. A little setup goes a long way.

Sleep

Sleep in your own bed, on whichever side is comfortable, in whatever position feels right. After Direct Superior, you don't need an abductor pillow, you don't need to sleep on your back, and you don't need to keep your legs apart. Pillow under or between the knees if it helps you get comfortable — totally fine. Pillow nowhere — also fine.

Sitting

A firm chair with armrests is your friend. Soft, deep couches and recliners make standing up harder than it needs to be. Get up and shift every 30 to 45 minutes, even if it's just to walk to the kitchen. Sitting still is what stiffens you up.

The bathroom

You don't need a raised toilet seat after Direct Superior — the height of a standard toilet is fine. A shower chair is useful the first week or two if balance is shaky. Grab bars near the shower and the toilet are smart upgrades regardless of what surgery you had.

Stairs

Up with the good leg, down with the operated leg, walker or crutch on the railing-free side. Take stairs slowly and one at a time. If you live in a two-story house and your bedroom is upstairs, plan to make the trip twice a day at most for the first week.

Not sure if something is normal?

Message me through the portal at sbortho.com. Faster than calling and it routes straight to the right person. If it's urgent and the office is open, call 574-247-9441 — we'll get back to you within one or two business days. After hours, the on-call surgeon answers the same number.

Week 2 — Start to move

Week 2 is the turn. Swelling starts coming down. The pain spikes from Days 6 to 9 ease. Your sleep starts to consolidate. And you start feeling like a person who had surgery, not a person recovering from surgery. This is the week where doing a little more starts to feel safe.

What changes this week

- **Walks get a little longer.** Around the house easily, around the yard or driveway in short loops, still with the walker.
- **PT is in full swing.** Three times a week, mostly gait training and gentle range of motion. Glute strengthening starts later — your PT will lead this.
- **Narcotic pain medication should be tapering.** Many patients are off it entirely by the end of week 2. If you're still relying on it heavily, tell me.
- **Dressing comes off around Day 14** or at your first follow-up appointment, whichever comes first. Don't pull it early.
- **Driving — not yet.** For the operated side, most patients are cleared somewhere between weeks 3 and 6, never while on narcotics.

Things to watch for

- **Pain that's getting worse, not better.** Some bumps are normal, a steady climb is not.
- **Calf pain, calf swelling, or a calf that feels hard.** Call us or go to the ER.
- **Drainage from the incision** that's new or increasing.
- **A fever that lasts more than 24 hours.**

Many patients leave the walker behind in week 2 or 3

For Direct Superior primary hips, the walker is often only needed for two to four weeks. Some patients are confidently on a cane by day 10, others want the walker through week 3 or 4. Don't race to drop it — use whatever lets you walk without a limp. A few extra days with a walker is far cheaper than the setback from a fall.

Weeks 3–4 — Build

This is the build phase. Swelling is mostly under control. Your incision is sealed. PT shifts from gait training and basic range of motion into real strengthening, particularly the gluteus medius — the muscle on the side of your hip that keeps your pelvis level when you walk. Strong glutes are why some patients walk without a limp at six weeks and others still favor the operated side.

What to expect

- **Walker to cane, for most.** Most Direct Superior patients are on a cane by week 3 or 4. Some are walking unaided indoors and using a cane only outdoors or on uneven ground.
- **Longer walks.** A trip around the block. A loop through a store. Build up gradually — if you walked 20 minutes today, don't try 60 tomorrow.
- **Strengthening exercises.** Your PT will introduce abductor work, glute bridges, and similar. Pay attention to form, not weight.
- **Most patients are off narcotic medication entirely** by this point. Tylenol and ice are usually enough.
- **Driving** — When you return to driving is a decision you make together with your therapist, once you feel comfortable, safe, and fully in control of the car. Two things have to be true first: you must be completely off narcotic pain medicine, and you need the strength and reaction time to move your foot quickly from gas to brake in an emergency stop. For most patients that point comes somewhere between two and six weeks. As a general rule, a left-side replacement lets you drive sooner than a right-side one, since your right leg does the braking. We'll also talk it through at your follow-up visit — but don't start driving on your own before you've had that conversation with your therapist or with us.

A reminder about that one restriction

Still no resisted hip rotation against weight or strong resistance through week 6. Walking and bending and twisting in normal ways — all fine. A loaded twist or a band pulling your foot outward against your hip — not yet. Your PT knows this and will hold off on those movements.

★ Sex after hip replacement

You can resume sexual activity whenever you feel comfortable, usually around weeks 3 to 6. For Direct Superior, there are no position restrictions — your hip will tell you what feels okay and what doesn't. Most patients find some positions more comfortable than others for the first few months while the muscles fully heal. This is normal and temporary.

Weeks 5–6 — Graduate

Weeks 5 and 6 are when most patients start feeling like themselves again. The hip itself usually feels good. What's lagging is endurance — you can do most things, but you tire out faster than you expect. That's the normal pattern. Strength catches up over the next several months.

Your six-week visit

I'll see you in the office around the six-week mark. We'll check the incision, take an X-ray, talk about what you're still being careful with, and decide together when to release the last restrictions. Bring your diary.

What's typical by now

- **Walking aid-free.** Indoors definitely. Outdoors, on uneven ground, or for long distances, some patients keep a cane around for confidence.
- **Full range of motion.** Sitting, standing, putting on shoes, getting in and out of a car — all comfortable.
- **Most strengthening is now home-based.** Formal outpatient PT often ends around week 4 to 6.
- **Resisted hip rotation restriction lifts.** At your six-week visit I'll clear you to twist, pivot, and load the hip in rotation. Your PT will introduce these movements gradually.
- **Most patients are cleared to drive** if they haven't already been.

What still takes time

- **Muscle bulk on the operated side.** The leg may still look a little smaller than the other. It catches up over months.
- **Endurance.** A long day on your feet still tires you out more than it used to. Normal.
- **Occasional stiffness in the morning.** Loosens up within a few minutes of walking around. Normal.

The dip

Around weeks 5 to 8, some patients hit what I call the dip. You're doing more, feeling stronger, and then — suddenly — you have a bad day. The hip feels tired and achy and you wonder if you've set yourself back. You haven't. The dip is your body recalibrating after a stretch of doing more than it's used to. Ice, rest, light walking. Usually passes in two to four days.

Beyond 6 weeks

By six weeks the surgical part of recovery is essentially done. What follows is the long, gradual phase where your new hip gets stronger and more reliable. Most patients are back to most normal activities by three months. Full recovery — the point where you stop thinking about your hip at all — averages six to twelve months, and small gains continue out to two years.

What you can return to

- **Most low-impact activity.** Walking, hiking, swimming, biking, golf, doubles tennis, pickleball, yoga — essentially all fine.
- **Travel and flying.** Long flights are okay after about four weeks. On any flight over two hours, get up every hour and walk the aisle. Wear compression stockings.
- **Work.** Desk jobs around weeks 2 to 4. Jobs that involve standing or walking, around weeks 4 to 6. Heavy labor, closer to 8 to 12 weeks.
- **Some sports with caution.** Skiing, doubles tennis, light running — most patients can return if they want to, with the understanding that high-impact use shortens the implant's lifespan.

Things that change permanently

- **Dental work and the new hip.** No dental work — including routine cleanings — for three months after surgery. After that, you'll need preventive antibiotics before any dental work for life. Call the office one week before each appointment and we'll send a prescription.
- **Other procedures.** Disclose your implant to any provider doing a procedure. Most don't need antibiotics. We'll prescribe when needed.
- **Yearly checks.** I want to see you at one year and then periodically after that. X-rays are how we catch wear or loosening early, long before they become problems.

Cross-reference

The Brief Patient Guide has a one-page summary of long-term joint protection — antibiotics, dental work, what to tell other doctors. Worth keeping in your records folder.

A few things patients always ask about

Why does one leg feel longer than the other?

Most patients perceive a small leg-length difference for the first few weeks, even when the measurements are equal. The reason is muscle tightness on the operated side and a habit of holding the pelvis slightly tilted before surgery that takes time to unlearn. If we measure your legs at six weeks and they're equal — which is almost always the case — the feeling fades over the following months. True structural differences are rare and we catch them on X-ray.

Why does my hip click sometimes?

A new ceramic ball moving inside a new metal-and-plastic socket sometimes makes small clicking or popping sounds, especially when you change positions. As long as it's painless, it's harmless. Painful clicking that's new — tell me.

When can I fly?

Short flights after about two weeks. Long flights after about four weeks. On any flight over two hours, walk the aisle once an hour and wear compression stockings. The combination of immobility and the slightly elevated clotting risk after surgery is what we're managing.

When can I have sex?

Whenever you feel ready, usually somewhere between weeks 3 and 6. After Direct Superior there are no position restrictions. Comfort is the only guide.

What's the dip?

A surprise bad day that often shows up around weeks 5 to 8 after a stretch of feeling great. It's a brief setback, not a complication, and it almost always passes within a few days.

What will my scar look like?

A pink line that fades to skin tone over six to twelve months. Mostly hidden by clothing. Massaging the scar with lotion after week six helps it soften and fade.

When will I feel normal again?

Different from when you'll feel better. Better — usually within a few weeks. Normal, in the sense that you stop thinking about the hip altogether — six months on average, sometimes a year. The slow last stretch is real and expected.

How to reach my team

My team and I are here for you before, during, and after surgery. Use whichever option below fits the situation, and use the right one for an emergency.

Use the patient portal first when you can. Messages through sbortho.com are the fastest way to reach us because they route directly to the right team member. If you call, expect a callback within one to two business days. Leaving one message is enough — calling repeatedly slows our response down for everyone, including you.

PATIENT PORTAL	CALL	AFTER HOURS
sbortho.com	**574-247-5164**	**574-247-9441**
Preferred. Faster than voicemail. Routes to the right person.	Callback within 1–2 business days. One message is enough.	On-call surgeon for urgent issues after office hours.

★ When to go to the ER (don't wait for a callback)

- **Chest pain or sudden shortness of breath.** Don't drive yourself — call 911.
- **Sudden swelling, redness, or pain in your calf** that didn't come from the surgery itself.
- **Heavy bleeding or fluid soaking through the dressing.**
- **A fall on the new hip,** especially if you can't bear weight afterward.

We'd rather hear from you twice than miss a real concern.