KEVIN M. ROTH, MD
ORTHOPAEDIC SPORTS MEDICINE

POST-OPERATIVE INSTRUCTIONS

Hip Arthroscopy

Labral repair or reconstruction and femoroacetabular impingement (FAI) — what to do for the first two weeks after surgery.

THIS SHEET COVERS THE FIRST TWO WEEKS

For the first two weeks, every hip arthroscopy patient follows the same instructions — the ones on this sheet. From about two weeks, your physical therapist guides your recovery, and the pace from then on depends on exactly what was done in your hip, such as whether the labrum was repaired or reconstructed. Some patients advance their weight bearing at two weeks; others stay foot-flat a few weeks longer. At your first post-op visit, about a week after surgery, we will go over which physical therapy protocol you will follow.

At a glance

Dressing	Multi-layer dressing over the hip. Remove outer layers on day 2; the small white tape strips touching the skin stay on.
Weight bearing	Foot-flat with crutches — no more than about 20 lb through the operative foot — for the first 2 weeks. From 2 weeks, your therapist tells you how fast to advance.
Hip precautions	For the first 2 weeks: do not turn the operative leg outward, keep hip bending under 90°, do not extend the hip past straight, and keep the leg out to the side under 30°.
Stationary bike	Start the day after surgery — no resistance, 10–15 minutes, every day. No access to a bike? Let us know and we will prescribe a motion machine (CPM) to use instead for the first 2 weeks.
DVT prophylaxis	Aspirin 81 mg twice daily for the first 2 weeks, and until you are off crutches.
First post-op visit	About 1 week after surgery — we will go over which physical therapy protocol you will follow.

Diet

Begin with clear liquids — Jell-O, broth, Gatorade — along with light foods like crackers or toast. Once you tolerate these without nausea, gradually progress to your normal diet over the following day.

Wound care

You will leave the operating room with a multi-layer dressing over the hip. From the outside in: medipore paper tape, then white gauze pads, then a yellow ointment-coated mesh (Xeroform), and small white tape strips (Steri-Strips) directly on the skin. Keep this dressing clean and dry for the first **2 days**.

© 2026 Kevin M. Roth, MD · All Rights Reserved

On day 2, remove the dressing in this order:

1. Peel off the medipore paper tape.
2. Remove and discard the white gauze pads and the yellow Xeroform mesh beneath them.
3. **Leave the small white tape strips (Steri-Strips) on your skin.** They will lift off on their own over the next 1–2 weeks. Do not pick at them.

Some blood staining on the gauze is normal. If the incisions are dry, place a Band-Aid over each. If small drainage continues, place a clean dry gauze pad daily until it stops; if drainage persists beyond a few days, call the office.

Once the incisions are completely dry for 24 hours, you may shower. Let water and soap run over the incisions; pat dry with a clean towel. Do not scrub. **Do not submerge under water — no baths, pools, hot tubs, or ocean** — until cleared at follow-up.

Understanding your pain

Some pain after surgery is normal and expected. Dr. Roth uses a 0–10 pain scale to guide medication use, where 0 is no pain and 10 is the worst pain imaginable. Pain in the 0–4 range is normal after surgery and is generally well-managed by the scheduled non-opioid regimen below. If your pain rises above a 4, the breakthrough oxycodone is available. If pain feels uncontrolled, unrelenting, or is getting worse rather than better, call the office.

Multimodal pain regimen

Your post-operative pain plan is based on multiple recent randomized controlled trials in patients undergoing the same type of surgery you are having.[1–5] These studies show that a scheduled regimen of non-opioid medications provides equal or better pain control than opioids, with fewer side effects and equally high patient satisfaction. Take these medications on the schedule below, even if you feel comfortable — they work best when taken consistently. Take with food when possible to reduce stomach upset.

DAYS 1–5 · SCHEDULED NON-OPIOIDS

MEDICATION	MORNING	NOON	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	—	1 tab
Gabapentin 300 mg	1 tab	1 tab	1 tab	—
Methocarbamol 750 mg	1 tab	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab	—

DAYS 6–7 · GABAPENTIN TAPER BEGINS

MEDICATION	MORNING	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	1 tab
Gabapentin 300 mg	1 tab	—	1 tab
Methocarbamol 750 mg	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab

DAYS 8–9 · GABAPENTIN TAPER CONTINUES

© 2026 Kevin M. Roth, MD · All Rights Reserved

MEDICATION	MORNING	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	1 tab
Gabapentin 300 mg	1 tab	—	—
Methocarbamol 750 mg	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab

DAYS 10–14 · MAINTENANCE

MEDICATION	MORNING	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	1 tab
Methocarbamol 750 mg	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab

The schedule above already contains the maximum safe daily amount of acetaminophen (3,000 mg) and anti-inflammatory. **Do not take any other Tylenol, ibuprofen, Advil, Aleve or aspirin product, including combination cold, sinus and sleep products.**

BREAKTHROUGH OXYCODONE — 10 TABLETS PRESCRIBED

Many patients do not need any oxycodone. If your pain rises above a 4 despite the scheduled medications, take 1 tablet of oxycodone 5 mg, no more often than every 4–6 hours, and no more than 6 tablets in 24 hours. Use only as needed, for as short a time as possible.

DRIVING AND OPERATING MACHINERY

Three medications in this regimen — **gabapentin** (days 1–9), **methocarbamol** (days 1–14), and **oxycodone** if taken for breakthrough pain — can cause drowsiness, dizziness, or impaired coordination. While taking any of these, do not drive, operate heavy machinery, or make important financial, legal, or major life decisions. Plan to have someone else drive for at least the first week, and do not drive until you have stopped gabapentin, are off oxycodone, and feel the methocarbamol is no longer affecting your alertness.

Being off these medications is not by itself clearance to drive. You must also be out of the sling, brace, or crutches and able to control the car confidently, and Dr. Roth must clear you.

You will not be cleared while on crutches. If the surgery was on your right hip, expect several weeks.

Journavx (suzetrigine) — optional

Journavx is a non-opioid prescription medication FDA-approved in 2025 for moderate-to-severe acute pain after surgery.[6,7] It carries no risk of addiction, no sedation, and does not impair driving. Clinical trials show pain relief comparable to hydrocodone with acetaminophen. If you want to avoid breakthrough oxycodone entirely, ask the office and a prescription will be sent to your pharmacy.

Cost: Often not covered by insurance — approximately $15 per pill. **First dose:** 100 mg on an empty stomach (1 hour before or 2 hours after food). Then 50 mg every 12 hours — subsequent doses can be taken with or without food. No grapefruit during treatment.

© 2026 Kevin M. Roth, MD · All Rights Reserved

DRUG INTERACTIONS — READ BEFORE REQUESTING

Do not take Journavx if you take: ketoconazole, itraconazole (Sporanox), voriconazole (Vfend), posaconazole (Noxafil), clarithromycin (Biaxin), ritonavir or cobicistat-containing HIV/HCV medications (Paxlovid, Norvir, Kaletra, Stribild, Genvoya, Symtuza, Evotaz, Prezcobix), nefazodone, carbamazepine (Tegretol), phenytoin (Dilantin), phenobarbital, rifampin, rifabutin, or St. John's wort.

Contact your prescribing physician before taking Journavx if you take: fluconazole (Diflucan), erythromycin, ciprofloxacin (Cipro), diltiazem (Cardizem, Tiazac), verapamil (Calan, Verelan), fluvoxamine (Luvox), or efavirenz (Sustiva) — a dose adjustment on your existing medication may be needed.

Hormonal contraception: If your contraceptive contains a progestin other than levonorgestrel or norethindrone, use a backup non-hormonal method during treatment and for 28 days after stopping.

Blood clot prevention

Hip arthroscopy carries a slightly higher blood clot risk than knee surgery due to the traction positioning used during the procedure. To reduce this risk, take one 81 mg aspirin ("baby aspirin") **twice daily** for the first 2 weeks, and continue until you are off crutches.

DO NOT START ASPIRIN IF ANY OF THE FOLLOWING APPLY — CALL THE OFFICE FIRST

- Allergy to aspirin
- Already taking a blood thinner (warfarin, Eliquis, Xarelto, Pradaxa, Plavix, etc.) or known bleeding disorder
- Ulcers, reflux that needs daily medication, or any prior gastrointestinal bleeding

If you already take aspirin daily for cardiac reasons, call the office to discuss the appropriate dose.

Activity and weight bearing

Use crutches at all times. For the first 2 weeks your weight bearing is **foot-flat**: rest the operative foot flat on the floor for balance, with no more than about 20 lb through it (practice on a bathroom scale) — the crutches carry your weight. From 2 weeks, your physical therapist will tell you how quickly to advance.

Avoid prolonged sitting with the leg below your waist or prolonged standing/walking for the first 7–10 days. Most patients return to sedentary work or school within **1–2 weeks** — sooner if you are comfortable, off oxycodone and no longer feeling the gabapentin or methocarbamol. Arrange a ride; you should not drive to get there.

HIP PRECAUTIONS — FIRST 2 WEEKS

Dr. Roth closes the hip capsule at the end of every hip arthroscopy. For the first 2 weeks, protect it:

- Do not turn the operative leg outward. When sleeping or resting, keep your foot pointing straight up rather than letting it fall out to the side.
- Keep hip bending under 90° — avoid low chairs, low couches and deep car seats.
- Do not extend the hip past straight.

© 2026 Kevin M. Roth, MD · All Rights Reserved

- Keep the leg out to the side under 30°.

After 2 weeks, your physical therapist will tell you when these can be relaxed — for some procedures they last longer.

Meloxicam — pain control and bone formation prevention

In addition to managing pain, the meloxicam in your regimen serves an important secondary purpose after hip arthroscopy: it reduces the risk of **heterotopic ossification** — abnormal bone formation in the soft tissues around the hip that can occur after this type of surgery. For this reason, it is important to take the full 14-day course even if your pain has already improved significantly. Do not stop the meloxicam early.

Ice and cold therapy

Cold therapy reduces pain and swelling and is one of the most effective non-medication tools you have. Begin icing as soon as you arrive home.

- **Bagged ice or gel packs:** 20 minutes at a time, no more than once per hour. Always keep a cloth between the ice and your skin. Do not exceed 20 minutes — frostbite is a real risk, especially after a nerve block.
- **Cold-therapy devices (Game Ready, Polar Care, Breg, etc.):** use for **20–30 minutes at a time, up to 4 times per day,** with a thin cloth between the pad and your skin — or follow the specific instructions for your device if different.

If you had a nerve block during surgery, the limb may be numb for 12–72 hours. Watch the clock carefully when icing during this period.

Exercises

Begin exercises 24 hours after surgery. Do them at least **3 times per day.** Try to perform 3 sets of 10 repetitions initially; you may increase to 15 repetitions if tolerated. Formal physical therapy starts after your first post-op visit. Do ankle pumps throughout the day to minimize the risk of blood clots.

STRAIGHT LEG RAISES ARE NOT PART OF THIS PROTOCOL

Unlike knee surgery protocols, straight leg raises are intentionally omitted after hip arthroscopy. The hip flexor tendon is under stress after this surgery, and loading it early significantly increases the risk of hip flexor tendonitis — one of the more common complications. Your physical therapist will introduce this exercise when the time is right.

Stationary bike

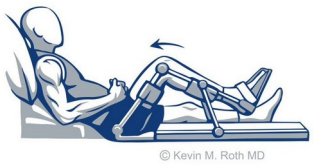
This is the single most important exercise for preventing hip stiffness. Start the day after surgery if possible — at home, at a gym, or at physical therapy. Sit upright (not in a racing position), set resistance to zero, and simply let the leg move with the pedals for 10–15 minutes. Do this daily. If you do not have access to a stationary bike, let us know — we will prescribe a motion machine (CPM) to use instead for the first 2 weeks.



© 2026 Kevin M. Roth, MD · All Rights Reserved

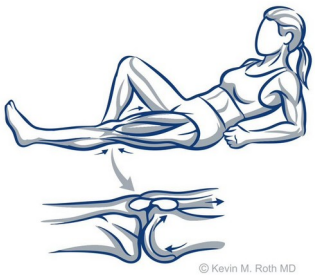
Motion machine (CPM)

If you were prescribed a motion machine (CPM): after a microfracture, use it **8 hours per day** in addition to the bike; if it was prescribed because you do not have a bike, use it **2–4 hours per day** instead of the bike. The hours do not need to be consecutive, and overnight use counts. Set it from 0° (fully straight) to 30° and increase the bending limit 3–5° per day as tolerated, with a goal of 0–70° by 2 weeks — never past 90°. It also keeps the foot from rotating outward.



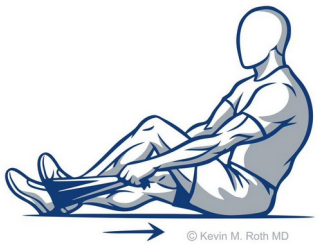
Quadriceps sets

Lie down or sit with your leg fully extended. Tighten the muscle on the front of your thigh to flatten the knee against the bed or floor. The kneecap should slide upward toward the thigh.



Heel slides

Sitting or lying on your back, loop a towel or strap around your foot and use it to slide your heel along the bed toward your buttock, bending the hip and knee — let your arms do most of the work. Hold a few seconds, then slowly straighten. Keep hip bending under 90°.



Ankle pumps

Move your foot up and down like pressing a gas pedal — 20–30 repetitions, every few hours. This circulates blood through the leg and reduces blood clot risk.



No tobacco or nicotine

Do not use tobacco or nicotine products for at least 3 months after surgery — cigarettes, cigars, vapes, smokeless tobacco, dip, chew, or nicotine patches and gum. Nicotine significantly increases the risk of infection, wound healing problems, and failure of the repair. For help quitting, call **1-800-QUIT-NOW**.

> **BLOOD CLOT WARNING SIGNS**
> Hip arthroscopy carries a slightly higher risk of blood clots than other lower extremity

© 2026 Kevin M. Roth, MD · All Rights Reserved

procedures due to the positioning required during surgery. Know these warning signs:

Signs of a blood clot in the leg (DVT):

- Swelling in the calf or thigh — can occur on either the operative or non-operative side
- Pain or tenderness in the calf, especially behind the knee
- Redness, warmth, or bluish discoloration of the leg

Signs of a blood clot in the lung (pulmonary embolism — a medical emergency):

- Sudden shortness of breath
- Sharp chest pain, especially with deep breathing
- Rapid heart rate
- Unexplained cough, sometimes with blood-tinged mucus

If you have any DVT symptoms, call the office at **(650) 853-2943** or go to the nearest emergency room. **If you have any PE symptoms, call 911 immediately.**

When to call

Call the office at **(650) 853-2943** for any concern, day or night. This number reaches Dr. Roth or a covering physician after hours.

- Pain not controlled by the regimen above, or getting worse rather than better
- Numbness or weakness that is still present 72 hours after surgery, that is spreading or worsening, or that returns after it had improved
- Fever above 101 °F (a low-grade temperature is normal in the first few days)
- Increasing redness, warmth, or tenderness around the incisions
- Persistent or increasing drainage or bleeding from the incision
- Calf pain or swelling
- Color change in the operative limb
- Blistering of the skin
- Any other concern

GO TO THE NEAREST EMERGENCY ROOM IMMEDIATELY FOR

- Difficulty breathing
- Severe chest pain
- Loss of consciousness
- Pain that is completely uncontrollable

Follow-up

If you do not already have a follow-up appointment, call **(650) 853-2943** to schedule. Your first follow-up visit is about 1 week after surgery.

REFERENCES

1. Moutzouros V, Jildeh TR, Khalil LS, et al. A multimodal protocol to diminish pain following common orthopedic sports procedures: can we eliminate postoperative opioids? *Arthroscopy.* 2020;36(8):2249–2257.

© 2026 Kevin M. Roth, MD · All Rights Reserved

2. Moutzouros V, Jildeh TR, Tramer JS, et al. Can we eliminate opioids after anterior cruciate ligament reconstruction? A prospective, randomized controlled trial. *Am J Sports Med.* 2021;49(14):3794–3801.
3. Jildeh TR, Okoroha KR, Kuhlmann N, et al. Multimodal nonopioid pain protocol provides equivalent pain versus opioid control following meniscus surgery: a prospective randomized controlled trial. *Arthroscopy.* 2021;37(7):2237–2245.
4. Jildeh TR, Abbas MJ, Hasan L, Moutzouros V, Okoroha KR. Multimodal nonopioid pain protocol provides better or equivalent pain control compared to opioid analgesia following arthroscopic rotator cuff surgery: a prospective randomized controlled trial. *Arthroscopy.* 2022;38(6):1077–1085.
5. Syed UAM, Aleem AW, Wowkanech C, et al. The effect of preoperative education on opioid consumption in patients undergoing arthroscopic rotator cuff repair: a prospective, randomized clinical trial. *J Shoulder Elbow Surg.* 2018;27(6):962–967.
6. Bertoch T, D'Aunno D, McCoun J, et al. Suzetrigine, a nonopioid NaV1.8 inhibitor for treatment of moderate-to-severe acute pain: two phase 3 randomized clinical trials. *Anesthesiology.* 2025;142(6):1085–1099.
7. Alvarez-Aguilar P, Picado-Loaiza S. Suzetrigine (a NaV1.8 inhibitor) versus placebo for acute postoperative pain: a systematic review and meta-analysis. *Medicine.* 2026;105(10):e47877.



Kevin M. Roth, MD
Board-Certified Orthopaedic Surgeon · Subspecialty Certification in Sports Medicine

Dr. Roth completed his orthopaedic surgery residency at Harvard Medical School and his sports medicine fellowship at the Kerlan-Jobe Orthopaedic Clinic in Los Angeles. In practice since 2013, he specializes in advanced arthroscopic techniques and sports medicine procedures, and sees patients at Palo Alto Medical Foundation's Palo Alto and Pleasanton offices.

Palo Alto Medical Foundation · Sutter Health · KevinRothMD.com

© 2026 Kevin M. Roth, MD · All Rights Reserved