

Posterolateral Corner Reconstruction with Allograft

Name _____ Date _____

Procedure _____

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Frequency 1 2 3 4 5 times/week Duration 1 2 3 4 5 6 weeks

FIRST THERAPY VISIT

- Therapy appointment should be scheduled for 3-5 days postoperatively.
- Goals of therapy visit include:
 - Surgical site evaluation (see below for instructions)
 - Brace/sling education and adjustment as needed
 - Review of therapy protocol, expectations, and plan
 - Initiation of early phase therapy ONLY if applicable (follow protocol as outlined below)
- Surgical site evaluation
 - Incisions are closed with one or combination of below methods
 - Staples
 - Nylon sutures (black sutures)
 - Monocryl sutures covered with steristrips or glue
 - Prineo dressing (clear adherent glue dressing)
 - Anytime the dressing is changed or examined, **please wash hands** prior with antibacterial soap.
 - There will be gauze and padding over the incisions and the extremity may be wrapped with an ACE wrap. The surgical dressing should be changed by the therapist using **sterile** technique. This includes sterile field, sterile gloves, betadine or chlorhexidine skin cleanser and sterile supplies when redressing the wounds. Do NOT remove steri-strips or glue dressing. DO NOT remove sutures or staples. The new dressing should include dry gauze and ACE wrap. Before the new dressing is applied the wounds should be clean and dry (without removing steri strips or glue dressing). Please do not use tegaderm unless it was used at the time of surgery or if specifically stated on the orders. If there are any concerns with the incisions or dressings, the therapist should call the office immediately – (219) 250-5038.
 - Unless otherwise instructed, incisions must remain dry for 7 days. They must be sealed off in the shower. The Prineo dressing/glue dressing is water resistant, and incisions covered by this dressing may get wet after 3-5 days. Once you are permitted to get the incisions wet, warm soapy water should **gently** rinse the surgical area. Do NOT scrub the area. Pat the area dry with a clean towel and keep free of lotions or creams. Do NOT soak in a pool, bath or hot tub until permitted by the surgeon's office. Please wear clean clothes following shower and be conscious of any pet hair or other contaminants near the surgical area. Do not apply any ointments or medications to the area.

*****Range of motion is an important progression of therapy, but limiting swelling is important.
Respecting swelling will decrease pain and improve motion.*****

Procedure

The popliteus tendon, the popliteofibular ligament, and fibular collateral ligament are reconstructed. This protocol can be combined with cruciate reconstruction protocols adhering to all restrictions for each protocol.

Postoperative Restrictions

1. Patient remains in the knee immobilizer in full-knee extension at all times during the first 6 weeks postoperatively other than when working on knee range of motion (ROM) or performing quadriceps exercises.
2. Patient remains non-weight bearing for 6 weeks. NWB 0-2 weeks postop, Toe touch / 25% body weight weeks 3-4 postop, 25-50% body weight weeks 5-6 postop, and FWB with cane support weeks 7-8, progressing to FWB by week 9.
3. Patient to avoid tibial external rotation, and external rotation of the foot/ankle, especially in sitting for the first 4 months postoperatively.
4. Patient avoids open-chain hamstring exercises until 4 months postoperatively. (Noyes indicates is ok to do weeks 9-12 up to 90 degrees)

Postoperative Red Flags

Signs and symptoms of infection (excessive swelling, fever greater than 101°, increasing redness around the surgical incisions) calf swelling, calf tenderness, lack of full knee extension, complaints of knee instability, complaints of catching or locking, and increased effusion following activity/therapy. If any of these red flag arise, contact MD.

Phase 1:

Weeks 1-2

- Edema management: ice, compression, elevation
- Quadriceps sets and straight leg raises (SLRs) performed in the knee immobilizer.
- Quadriceps sets can be performed hourly up to 30 repetitions and SLR up to 30 repetitions 4 to 5 times per day.
- Four times a day gentle passive and active assisted ROM exercises. Goal is 90° of knee flexion by the end of 2 weeks, and 0° of knee extension.
- Core (lumbopelvic and hip) stabilization exercises in knee immobilizer that do not increase knee forces in varus, hyperextension, or tibial external rotation.

Weeks 3-6

- Continue with passive and active assisted ROM exercises 4 to 6 times per day. Patient should achieve full extension at this time, and 120° of flexion.
- Continue with quadriceps sets and SLRs.

Phase 2:

Weeks 7-12

- Start partial weight bearing using crutches. Goal is to ambulate full weight bearing without crutches within 2 weeks. Patient must be walking without a limp to discharge crutches. Discontinue knee immobilizer if able to perform SLR without a knee extension lag.
- Initiate use of stationary exercise bike if 105° of knee flexion ROM is achieved. Working on motion, beginning with 5 minutes every other day and increasing to 20 minutes daily, based on the knee's response to increased activity. If soreness or effusion is evident reduce time or days utilizing the bike.

Weeks 13-16

- At this time the patient should have a normal gait pattern, without the presence of a limp or Trendelenburg sign.
- The physician should be notified if patient is lacking 5° (or more) of extension or has less than 110° of flexion.
- Leg press up to 25% of the patient's body weight to fatigue. Knee flexion allowed to a maximum of 70°.
- Squat rack/squat machine: using weight up to 50%, body weight 10 repetitions, again not exceeding 70° of knee flexion. Slow progression to full body weight.
- Closed kinetic chain exercise progression: double-limb squatting, lunges, single-limb squatting, etc. All exercises performed with less than 70° of knee flexion.
- Daily biking or swimming. If swimming, no whip-kicks or flip turns.

Phase 3:

Weeks 16-24

Physical therapy goals: improve quadriceps strength and function, increase endurance, improve coordination, and improve proprioception.

- Walking program: 20 to 30 minutes daily with a medium to brisk pace. Add 5 minutes per week.
- Resistance can be added to bicycling as tolerated. Biking done 3 to 5 times per week for 20 minutes, and the lower extremities should feel fatigued post biking.
- Advanced closed kinetic chain exercise progression: addition of unstable surface, movement patterns, resistance, etc.
- Return to run program once patient is able to perform 20 repetitions of involved lower extremity single-limb squatting to greater than 60° of knee flexion with good control. It is important to point out that other authors (Noyes) report not to start running program until month 9th, so functional testing may be required to start running. As with ACL protocol, Dr. Levenda would like a gradual running program such as Delaware running program.
- Plyometric progression: supported jumping, jumping, leaping, hopping, etc.

Week 28 and beyond

Goal: achieve maximum strength of operative extremity.

- Maintain home exercise program 3 to 5 times per week.
- Physician will give clearance for cutting and pivoting and sports simulation activities as appropriate. Physician clearance is based on favorable outcomes with imaging studies, clinical exam findings, and

functional progression with therapy. The coordination of care between the surgeon and physical therapy staff is critical for a complete assessment of patient function and a complete recovery from the surgery.

****Functional testing often performed at this time. A progressive return-to-play program is initiated if the limb symmetry index is greater than 85% with functional testing and satisfactory varus stress radiographs.**

Comments:

FCE _____ Work Conditioning/Work Hardening _____ Teach HEP _____

Every patient's therapy progression will vary to a degree depending on many factors. Please use your best clinical judgment on advancing a patient. If other ideas are considered to improve patient's outcome do not hesitate to call.

Patient's recovery is a team approach: Patient, family/friend support, therapist, and surgeon. Every team member plays an important role in recovery.

Signature _____