TWIN CITIES ORTHOPEDICS

Brian Bjerke, MD

Achilles Tendon Repair

Post-Operative Protocol

First Post-Op Visit: (10-14 days)

1. The patient's surgical splint and sutures are removed at this appointment. The wound is assessed and steri-strips are placed over the wound.
2. The patient is placed into a CAM walking boot at this appointment with 6 heels lifts/wedges. The patient will be toe touch weight bearing at this time.
3. The patient will start physical therapy and 1 heel lift will be removed from the CAM boot every 4-7 days.

Second Post-Op Visit: (5 weeks)

1. Follow up appointment to check the incision site and repair integrity.
2. Patient to continue physical therapy at this time to continue removing heel lifts (1 heel lift every 4-7 days if okayed by Dr. Bjerke).
3. Once the patient is flat-footed in the CAM boot, the patient may start partial weight bearing. Patient will remain in the boot at all times while starting weight bearing portion of physical therapy.

Physical Therapy:

1. Discuss tissue quality and strength of the repair with the physician. Discuss combination procedures and modifications to the protocol.
2. "General" tissue healing times:
    - Immobilization to protect the repair, 4 weeks s/p
    - A/AROM: 4 weeks s/p, based on pain, swelling, and tissue quality of repair.
    - AROM: 4-6 weeks s/p, based on pain, swelling, and tissue quality of repair.
    - Resistive ROM: 8-10 weeks s/p, based on pain, swelling, and tissue quality of repair.
    - Progress as tolerated: 10-12 weeks s/p, based on pain, swelling, and tissue quality of repair.

4-8 Weeks Post-Op:

Goals:

- Complete protection of repair.
- Look to have neutral dorsiflexion between 4-6 weeks post-op.
- Progressive edema reduction, pain control, desensitization and scar mobility.

1. Progress from PWB to FWB with crutches/cane by 6-8 weeks based on pain, swelling and tissue quality of repair.
2. CAM boot worn during FWB ambulation.
3. Limit active dorsiflexion ROM to neutral with knee flexed to 90 for first four weeks.
4. No passive stretching into dorsiflexion until 8 weeks s/p.
5. Bicycle; light resistance, with brace on until 8 weeks s/p, then progress as appropriate.
6. Proximal musculature PRE's as tolerated, no closed chain Dorsiflexion past neutral until 8 weeks s/p.
7. Modalities for edema reduction, pain control, desensitization and scar mobility.

6-12 Weeks Post-Op:

Goals:

- Restoration of normal gait.
- Elimination of edema, pain, normalize sensitivity and normalize scar mobility.

1. Static balance progression and proprioceptive training (6 weeks).
2. Bicycle, increase resistance as tolerated (8 weeks).
3. Inversion and eversion isometrics.
4. Low resistance isotonics, through a pain-free ROM.
5. Gentle passive dorsiflexion beginning at 8 weeks.
6. Continue to remove heel lifts. Should be foot flat in CAM boot at 10 weeks
7. Wean from CAM boot into shoe at 10-12 weeks
8. Dynamic balance progression and proprioceptive training (8-10weeks) based on pain, swelling and tissue quality of repair.
9. Retro walking (10-12 weeks) once pain free ambulation and minimum 5-10° active Dorsiflexion.

12-20 Weeks Post-Op:

Goals:

- Normalization of strength.
- Restore normal A/PROM.
- Progression/Return to sport.

1. Progressive plantar and dorsiflexion PRE's as tolerated, emphasize plantar flexion

eccentrics.
2. Inversion/eversion PRE's as tolerated.
3. Plantar and Dorsiflexion Isokinetics as appropriate.
4. Sedentary patients may be discharged to Independent Home/Gym program. Athletic patients should continue with late stage rehabilitation drills including sport specific drills.
5. Closed Kinetic Chain drills including progression to ballistic/plyometric activities as appropriate.
6. Continue proximal musculature PRE's.
7. Reassess entire LE Biomechanics identifying areas that would increase long-term stress to the reconstruction.
8. Progression to walk/jog program (12 weeks) if appropriate strength and function. (Minimum 15-20 single leg toe raises)

Progressive return to athletic activities (~20 weeks): if all above goals are achieved.

1. Continue functional closed chain rehabilitation.
2. Advanced proprioceptive retraining, Fitter, BAPS, Plyoback, Agility drills, etc.
3. Continue full LE PRE's.
4. Progressive running program. Isokinetic testing.
5. Sports Performance and Speed and Agility Drills/Testing.

*Please feel free to contact Dr. Brian Bjerke's office with any questions or concerns. Dr. Bjerke's care coordinator Andria Larson is available by phone at 952-456-