

Patellar/Quadriceps Tendon Repair or Patella Fracture Open Reduction Internal Fixation

Justin A. Walker, MD

Patient Name: _____

Side: Right Left

Procedure: Patellar Tendon Quadriceps
Tendon Patella Fracture ORIF

Evaluate and treat – no open chain or isokinetic exercises

Provide patient with home exercise program

Phase 1 (0-6 weeks): *Period of protection. A home program alone may suffice during this time*

- **WBAT with crutches, brace locked in extension during sleep and all weightbearing activity (walking)**
- **ROM:**
 - Knee: active prone knee flexion as tolerated 2-3x/day. No active extension or passive flexion
 - 0-2 weeks: Brace unlocked from 0-30 degrees
 - 2-4 weeks: Brace unlocked from 0-50 degrees
 - 4-6 weeks: Brace unlocked from 0-90 degrees
 - Hip: ROM exercises 2-3x/day
 - Strict elevation while seated
 - No quadriceps strengthening at this time

Phase 2 (6-12 weeks): *Begin regular, supervised strengthening and wean from brace*

- **Wean from crutches. D/C brace when ambulating with normal gait and patient can perform SLR without extension lag**
- **Knee ROM:** Brace fully unlocked (no flexion limit); advance active and active-assisted ROM as tolerated; gentle passive stretching at end-range. Goal 0-120 or greater by 12 weeks
- **Strengthening:**
 - Begin isometric quad sets, straight leg raises
 - Progress to closed chain strengthening (no open chain) once out of brace

Phase 3 (3-6 months): *Begin sport or activity focused conditioning*

- Advance strengthening as tolerated, continue closed chain exercises. Increase resistance.
- At 4.5 months, OK to start jogging and progress to agility training and/or other sport specific rehab
- Begin to wean from formal physical therapy encouraging independence with home exercise program by 6 months

Modalities as tolerated/needed

Frequency: 2x/week for 12 weeks. May reduce frequency during Phase 1 if home exercise program appropriate

By signing this referral, I certify that I have examined the patient and physical therapy is medically necessary.

Physician Signature: _____

Date: _____

Physician Name: **Justin A. Walker, MD**