



Distal and/or Proximal Patellar Tendon Realignment

Guidelines/Precautions

- No closed-kinetic chain exercises for 6 weeks
- Same rehab protocol is followed for proximal and distal procedures except weight-bearing and other limitations as noted
- After combined proximal and distal realignment, the protocol for distal realignment is used

Phase I (1 – 5 days post-op)

- Wound care: Observe for signs of infection
- Modalities: prn for pain and inflammation (ice, IFC)
- Brace
 - Locked in full extension for all activities except therapeutic exercises and CPM use
 - Locked in full extension for sleeping
- Gait
 - WBAT with two crutches for proximal realignment procedure
 - 50% weight bearing with two crutches for distal realignment
- ROM
 - 0 – 30 degrees of flexion
 - Ankle AROM
- Strengthening: none

Phase II (5 days – 4 weeks post-op)

- Wound care: Monitor site for signs of infection and initiate scar management techniques when incision closed
- Modalities: Modalities PRN for pain and inflammation (ice, IFC)
- Brace
 - 0-4 weeks locked in full extension for all activities except therapeutic exercises and CPM use
 - Locked in full extension for sleeping
- Gait
 - WBAT with two crutches for proximal realignment procedure
 - 50% weight bearing with two crutches for distal realignment
- ROM
 - 0 – 2 weeks: 0 – 30 degrees of flexion
 - 2 – 4 weeks: 0 – 60 degrees of flexion
 - Goal of full knee extension by week 6

- Strengthening
 - Quad sets for isometric adduction with biofeedback and E-stim for VMO (no E-stim for 6 weeks for proximal realignment). Goal of regaining active quad and VMO control by end of 6 weeks.
 - Heel slides from 0 - 60 degrees of flexion for proximal realignment, 0 - 90 degrees of flexion for distal realignment
 - CPM for 2 hr, bid from 0 - 60 degrees of flexion for proximal realignment, 0 - 90 degrees of flexion for distal realignment
 - NWB gastroc, soleus, and hamstring stretches
 - SLR in four planes with brace locked in full extension lying down or standing
 - Resisted ankle ROM with Theraband
 - Patellar mobilization (begin as tolerated)
 - Begin aquatic therapy at 3 - 4 weeks, emphasis on gait

Phase III (4 - 10 weeks post-op)

- Wound care: Observe for signs of infection, continue scar mobs
- Modalities: continue prn for pain and inflammation (ice, IFC)

4 weeks to 6 weeks:

- Brace: Unlocked for sleeping, locked in full extension for ambulation
- Gait
 - WBAT with two crutches for proximal realignment procedure
 - 50% weight bearing with two crutches for distal realignment
- ROM: 0 - 90 degrees of flexion
- Strengthening: continue same as phase II

6 weeks to 8 weeks:

- Brace: Discontinue use for sleeping, unlock for ambulation as allowed by physician
- Gait: As tolerated with two crutches
- ROM: Increase flexion gradually to normal range for patient
- Strengthening:
 - May begin NMES for proximal realignment
 - Continue exercises progressing to full flexion with heel slides
 - Progress to weight-bearing gastroc, soleus stretching
 - D/C CPM if achieved 90 degrees knee flexion
 - Continue aquatic therapy
 - Closed chain balance exercises
 - Stationary bike, low resistance, high-seat
 - Wall slides progressing to mini-squats, 0-45 degrees of flexion

8 weeks to 10 weeks

- Brace: D/C
- Gait: May D/C crutches if no extension lag is present, patient is able to achieve full extension, and gait pattern is normalized with one crutch.

- Strengthening:
 - Should be able to demonstrate SLR without extension lag
 - May begin closed chain strengthening including step-ups (begin at 2 inch step)
 - Moderate resistance for stationary bike
 - Four way resisted hip strengthening
 - Leg press for 0-45 degrees of flexion
 - Swimming and/or stairmaster for endurance
 - Toe raises, hamstring curls and proprioceptive exercises
 - Treadmill walking
 - Flexibility exercises continued

Phase IV (10+ weeks post-op)

- Criteria
 - Clearance from physician to begin more concentrated closed-kinetic chain exercises and resume full or partial activity level
 - At least 0 - 115 degrees AROM with no swelling and complete voluntary contraction of quad
 - No evidence of patellar instability
 - No soft tissue complaints
- Strengthening
 - Progression of closed-kinetic chain activities including partial squats (60 degrees), leg press forward and lateral lunges, lateral step-ups, leg extensions 60 - 0 degrees, bicycle and /or stepper.
 - Functional progression, sport specific activities
- Functional testing: Performance to < 25% deficit compared to non-surgical side by D/C

Adapted from:

- 1) Brozman SB, Wilk KE. Clinical Orthopedic Rehabilitation. 2nd Ed. Philadelphia: Mosby; 2003
- 2) Wilk KE, Reinold MM, Andrews, JR. Rehabilitation Following Lateral Retinacular Release and Medial Retinacular Thermal Shrinkage/Plication. Winchester, MA: Advanced Continuing Education Institute, 2004.
- 3) Wilk KE, Reinold MM, Andrews, JR. Rehabilitation Following Lateral Retinacular Release and Medial Retinacular Thermal Shrinkage/Plication. Winchester, MA: Advanced Continuing Education Institute, 2004.