Osteochondral Allograft Physical Therapy Protocol

Patient Name: ___________________________ Date: ____________

Surgery: Right/Left Knee Osteochondral Allograft Transplantation

Date of Surgery: ________________________

Frequency:  1   2   3   4   5   6   7   8   9   10   11   12   13   14   15   16   17   18   19   20   21   22   23   24   25   26   27   28   29   30   31   32   33   34   35   36   37   38   39   40   41   42   43   44   45   46   47   48   49   50   51   52   53   54   55   56   57   58   59   60   61   62   63   64   65   66   67   68   69   70   71   72   73   74   75   76   77   78   79   80   81   82   83   84   85   86   87   88   89   90   91   92   93   94   95   96   97   98   99   100

Weeks 0-6
___ Toe-Touch (TTWB) x 6 weeks
___ Use CPM for 6 hours/day, beginning at 0- 40°; advance 5- 10° daily as tolerated
___ Weeks 0-2: Brace locked in extension at all times
___ Open hinges on brace at 2 weeks while walking
___ Weeks 0-2: Quad sets, SLR, calf pumps, passive leg hangs to 90° at home
___ Weeks 2-6: PROM/AAROM to tolerance, patella and tibiofibular joint mobs, quad, hamstring, and glut sets, SLR, side-lying hip and core
___ Achilles Tendon Stretching
___ Electrical Stimulation for Quadriceps
___ Iliotibial Band/Hamstring/Adductor Stretching / Strengthening

Weeks 6-8
___ Begin to progress to WBAT, 25% per week, until full by 8-10 weeks

Weeks 8-12
___ Gait training, begin closed chain activities: wall sits, shuttle, mini-squats, toe raises
___ Begin unilateral stance activities, balance training

Months 3-6
___ Advance prior exercises; maximize core/glutes, pelvic stability work, eccentric hamstrings
___ May advance to elliptical, bike, pool as tolerated

Months 6-12
___ Advance functional activity
___ Return to sport-specific activity and impact when cleared by MD after 8 months

_____ Functional Capacity Evaluation  _____ Work Hardening/Work Conditioning  _____ Teach HEP

Modalities
___ Electric Stimulation  ___ Ultrasound  ___ Iontophoresis  ___ Phonophoresis  ___ TENS  ___ Heat before
___ Ice after  ___ Trigger points massage  _____ Therapist’s discretion

Signature: ___________________________ Date: ________________