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Mgh acl repair protocol

arthroscopic techniques. Concepts of postoperative rehabilitation after reconstructive knee surgery have also changed. Instead of immobilization, early movement is encouraged after surgery. The extension of this approach is to use an immediate and continuous controlled movement of the knee after uterine cruciate ligament (ACL) backup surgery. Donald Shillborn developed the concept of accelerated postoperative rehabilitation. (9.10) This article will describe a postoperative rehabilitation protocol used by a senior author (BZ) at Massachusetts General Hospital that balances an early return to the gym participation with sufficient time for graft healing. METHODS We use an accelerated rehabilitation protocol when we replace the torn anterior cruciate ligament with mid-third patellar tendon graft (bone tendon-bone) using an endoscopic method. In the mocked lenses of the distal thigh and proximal tibia, bioabsorbed interference screws are used to ensure graft fixation comparable to metal screws. (18,19) This method ensures immediate stable fixation and allows the lifting to be moved safely by means of continuous passive movement (CPM) equipment after surgery. We believe that autologous mid-third-perone tendon graft is the best graft ACL for backup surgery, and we use this graft for all patients for whom we replace torn ACL unless the patient strongly wants an alternative transplant. If the patient has had a previous patellar tendon graft that does not, we will use a hamstring tendon autograft for review surgery, if available. We do not use the accelerated rehabilitation program described here after reviewing ACL backup operations. Dr. Zarins is chief of the Sports Medicine Service, Massachusetts General Hospital and Associate Clinical Professor of Orthopaedic Surgery at Harvard Medical School Dr. Worker is a sports medicine fellow at Harvard Medical School and Massachusetts General Hospital Alex Petruska is a physiotherapist at Massachusetts General Hospital Please address correspondence with: Bertram Zarins, M.D. Wang Ambulatory Care Center Suite 514 Massachusetts General Hospital Boston, MA 02114 bzarins@partners.org Rehabilitation: Preoperative Protocol Patient is seen in the office for several days before surgery, during which during preoperative history and physical examinations are conducted. After the surgeon explains the procedure, the patient watches a video tape detailing preoperative instructions, surgical procedure, risks, benefits, complications, anesthesia and Course. Physiotherapist Physiotherapist exercises that will be accomplished during the first week after surgery. Phase I phase I starts immediately after surgery. The doctor applies a continuous passive movement (MPT) machine to the patient's knee in the operating room before the patient awakes. The patient remains in hospital overnight using an MPT machine continuously. The patient is discharged home the next morning after receiving final instruction on the operation of the CPM machine from a physical therapist. Hinges after operation on braces blocked by extension are set to be used during outpatient operation. The patient is allowed to ambulate, a full weight bearing, with postoperative braces in place using crutches. The patient stays at home for the first seven days after surgery with the knee moving 23 hours a day in the CPM machine. The remaining one hour per day is selected for the necessary daily activities and for performing prescribed exercises three times a day (Table 1). Painmedieres are pre-inscribed, as well as elastic socks and cryotherapy. By the end of the first week the patient should have a full knee extension, and 90 degrees of knee bending. The MPT machine is set to a hyperextend of five degrees in which position it stops for five seconds (extensor breaks control on the CPM machine). The importance of having a knee go into a full extension with each cycle of CPM is emphasized to the patient, as bending contracture can develop if there is no vigilant attention to regain the full extension. The speed at which the CPM moves and the bending volume is less important in stage I of Annex I, Stage I exercise Protect the reconstruction— avoid falling 1. Heel support for passive knee extension Provides wound healing 2. Prone Hang passive road extension Reach and maintain road extension 3. Quadriceps Setting with an emphasis on getting active control of the bolt home mechanism promote quadriceps muscle strength 4. Heel Slides to get the bending range of motion gain knee bending to nearly 90 degrees 5. Sitting Heel Slides to get a continuous passive movement (MPT) machine to the patient's knee in the operating room before the patient awakes. The patient remains in hospital overnight the first postoperative week, the patient returns to the office for seam removal and examination by a surgeon. The postoperative brace is shortened, but the hinges remain blocked in the extension. The patient is instructed to have phase II exercises that will follow the next four weeks. A full-weight bearing is encouraged, and postoperative braces and crutches can be used as necessary to support and comfort. The patient can gradually stop using crutches and braces as soon as the knee feels strong enough to be stable. Most patients stop on braces and crutches about two weeks after surgery. The gait is independent (without braces or 3 to 5 weeks after surgery. Table 2 The patient is instructed to continue all exercises from Phase I at this time. Phase II exercises are added, which should be performed twice a day (Table 2). Braces are removed in implementation. Non-resistance-free stationary cycling is recommended daily for 10 to 15 minutes. If the patient does not have enough knee bending to complete the full revolution, then he or she pedals on everyone and back until the knee will flex enough to allow a full cycle. Phase II exercises include a towel extension stretch with a four-figure setting. The patient, sitting on the floor or bed, loops a towel around the foot-operated knee. The patient allows the knee to expand completely and flatten against the surface he or she sits on. The patient is instructed to pull gently on towel with both hands until the heel lifts slightly from the surface, keeping the posterior aspect of the knee and calf against the surface. This operation helps to passively extend the path to a full extension. While holding this position, the patient should actively tighten the quadriceps and hold the contraction for five to ten seconds. The next task is a straight leg lift. If the knee has extensor lag, the patient should not do this task. Phase II Stage II exercise objectives Protect reconstruction – avoid falling 1. Extension of the towels extends under four-figure conditions Make sure that the wound heals 2. Straight leg lift Keep the knee extension full (straighten your knee completely) 3. Permanent hamstring curl Start quadriceps muscle strengthening 4. Standing toe raises reach the road bending by 90 degrees or more 5. Hip abduction Reduce knee and leg swelling 6. Mini-Squat Normal gait without crutches 7. Wall slide The patient should continue to try to do a quadricen setting exercise until he or she can lift the limb off the bed without allowing the knee to flex. Additional exercises include standing hamstring curls for active knee bending and standing in the purchased poses. The wall slide involves supporting the body against the wall and gently squatting to 30-45. Rounding out phase II exercises are side-lying hip abduction, mini-squats from 45 to 60 degrees knee bending, and wall slides from 45 to 60 degrees knee bending. Phase III : Five to nine weeks after surgery, Phase III starts at week 5 and continues through week 9 (Table 3). Swimming can begin this time using only a standard freestyle kick, also called a flutter kick. This kick allows only vertical scissoring movement of the legs in the sagittal plane, avoiding the rotational motion involved in other kicks (such as a breaststroke kick). Strokes that are allowed are freestyle and backstroke. Swimming with a kick board is allowed while a flutter kick is used. If a road extension is obtained and the length of the road can be fully stretched during the four-leuks assembly, the phase I may discontinue treatment. However, the four-count determination of exer-cises should continue. Resistance through ankle weights is added to hamstring curls and straight leg lifts, and exercise frequency is reduced to 3 times a week. The development of one foot strength is emphasized at this time. The four-year exercises should continue to be carried out to ensure that a full active extension of the road is maintained. During phase iii, you can perform an optional weight room exercise regime. For patients who wish to use sports equipment, the following former cises are considered additional: foot press, quadriples and a hamstring curl machine. The knee extension machine and Stairmaster should be avoided because they cause high patellofemoral contact plan (20,21), which can cause or exacerbate, pre-acl joint pain after ACL backup surgery. The patient must refrain from driving, jumping, swiry, and sudden changes in direction. Table 3 Objectives of Phase III Phase III Exercise 1. Protect the reconstruction; avoid falling. 1. Chair squat 2. Maintain road extension 2. One limb concentric eccentric closed chain extensions 3. Achieve full knee bending 3.Single limb wall slides 4. Walk with a normal heel until the gait without soft. 4. One limb of the calf produces 5. Muscle strength and conditioning improvements 5. Hamstring stretch 6. Quadriceps stretch 7.Calf stretch phase IV – from ten weeks after surgery, the patient has a phase IV accelerated ACL rehabilitation protocol. The objectives of Phase IV are to regain full muscle strength, improve cardiovascular conditioning and perform sports-specific trains. Table 4 The patient is instructed to continue muscle strengthening exercises from Phase II (Table 2) and Phase III (Table 3) three times a week. To create cardiovascular fitness facilities, the patient is allowed to use any combination of Nordic track, stationary bike, rowing machine and swimming. For patients who want to return to running sports, the patient does not have an orderly sequence of workouts designed to retrain the proprioceptive feed for the back loops needed to ensure neuromuscular control is running in the knee, but usually does not start running for up to four to six months after surgery (Table 4). Phase IV goals are to safely restore the knee, provide a logical sequence of pro-gressive workouts in presports conditioning and provide objec-tive criteria for patients safe return to sports (Table 5). Sport-specific training and the development of functional strength and proprioceptive time are improved and improved as the patient progresses throughout the progression. Progression phase 1 of the operational progression prerequisite phase. Straight ahead in stage 1. Full movement 2. Change of directional phase 2. Strength of at least 80% of the uninjured limb 3. Improved directional change and impact step 3. Thigh inches from the uninjured limb 4. Specific stage of sport 4. Symmetrically quadriced and hamstring elasticity 5. Perform and pass functional tests Table 6 Activity Weekly Postoperative 1. Jogging 12 2. Slow start-to-slow stop back and forth running 16 3. Fast start-to-fast stop back running 20 4. Zig-zag runs 26 5. The circle runs 26 6. Image-of-eight runs 26 7. Carioca works 28 8. Hop-to-jump progression 30 9. Race to cut progress 32 10. Sports practice 34 11. Complete return to sport 40 40

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