



## PATELLA OPEN REDUCTION INTERNAL FIXATION (ORIF)

### PHYSICAL THERAPY PROTOCOL

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Patient Name: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Procedure: Right / Left Patella ORIF

\_\_\_ Evaluate and Treat

\_\_\_ Provide patient with home program

Frequency: \_\_\_\_\_x/week x \_\_\_\_\_weeks

\_\_\_ **Phase I (0-6 wks):** *Period of protection. A home-program alone may suffice for this period of time. Formal PT may be helpful after 6 weeks once ROM is initiated in the brace.*

**-WBAT with crutches, brace locked in extension during all weight-bearing activity and during sleep.**

**-ROM :**

**-Knee:** patients to perform active prone knee flexion as tolerated 2-3 x per day within the confines of the brace wear. No active extension or forced passive



flexion. All ROM should be non-weightbearing and with the brace on, following the progression below:

0-6 wks: Brace locked in full extension (0 degrees).

6-7 wks: Brace unlocked from 0-30 degrees.

7-8 wks: Brace unlocked from 0-60 degrees.

8-9 wks: Brace unlocked from 0-90 degrees.

-Ankle/Hip: ROM exercises 2-3 x per day.

-Strict elevation while seated.

-No quadriceps strengthening until at least 6 wks post-op.

\_\_\_ **Phase II (6-12 wks): *Begin regular, supervised strengthening and wean from the brace.***

-Wean from crutches, then D/C brace once ambulating with a normal gait and can perform SLR without an extension lag.

-ROM – after 9 weeks postop, brace fully unlocked; 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, SLRs

-progress to closed chain strengthening (no open-chain) once out of the brace.

\_\_\_ **Phase III (3-6 months): *Begin more sport-focused conditioning.***

-Advance strengthening as tolerated, continue closed-chain exercises. Increase resistance on equipment.

-At 5 months, start jogging and progress to agility training and/or other sport-specific rehab as tolerated

-Begin to wean patient from formal supervised therapy encouraging independence with home exercise program by 6 months.

\_\_\_ **Other:**

\_\_\_ Modalities

\_\_\_ Electrical Stimulation

\_\_\_ Ultrasound

\_\_\_ Heat before/after

\_\_\_ Ice before/after exercise



**By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary. This patient \_\_\_ would \_\_\_ would not benefit from social services.**

\_\_\_\_\_

**Date:**\_\_\_\_\_

**Bryan M. Saltzman, MD**