

# PHYSICAL THERAPY PRESCRIPTION



**UC Irvine Health**

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PATIENT STICKER

## KNEE OSTEOCHONDRAL GRAFT CARTILAGE PROTOCOL: WEIGHT-BEARING FEMORAL CONDYLE

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

**Side:**  Right  Left

**Diagnosis:**  Osteochondral Autograft Transfer  Osteochondral Allograft Transplantation

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

Postop	Goals	Precautions	Exercises
<b>Weeks 0-6</b> HEP daily	Full passive extension 130° knee flexion Prevent quad inhibition Edema and pain control Promote independence FWB by 6 weeks	TTWB (20%) After Week 2, progress to WBAT Brace locked at 0° except for approved exercises and CPM  CPM (3 hrs/day) Weeks 0-2: 0-60° Advance 5-10° per day as tolerated	Weeks 0-3: Patella mobilization Quad sets/SLR Calf pumps Passive leg hangs to 90°  Weeks 3-6: AA/PROM pain free, towel extension Quad re-education SLR in all planes Hip/Core resisted exercises LE flexibility exercises
<b>Weeks 6-12</b> HEP daily	Full ROM Normal gait pattern Ascend 8" step with control Normal patella mobility Improve ADL endurance	DC brace when adequate quad Avoid descending stairs reciprocally Avoid painful activities No running	Continue above exercises Closed chain activities: wall sits, mini-squats, toe raises, stationary bike, leg press 0-90° Proprioception training Initiate step-up program
<b>Weeks 12-18</b> HEP daily	Return to normal ADLs Improve endurance Descend 8" step with control 85% limb symmetry on isokinetic and forward step down tests Improve strength/flexibility	WBAT Avoid painful activities No running	Continue and advance above Progress squat program Leg press (emphasize eccentrics) Retrograde treadmill Initiate step down program Advance to elliptical, bike, pool Open chain extension to 90°
<b>Weeks 18+</b> HEP daily	No apprehension with sport specific movements Maximize strength and flexibility to meet sporting demands	Avoid painful activities No running until: Strength >70% contralateral No agility training until: Strength >90% contralateral No RTP until MD clearance	Continue and advance above Begin forward running Begin plyometric program

**Frequency & Duration:**  1-2  2-3 x/week for \_\_\_\_\_ weeks \_\_\_\_\_ Home Program

**Physician's Signature:** \_\_\_\_\_ **M.D.**