ILLINOIS BONE & JOINT INSTITUTE®
Move better. Live better.

Dr. Anand Vora

ANKLE REPLACEMENT REHABILITATION PROTOCOL

Recovery at a glance:
2 wks non weight bearing in boot postop
At 2 wks may begin weight bearing in boot only
At 6 wks may begin weight bearing in regular shoe with brace
One year for majority of improvement

Post op transition immediately into CAM boot NWB with instruction of AROM DF/PF as HEP until start of therapy at 2-3 weeks post-op.

Therapy at 2-3 weeks post op:

Progression with boot to WBAT (per tolerance, no pain with WBAT) with use of crutches, cane, walker, etc. May use Roll-a-bout for community ambulation.
CAM boot is to be worn all times, including sleep, until 6wks post op. Boot can only be removed for bathing and therapy exercises.

Patient seen 1-2x/wk visits (mindful of insurance limitations) emphasis placed on soft tissue massage gastroc/soleus, AAROM, PROM to ankle DF/PF and toes (to prevent adhesion of the EHL, and ATT which is critical to maximize plantarflexion) in the sagittal plane only and NWB gastrocnemius stretching with a strap in a nonweightbearing position. Critical to monitor incision healing, avoid aggressive ROM/stretch if any anterior wound complications. Once incisions are closed, important to be aggressive with STM to Achilles (from lengthening) and dorsal incision to prevent adhesions. At NO time, PROM aggressive inversion/eversion to be peformed.

Important to work on NWB hip/knee LE exercises to maintain strength (SLR, SAQ, sidelye hip abd, etc).

Avoid aggressive rotary movement at ankle both A/PROM including inversion/eversion throughout therapy program. Emphasis on restoration of sagittal plane motion to avoid prosthetic loosening.

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Therapy at 6 weeks:

Once cleared by Dr. Vora, slowly transition out of CAM boot into athletic shoe (no flip flops, unsupported shoes). May need ASO/orthotic to provide additional support.

Emphasis should be placed on standing talocrural mobilizations to facilitate functional DF/PF. Can initiate standing WB gastroc/soleus stretch to improve DF mobility. Exercises should progress to standing weight shifts in athletic shoes, tandem balance/stride stance on stable floor with overhead punches/hands clasped and head rotations, push off's, forward lunges, squats, step work and gait training. Work on stationary bike progressing to treadmill can also begin.

Patient is NEVER to be placed on unstable surfaces throughout the entirety of rehab program due to risk of instability/prosthetic loosening (BOSU, foam, wobble board, etc).

Therapy at 10-12 weeks:

Progress into DL into SL heel raises, more advanced proprioceptive exercises on STABLE floor (cone taps, SL balance activites, etc)

Discharge goals:

1. Normalized gait pattern in shoe pain free.
2. AROM 10 deg DF, 35 deg PF. (may be less dependent on pre-operative motion, such as limited mobility due to severe OA).
3. SL heel raise at least 50% of uninvolved. This may take longer in patient's with Achilles lengthening procedures.

Imperative to avoid any early wound complications. Patients prone to dorsal incision complications, change steri-strips/gauze/occlusive dressing at therapy sessions. If any wound complications, do not hesitate to have patient see Dr. Vora immediately or seek medical attention ASAP.

Once wounds have closed, initiate with aggressive STM to incisions and Achilles/gastroc to avoid any adhesions.