SBO SOUTH BEND ORTHOPAEDICS
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THUMB MCP JOINT CAPSULODESIS
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0-2 WEEKS POST OP
Patient should be immobilized in a thumb spica cast with IP free.

2-4 WEEKS POST OP
Cast is removed.
Custom fabricated forearm-based thumb spica with IP free for motion.
Edema management needs to be monitored closely to reduce adhesions. Recommend light compressive dressing, kinesiotape, and active motion.
Pain management with use of e-stim, moist heat, and ice.

4-6 WEEKS POST OP
AAROM and AROM are initiated to the thumb and wrist.
Exercises should emphasize CMC abduction, radial extension, and opposition to each fingertip.
Isometric thenar abduction strengthening may be initiated at this time.
Early MCP flexion and adduction puts undue stress on the reconstructed ligament and should be minimized at this time. Do not promote thumb MCP extension, neutral is safe.

Complete flexion across the palm to the base of the fifth MCP should not be attempted until the thumb can be opposed to each fingertip with ease and gradually be worked down to the base of the small finger actively.

Splint to be continued in between exercises and at night for comfort.
Transition to hand based thumb spica if wrist motion is pain free.
May initiate light ADLs while wearing splint, as long as they are asymptomatic.

8-10 WEEKS POST OP
Static splint can be discontinued if the joint is stable and patient is asymptomatic.
Initiate gentle strengthening, including grip and pinch strengthening. No attempt should be made to pinch the ring and small fingers, because of this risks stretching out the ligament reconstruction.

10-12 WEEKS POST OP
Normal use of the hand may be resumed without restrictions following the last MD follow-up
*Do not promote thumb MCP into extension, neutral is the goal. This should be educated to the patient, even after discharge.