SOUTH BEND ORTHOPAEDICS
A DIVISON OF ASCENDANT ORTHOPEDIC ALLIANCE, LLC
Phone: 574.247.9441 • **Fax**: 574.247.9442 • www.sbortho.com

PLANTAR FASCIA EXCISION

The thickened, injured plantar fascia is removed from the heel. At times, a bony spur may require excision as well, but typically it is the plantar fascia that is the source of the symptoms. In the right patient, this can be a very successful surgery. However, it is done when all else has failed, as there may be additional discomfort from the scar that forms on the heel.

**This is a general guideline. Specific changes may be indicated on a case by case basis at the discretion of your surgeon. Please note that this is a rough guideline and your case may vary, especially if it is a revision case.*

Preoperative Physical Therapy

Pre surgical Gait Training, Balance Training, Crutch Training and Knee Scooter Training

Phase I – Protect Incision (0 to 4 Weeks)

WEEK 1: Strict elevation of the leg above the heart
- 23 hours/day!
- Ice behind knee (vascutherm or ice bag) to minimize swelling and control pain
- Wiggle toes, bend hip and knee to avoid muscle atrophy
- Nonweightbearing (NWB) in splint. Crutches or walker for balance.

WEEK 2: Sutures out 10-14 days postoperative
- Transition to full WB in CAM boot
- Elevation/ice as needed
- Regular shoe when swelling allows
- An orthotic is often indicated to provide further external support to the foot
- Come out of the boot and begin to move your ankle up and down for 5-10 minutes, 5 times per day to maintain range of motion
- Compression stocking to be worn to control swelling along with ice/elevation
- Sleep in boot
- Physical therapists to communicate with physicians as to severity of the fracture, quality of fixation and bone quality.

Phase II – Early Range of Motion/Gait Training (4 to 8 weeks)

WEEKS 4-6:
- Continue with edema control strategies as necessary.
- AROM to tolerance
- Initiate AAROM/stretching program
- Seated towel crunch for intrinsics
- Soft tissue mobilization
- Midfoot joint mobilizations
- Stationary bike

WEEK 6: tentative office recheck if continued symptoms or concerns
- May otherwise gradually progress to full activity as tolerated
- Advance daily stretching
- Ankle isometrics progressing to open chain isotonics
- Closed chain exercise (weight machines, weight shifts, seated BAPS)
- Proprioception exercise (SLB, diagonal doming and foot intrinsic strengthening)
- Joint mobilizations to increase talocrural and subtalar ROM
- Treadmill walking program

Phase III – Return to Function (8 to 12 weeks)

WEEKS 8-10:
- Progress closed chain exercises (Sportcord, lunges, heel raises etc, standing BAPS, exercise bike, swimming)
- Dynamic balance progression (mini tramp, SLB on uneven surfaces, Star excursion, steamboats, lunges)
- Advanced proprioception exercises
- Continue to advance weight machine exercises, stretching, ROM and joint mobilizations

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PHYSICAL THERAPY: start between 2-6 weeks post op, focus on motion and swelling at first, then gait training and strengthening. At 12 weeks begin gentle running / higher impact activities.
DRIVING: Prior to driving, you must be able weightbear on your right foot without crutches. If left heel, may drive automatic transmission car when off narcotic pain medication
FULL RECOVERY: may take up to one year for complete recovery depending on pain, swelling, and the scarring that is common
PHYSICAL THERAPY: start between 4-6 weeks post op, focus on motion and swelling at first, then gait training and strengthening

- focus on hip/knee/core for first 6-10 weeks
- patient specific desires on gait training with/without therapist
- DO NOT attempt to gain motion in the planes that were fused: for subtalar/triple arthrodesis, focus only on dorsiflexion/plantarflexion (DO NOT ATTEMPT side to side motion)

DRIVING: Prior to driving, you must be able weightbear on your right foot without crutches. In addition, you may begin driving at 9 weeks if surgery on right ankle; if left ankle, may drive automatic transmission car when off narcotic pain medication
FULL ACTIVITY: This may take 6 to 18 months. There is no guarantee on outcome. All conservative management options have risk of worsening pain, progressive irreversible deformity, and failing to provide substantial pain relief. All surgical management options have risk of infection, skin or bone healing issues, and/or worsening pain. Our promise is that we will not stop working with you until we maximize your return to function, gainful work, and minimize pain.

SHOWERING: You may shower with soap and water 1 day after surgery. Avoid lotions, creams, or antibiotic ointments on surgical site until directed by your orthopaedic surgeon. No baths or submerging operative site under water until incision has completely healed.
SKIN CARE: Steristrips are typically placed on your incision at your follow up appointment. Steristrips will typically fall off on their own. Remove steristrips in shower after 3 weeks if they remain on incision.Incisions may become sensitive. Some surgical incisions based on their location and patient factors are more likely to require postoperative scar desensitization with physical therapy. You may use Mederma or other skin protectant lotion once incisions have completely healed and approved by your orthopaedic surgeon. Do not placed cortisone or other steroid on your incision unless directed by your orthopaedic surgeon. Incisions and surgical site scars are more prone to burn by ultraviolet radiation when out in the sun. Always apply sun screen onto the healed incision once fully healed.
STOOL SOFTENERS: While on narcotic pain medication (e.g. Norco/hydrocodone or Percocet/oxycodone) especially within first 72 hours of surgery, you should take stool softener (e.g. Miralax, docusate, senna). Discontinue if you develop loose stool or diarrhea.