
ANKLE ARTHROSCOPY PROTOCOL

A small camera and instruments are inserted into your ankle joint to address the conditions you experience. This may be the removal of a loose piece of bone, removal of impinging or inflammatory tissue, or the treatment of an osteochondral defect of the talus (bone and cartilage cyst). At times, a small open incision also needs to be made to remove extra bone that stops motion in your ankle.

****Note that these are guidelines and may be adjusted by your surgeon based on your diagnosis and intra-operative findings****

Preoperative Physical Therapy

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

Impingement, loose body removal (without additional procedures)**WEEK 1:** Postop dressing/boot

- Initiate partial weightbearing with crutches or walker unless there was an osteochondral defect and indicated by MD
- Elevate leg above heart 23 hours/day
- Ice behind knee to control pain and swelling
- Acetaminophen (e.g. Tylenol) 500mg every 6 hours alternating with ibuprofen 600mg every 6 hours or meloxicam 15mg once daily. Narcotic pain medication (hydrocodone or oxycodone) should be reserved for breakthrough pain as second line medication. Do not take over 4,000mg of acetaminophen per day.

1ST POST OP (5-7 DAYS): Dressing Change

- Begin ROM exercises

2ND POST OP (10-14 DAYS): Suture Removal

- Full weightbearing (WB) in boot, transition to regular shoe as tolerated
- Begin physical therapy if needed/indicated determined by your MD
- Transition to shoe gear weightbearing as tolerated (WBAT) as gait normalizes
- Begin ankle range of motion (ROM) exercises (AROM, Biomechanical Ankle Platform System/BAPS board in seated)
- Gastroc/soleus stretching: begin in long sit NWB and progress to standing stretches

WEEKS 4-6: Office Visit

- Progress to sports' specific strengthening and return to activity as tolerated
- Begin ankle progressive resistance exercises (PREs, theraband 4 way)
- Progress to WB exercises as tolerated (Heel Raises, BAPS board in standing)
- Begin static balance, single leg balance, stable surface proprioceptive training
- Gait should be normalized in normal shoe with ankle stabilizing orthosis (ASO)

WEEKS 6-8

- Progress proprioceptive training to dynamic/unstable surfaces
- Begin agility training as tolerated

Osteochondral Defect (OCD) of the Talus**WEEK 1:** postop dressing/boot

- Nonweight bearing (NWB) with crutches, walker

1ST POST OP (5-7 DAYS): Dressing change

- begin ROM exercises

2ND POSTOP (10-14 DAYS): Sutures removed

- Continue NWB, elevation

WEEK 6: recheck with xrays in office

- begin progressive WB in boot, using crutches/walker, starting with 25% weight and increasing by 25% every 1-2 weeks until fully WB in boot
- use a scale if available to estimate weight bearing. Put most of your weight on the crutches and opposite leg, then load the scale with the operative leg until it reads 25% of your weight. This is a rough guide that should be used for the first week, then increase to 50%, etc
- when you hit 75%, begin to use one crutch in the OPPOSITE arm
- may begin physical therapy if indicated/desired

WEEK 10: Recheck in office with xrays

Developed in conjunction with the physicians at South Bend Orthopaedics

- transition to regular shoe, first around the house, then for outdoor activities
- exercise bike, swimming, elliptical ok

WEEK 12: sports specific exercises and return to activity as tolerated

- Please remember that full recovery may take up to 6 months to a year. There may be times that you feel you have plateaued in your recovery but continue to persevere in your exercises. If your pain or swelling worsen or if you have additional questions or worries please contact your surgeon

PHYSICAL THERAPY: Physical therapy typically begins 2-4 weeks post op to focus on restoration of ROM, edema control, scar reduction, and restoration of proper gait mechanics with emphasis on weight bearing through the first ray in stance phase.

DRIVING: Prior to driving, you must be able weightbear on your right foot without crutches. If your left ankle, you may drive automatic transmission car when off narcotic pain medication.

FULL ACTIVITY: This may take 6 to 18 months. 6 months to one year for all swelling/soreness/discomfort to resolve. 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 place 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.

REFERENCES

1. Anterior impingement syndrome in dancers. O'Kane JW and Kadel N. Curr Rev Musculoskelet Med. 2008; 1:12-16.
2. Diagnosis of anterolateral ankle impingement. Comparison between magnetic resonance imaging and clinical examination. Liu SH, Nuccion SL, Finerman G. Am J Sports Med. 1997 May-Jun; 25(3): 389-93.
3. Update on anterior ankle impingement. Vaseenon T and Amendola A. Curr Rev Musculoskelet Med. June 2012; 5 (2): 145-150.