SOUTH BEND ORTHOPAEDICS

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TARSAL TUNNEL RELEASE PROTOCOL

The nerve behind the medial malleolus, or inside ankle bone, is released from surrounding swelling and scar tissue. The main goals of this surgery are pain relief and improved sensation. Nerve surgery can be very challenging from a technical standpoint, and the utmost care is taken to avoid nerve injury. The damage that was done to the nerve over months to years of it being compressed is frequently not reversible, and when it is, it can take up to 18 months for nerve recovery. In addition, the wound from this surgery is notorious for having complications. The wound will be the rate limiting step before weight bearing and further activity are advanced.

Please note that this is a rough guideline and your case may vary, especially if it is a revision case.

WEEK 1: Nonweightbearing (NWB) in short leg splint

1) Elevate the leg above the heart to minimize swelling 23 hours/day
2) Ice behind the knee 30 min on/30 min off (Vascutherm or ice bag)
3) Crutches or walker for balance

WEEK 2: Sutures removed 10-14 days postoperatively

- Transition to full WB in boot
- Elevation/ice as necessary
- Regular shoe when swelling allows

WEEK 6: Tentative office recheck if continued symptoms or concerns

- May otherwise gradually progress to full activity as tolerated

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

RETURN TO FUNCTION: May take up to 6 to 18 months depending on pain, swelling, and scarring that is common. 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.