53880 Carmichael Drive • South Bend, IN 46635
60160 Bodnar Boulevard • Mishawaka, IN 46544
Phone: 574.247.9441
Fax: 574.247.9442
www.sbortho.com

Patient name:
Date of Surgery:
Surgery performed:

Tyler McGregor D.O.
General Ortho and Sports Medicine
South Bend Orthopaedics
Discharge Instructions and Rehabilitation Protocol
Postop Ankle ORIF PT Protocol
With Syndesmosis Fixation

This is a general guideline. Certain patients may require extra attention to certain areas of their body or portions of the protocol. Always listen to your therapist; a protocol never replaces their good clinical judgement. Do not attempt to increase weight, perform a new exercise, or increase your range of motion without their direction.

General information

Pain Medication:

- Narcotic Pain Medication is best utilized for acute pain and for short durations. It is given to allow for tolerable discomfort.
- ONE prescription of narcotic pain medication is typically sufficient after these procedures. Hydrocodone/acetaminophen (7.5/325 mg) may be taken 1 time every 6 hours as needed for pain. A maximum of 4 tablets may be taken in a given day. 20 tablets will be prescribed.
- Common side effects of narcotic medication include: flushing, dizziness, nausea, drowsiness, constipation, delirium. If you are using narcotics, minimize constipation by drinking adequate amounts of water and consuming a high-fiber diet. A stool softener such as docusate and/or a GI motility agent such as Senna may be purchased over the counter as well.
- DO NOT operate a motor vehicle or heavy machinery while on narcotic medication.
- Alternatives to narcotic pain medication include ibuprofen (600 mg every 6-8 hours) and Tylenol. You may take ibuprofen in conjunction with Norco if you are having breakthrough pain**. Tylenol is not to be taken with Norco**.

Minimizing Risk for Deep Vein Throboses (DVT, blood clots)

- Blood clots in the extremities (DVT) or lungs (pulmonary embolism- PE) are possible after having surgery due to decreased mobility. If a blood clot travels out of the extremities and into the lungs, it can be a serious and life-threatening condition. Concerning symptoms include calf pain, leg foot and swelling, shortness of breath, increased breathing or heart-rate and fever.

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- Mechanical methods for preventing DVT include contracting (flexing) the muscles of the legs, including the calves, quadriceps and gluteals. These should be done 10-15 times per hour.
- Compressive TED stockings may be placed on your legs after surgery.
- **Aspirin 325mg is recommended once per day for 4 weeks following surgery**. Patients with allergies sensitivities or other contraindications to aspirin or other anti-coagulation agents should not take aspirin and should consult with their surgeon and/or primary doctor.
- Contraceptive medications should be temporarily suspended for 6 weeks after surgery.
- Avoid prolonged sitting, laying down, immobility and long distance travel immediately after surgery, as this may increase the likelihood of DVT as well.

Return to Driving:

- You **must** be off of narcotic pain medication to resume driving.
- You must feel safe and comfortable behind the wheel. You must be confident in moving your foot from the gas pedal to the brake with ease.
- Research suggests that it takes up to 6-9 weeks after the initiation of weight-bearing, if your surgery involved your RIGHT LEG, to regain reaction time after having general anesthesia.

Immediate postop

- Ice/elevate 20 minutes every hour while awake
- gentle toe flexion/extension hourly
- **Non-weight bearing to extremity with crutches, walker, wheelchair or rolling scooter**
- **Maintain postoperative dressing – keep clean and dry**
- **Take pain medication as prescribed**

Postop Visit #1: 10-14 days after surgery

- Postop split removal and X-rays– placed into CAM walker boot
  - Ok to remove boot for therapy and showering
- Continue ice/elevation for pain and swelling control
  - Do not apply ice directly to skin
- Wound check
  - Suture removal, steri-strips placed. Allow these to fall off on their own.
  - **Do not submerge the knee underwater in a bath, swimming pool or any other body of water until the incisions are completely healed, typically 4-6 weeks following surgery**. Premature submersion may lead to infection.
  - SPF 30 or greater is recommended over the incisions for the first year to minimize darkening of the scar.

Week 3

- Initiate formal postop rehab 1-2 times weekly and daily home exercise protocol
  - Active/Passive dorsiflexion, plantarflexion
  - Active Inversion/Eversion exercises
  - Ice/elevation, fluid mobilization
- Begin scar massage during PT sessions

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Week 4:

- X-rays at clinic visit
- Passive / active dorsiflexion and plantar flexion stretching
- Inversion / Eversion ROM exercises – active assist and gentle passive
- Begin dorsiflexion and plantar flexion gentle isometrics

POST-OPERATIVE VISIT #2

FIXATION WITH TIGHTROPE (suture)

Week 6

- Continue above exercises
- Goal is to have normal motion during this phase
- **Partial (25%) weight bearing in CAM boot**
    - **Increase weight bearing by 25% every two weeks**.

Post-operative visit #3 postop week #11

- **Weight bearing X-rays**
- Wound check
- **Discontinue crutches if x-rays stable**
- **Stationary bike**

Week 12 +:

- **Discontinue boot**
- Elliptical, Progress under supervision of physical therapist

FIXATION WITH SCREWS

Week 6

- Continue above exercises
- Goal to have normal motion during this phase

Post-operative visit postop week #11

- **X-rays**
- Wound check
- **Plan for possible syndesmosis screw removal after week 12 / 3months**

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Week 12 +:

- Initial partial weight bearing in boot after screw removal
    - Alternatively, you may begin partial weight bearing at this time if avoiding another procedure is a priority
        - The screw may break within the bone. Certain cases can be handled this way and may not be symptomatic. You and Dr. McGregor will reach a conclusion as to the best individual course of action.

Two weeks after removal of the syndesmosis screw(s) you will have a follow up with weight bearing x-rays. The CAM walker boot may be discontinued at this time. Therapy will be ordered if required. Further recommendations will be made based on your anticipated return of function, range of motion, and strength.

Other postop visits based on clinical and radiographic union and anticipated functional demand requirements.