MENISCAL BODY REPAIR (ALL-INSIDE)
Physical Therapy Protocol

Patient Name: ___________________________________ Date of Surgery: ____________________

_____ **Evaluate and Treat**

_____ **Provide patient with home exercise program**

Frequency: ______ x/week x ______ weeks

_____ **Phase I (0 – 2 weeks):**

- **Weightbearing:** TTWB in Brace locked in extension with crutches.***
- **Brace:** Locked in full extension for sleeping and all activity.*
  Off for exercises and hygiene.
- **Rom:** 0-90° when non- ambulatory (active/passive).
- **Exercises:** Heel slides, quad sets, patellar mobs, SLR, SAQ.**
  No weight bearing with flexion >90°

_____ **Phase II (2-6 weeks):**

- **Weightbearing: 2-4 weeks:** TTWB in Brace unlocked 0-90°.
  4-6 weeks: Full w/ brace as above, transition to w/o brace.
- **Brace: 2-4 weeks:** Unlocked 0-90°.
  Off at night.
  4-6 weeks: Full.
  Discontinue brace (when quad strength adequate).
  Discontinue crutches when gait normalized.
- **Rom:** As tolerated within confines.
- **Exercises:** Addition of heel raises, total gym (closed chain), wall sits to 90 degrees, terminal knee extensions.**
  Activities w/ brace until 6 weeks; then w/o brace as tolerated.
  No weight bearing with flexion >90°

_____ **Phase III (6-12 weeks):**

- **Weightbearing:** Full WBAT without brace.
- **Brace:** None.
- **Rom:** Full.
- **Exercises:** Progress closed chain.
  Begin hamstring work, lunges/leg press 0-90°,
  proprioception exercises, balance/core/hip/glutes.
  Begin stationary bike when able.

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_____ **Phase IV (12-20 weeks):**

- **Weightbearing:** Full.
- **Brace:** None.
- **Rom:** Full.
- **Exercises:** Progress Phase III exercises and functional activities: single leg balance, core, glutes, eccentric hamstrings, elliptical, and bike.
  Swimming okay at 12 weeks.
  Advance to sport-specific drills and running/jumping after 16 weeks once cleared by MD.

*Brace may be removed for sleeping after week 4 postoperative

**Avoid any tibial rotation for 8 weeks to protect meniscus

***Weight bearing status may vary depending on nature of meniscus repair. Please refer to specific PT Rx provided to patient for confirmation of WB status

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary.
This patient ______ would ______ would not benefit from social services.

Physician Name: ____ Date: ____________________

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