POSTERIOR CRUCIATE LIGAMENT (PCL) AVULSION REPAIR
Physical Therapy Protocol

Patient Name: _____ Date of Surgery: _____

_____ **Evaluate and Treat**

_____ **Provide patient with home exercise program**

Frequency: _____ x/week x _____ weeks

_____ **Phase I (0-4 weeks):**

- **Weight Bearing:** Full in brace.*
- **Brace:**
  0-2 weeks: Locked in full extension for ambulation and sleeping.
  2-6 weeks: Unlocked for ambulation, remove for sleeping.**
- **ROM:** As tolerated.
- **Exercises:** Quad sets, patellar mobs, gastroc/soleus stretch.
  SLR w/ brace in full extension until quad strength prevents extension lag.
  Side-lying hip/core.
  Hamstrings avoidance until 6 weeks post-op.

_____ **Phase II (4-12 weeks):**

- **Weight Bearing:** Full.
- **Brace:** Discontinue at day 28 if patient has no extension lag.
- **ROM:** Full.
- **Exercises:** Begin toe raises, closed chain quads, balance exercises, hamstring curls, stationary bike, step-ups, front and side planks; advance hip/core.

_____ **Phase III (12-16 weeks):**

- **Weight Bearing:** Full.
- **Brace:** None.
- **ROM:** Full.
- **Exercises:** Advance closed chain strengthening.
  Progress proprioception activities.
  Begin stairmaster, elliptical and running straight ahead at 12 weeks.

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_____ **Phase IV (16-24 weeks):**

- **Weight Bearing:** Full.
- **Brace:** None.
- **ROM:** Full.
- **Exercises: 16 weeks:** Begin jumping.
  20 weeks: Advance to sprinting, backward running, cutting/pivoting/changing direction, initiate plyometric program and sport-specific drills.

_____ **Phase V (>16 months):**

- **Weight Bearing:** Full.
- **Brace:** None.
- **ROM:** Full and pain-free.
- **Exercises:** Gradual return to sports participation after completion of FSA.***
  Maintenance program based on FSA.

*Modified with concomitantly performed meniscus repair/transplantation or articular cartilage procedure

**Brace may be removed for sleeping after first post-operative visit (day 7-10)

***Completion of FSA (Functional Sports Assessment) not mandatory, but recommended at 22-24 weeks post-op for competitive athletes returning to play after rehab

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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