



POSTERIOR CRUCIATE LIGAMENT (PCL) AND POSTERIOR Lateral Corner (PLC) RECONSTRUCTION Physical Therapy Protocol

Patient Name: _____ Date of Surgery: _____

_____ Evaluate and Treat

_____ Provide patient with home exercise program

Frequency: _____ x/week x _____ weeks

_____ Phase I (0-6 weeks):

- **Weight Bearing:** Heel touch WB in brace.*
- **Brace:**
 - 0-2 weeks: Locked in full extension for ambulation and sleeping.
 - 2-6 weeks: Unlocked for ambulation 0-90, remove for sleeping.**
- **ROM:**
 - 0-2 weeks: 0- 45.
 - 2-6 weeks: Advance slowly 0-90.
- **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 (6-12 weeks):

- **Weight Bearing:** Advance 25% weekly until full by 8 weeks.
- **Brace:** Discontinue at 6 wks if 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.

_____ **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 IV (>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 wks 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: _____