



LATARJET / DISTAL TIBIAL ALLOGRAFT (DTA) Physical Therapy Protocol

Patient Name: _____ Date of Surgery: _____

_____ Evaluate and Treat

_____ Provide patient with home exercise program

Frequency: _____ x/week x _____ weeks

_____ Phase I (Weeks 0 – 6):

- **Sling with abduction pillow:** Continue for a total of 6 weeks; remove only for hygiene
- **Range of Motion:** PROM only for first 6 weeks, to patient tolerance
 - Weeks 0-4: Goals of FF 140°, ER 25° in 30° of ABD, ABD 60-80°; limit IR to 45° in 30° of ABD
 - Weeks 4-6: Increase PROM to tolerance, increase ER to 45° in 30° of ABD
- **Exercises:**
 - Weeks 0-4: Pendulums, grip strengthening, isometric scapular stabilization; elbow/wrist/hand ROM
 - Weeks 4-6: Begin gentle joint mobilizations; limit ER to passive 45°
 - No active IR or extension; no canes or pulleys
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

_____ Phase II (Weeks 6 – 12):

- **Sling:** Discontinue (unless in crowd or in slippery environment)
- **Range of Motion:** Increase PROM as tolerated, begin AAROM/AROM
- **Exercises:**
 - Weeks 6-8: Begin light cuff/deltoid/biceps isometrics
 - Weeks 8-12: Begin light resisted ER, FF, ABD, and IR exercises; begin extension and scapular retraction **exercises**
- **Modalities:** Per therapist, including electrical stimulation, ultrasound, heat (before), ice (after)

_____ Phase III (Months 3 – 6):

- **Range of Motion:** Full without discomfort
- **Exercises:** Continue Phase II, advance as tolerated, include closed chain scapular rehabilitation and functional rotator cuff strengthening; focus on anterior deltoid and teres
 - Month 4: advance strengthening as tolerated from isometrics to therabands to light weights; emphasize low-weight, high rep exercises
- *Consider return to sport at 20-24 weeks pending surgeon approval*

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: _____