OSTEOCHONDRAL ALLOGRAFT TRANSPLANTATION (OAT) WITH HIGH TIBIAL OSTEOTOMY (HTO) 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:** Heel touch only.
- **Brace 0-2 week:** Locked in full extension at all times.*
  Off for hygiene and home exercise only.
- **ROM:** Gentle passive 0-90°.
  CPM 6 hrs/day; begin 0-40° and advance 5-10° daily as tolerated.
- **Exercises:** Heel slides, quad sets, patellar mobs, SLR, calf pumps at home.

_____ **Phase II (2-8 weeks):**

- **Weightbearing: 2-6 weeks:** Heel- touch only.
  6-8 weeks: Advance 25% weekly until full.
- **Brace**: **2-6 weeks:** Locked 0-90°.
  Discontinue brace at 6 weeks.
- **ROM:** Advance as tolerated.
  CPM continues 6 hrs/ day 0-90°.
- **Exercises: 2-6 weeks:** Add side-lying hip and core, advance quad set and stretching.**
  6-8 weeks: Addition of heel raises, total gym (closed chain), gait normalization, eccentric quads, eccentric hamstrings.
  Advance core, glutes and pelvic stability.

_____ **Phase III (8-12 weeks):**

- **Weightbearing:** Full.
- **Brace**: None.
- **ROM:** Full.
- **Exercises:** Progress closed chain activities.
  Advance hamstring work, lunges/leg press 0-90° only, proprioception/balance exercises.
  Begin stationary bike.

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_____ **Phase IV (12-24 weeks):**

- **Weightbearing:** Full.
- **Brace**: None.
- **ROM:** Full.
- **Exercises:** Progress Phase III exercises and functional activities: walking lunges, planks, bridges, swiss ball, half-bosu exercises.
  Advance core/glutes and balance.

_____ **Phase V (6-9 months):**

- **Weightbearing:** Full.
- **Brace**: None.
- **ROM:** Full.
- **Exercises:** Advance all activity w/o impact such as running, jumping, pivoting, sports until cleared by MD.

*Brace may be removed for sleeping after first post-operative visit (day 7-14)

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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