



ORTHOPEDICS & SPORTS MEDICINE

BAYCARE CLINIC®

Dr. Klika & Dr. Kirkpatrick TFCC Debridement

Phase 1- Early Protective Phase Weeks 0 - 4

Goals for phase 1

- Immobilize and protect reconstruction
- Pain and edema control
- Educate patient in home program and importance of wearing splint at all times
- Educate patient to return to clinic for splint adjustments as needed to ensure comfort and compliance with splint use.

Other considerations

Patient will most often be referred to therapy for initial therapy visit after his/her 2-week follow-up with surgeon. Patient is usually only seen for one appointment during this initial immobilization phase. This appointment consists of splint fabrication and patient education in ROM of uninvolved joints, edema, and scar management. Patient begins therapy at 4 weeks post-op.

Splint

- Muenster splint- elbow at 90 degrees, wrist in neutral, forearm in neutral
- To be worn at all times except hygiene

ROM

- AROM to uninvolved joints (shoulder, elbow, digits)
 - no wrist or forearm ROM

Scar Management

- Begin scar massage no sooner than 2 days after suture removal after scar is fully closed with no scabbing present. Begin with light massage using lotion.
- Apply scar remodeling products as needed

Edema Management

- Light compression with coban or compression sleeves to digits, hand, and forearm
- Elevation
- Manual Edema Mobilization (MEM)

Functional Activity

- Splint on at all times
- Allow use of involved UE with non-resistive, light ADL/IADL only within limits of the splint.



Phase 2 – Initiate Motion- Weeks 4 - 8

Goals for phase 2

- Restore full active range of motion
- Continue pain, edema control, and scar management

Splint

- If patient is doing well with very little pain or swelling and with MD approval, may consider cutting Muenster down to wrist hand orthosis
- 6 weeks: Patient may begin weaning from Muenster or wrist hand orthosis. Therapist may recommend weaning schedule variations as appropriate.
- May issue a Wrist Widget support for ulnar wrist pain as patient weans from orthosis

ROM

- Initiate gentle active ROM to wrist and forearm 6x/day for 10-minute sessions
- Continue with active and passive ROM to shoulder, elbow, digit ROM as appropriate

Strengthening

Initiate submaximal pain-free isometrics for wrist and forearm after 1 week of AROM

Manual Therapy

- Continue phase 1 scar and edema management
- Desensitization

Modalities

- Fluidotherapy for heat, ROM, and desensitization
- Paraffin may be used for deep heat

Functional Activity

- Encourage participation of involved upper extremity in non-resistive ADL/IADL
- Wrist support to be worn with heavier ADL/IADL within physical activity restrictions



Phase 3 – Maximize ROM, Strengthening, Weeks 8+

Goals for phase 3

- Restore functional pain-free range of motion and strength
- Continue to control edema and minimize scar adhesions

Other considerations

- PROM to forearm should be performed by securing at the forearm and not distal to the wrist to avoid torsional load on the TFCC
- Although PROM is indicated for joint and soft tissue restrictions, avoid painful ROM and stretching beyond a functional range of motion. The end goal of surgery is to stabilize the wrist for pain-free function

Splint

Continue splint or Wrist Widget with heavy activities

ROM

- Continue active ROM to wrist and forearm
- Initiate pain-free PROM to wrist and forearm to restore functional motion, as needed

Strengthening

- Initiate hand, wrist, and forearm strengthening
- Initiate isotonic strengthening including weighted wrist and forearm exercises and gentle grip and pinch strengthening with putty
- Proprioceptive/stabilization- wrist alphabet with 1# hand weight, oscillation with flex bar, gyroball
- Scapula stabilization and proximal upper extremity strengthening

Manual Therapy

- Continue phase 1 scar and edema management
- Desensitization, as needed

Modalities

- Fluidotherapy for heat, ROM, and desensitization, as needed
- Paraffin may be used for deep heat, as needed

Functional Activity

Continued use of involved upper extremity with ADL/IADL within physical activity restrictions

Work Conditioning

After 10-12 weeks and with MD consent a comprehensive work conditioning program for patients with high demand / heavy manual labor occupations may be appropriate

References

Cannon, Nancy M. et. al. Diagnosis and Treatment Manual for Physicians and Therapists, 5th Ed. The Hand Rehabilitation Center of Indiana. Indianapolis, Indiana. 2021.

This protocol was reviewed and updated by Brian Klika, MD, Lacey Jandrin, PA, Andrew Kirkpatrick, MD, Tiffany Terp, PA, and the Hand Therapy Committee 8/9/2021.