

ValleyOrtho Rehabilitation Playbook Series

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Surgical Procedure: Vertical Longitudinal & Peripheral Meniscus Repair **GREEN Playbook**

The intent of this information is to inform the treating clinician on the evidence-based considerations to be used as a guideline regarding the surgery noted above. This is not a substitute for appropriate clinical decision making, but a supplement to that effect. If at any time a clinician feels uncertain about a given phase discrepancy or patient presentation they are strongly encouraged to discuss this with the referring physician and his/her team.

****It is the responsibility of the therapist to read the operative report before providing care to the patient to improve treatment communication***.*

Therapeutic Activity Progression Disclaimer: Progression to the next phase should be strongly based on meeting clinical criteria (not solely based on the post-operative timeframes) and in collaboration with the referring surgeon. Exercise prescription should be clinically directed by pain and performance absent of detrimental movement patterns with respect to proper biomechanics of the spine, hip, knee and ankle.

Communication Recommendations from Therapist to Surgical Team:

When a treating therapist feels the need to reach out to Dr. George, or a member of his team, at any point for any reason they are strongly encouraged to do so. All concerns are not explicitly written and clinical judgement is paramount. Below is a handful of reasons and suggested methods of contact to promote communication:

Urgent Red Flag Communication: the patient is in clinic and an action is required as directed by referring staff office

- Uncontrollable and unremitting pain.
- Signs of infection at incision or treated limb.
- Severe palpation tenderness, swelling, tachycardia (UE or LE DVT).
- Labored breathing (PE).
- Drastic decline in ROM.
- After a fall/trauma, or near fall/trauma, resulting in a clinical change.

Preferred Contact Method: Immediate phone call to speak with MA or ATC until answer.

Administrative Needs

- Rehabilitation Prescription needed or prescription change requests
- Appointment needed with the physician office, or medication refill

Preferred Contact Method: Phone call to MA/ATC

Other Patient Concerns During Clinic Hours M-TH 9-5pm F 9-3pm

- Abnormal pain, comorbidities or complications that may prevent attainment of established discharge criteria.
- Patient is noncompliant with rehabilitation process.
- Excessive muscle guarding/motion phobia after 1-2 outpatient visits.
- Adverse work or home practices negatively impacting recovery.
- Patient expresses discontent or concerns with the current POC established by PT and/or by MD/PA

Preferred Contact Method: Phone call to MD &/or PA

Preferred Updates before checkup visits with MD/PA

During Clinic Hours M-TH 9-5pm F 9-3pm

- Information regarding adherence/participation in rehabilitation process.
- Comments on progress and trending nature of the patient's rehab course.

Preferred Contact Method: Phone call to MD &/or PA. Or Fax update



Phase 1: Edema, Quadriceps & ROM Recovery (wks 0 to 3)

Goals:

- Minimize pain/swelling to decrease quad inhibition¹³
- Normalize quadriceps activation/control¹³
- Set baseline KOOS-pain/KOOS-Sport for RTS readiness²² (Appendix A)

Precautions/Restrictions:

- WB/Gait:
 - Refer to Dr. George's physical therapy prescription for brace and WB status for weeks 1-6
- A/AA/PROM:
 - Refer to Dr. George's physical therapy prescription for OKC and CKC ROM restrictions for week 1-6
- Activity:
 - No isolated RROM HS for 6 weeks^{1, 2}
 - No pivot/twisting training until week 10²

Phase 1 Therapeutic Activities:

- Gait:
 - Progression from bilateral crutches to single crutch
 - D/C or unlock Brace for gait once 20 SLR + 10 TKE stance marches is possible ≠ quad lag/TKE loss¹⁶
 - D/C single crutch when patient can ambulate ≠ limp
- ROM:
 - Manual & self-management for flexibility, swelling and full ext²
 - Scar mobilizations on healed incisions¹
 - Stationary bike at <50% BW loading 0-90°¹¹
- Strengthening:
 - Quad TKE focused activity^{2, 13}
 - NMES to quad with volitional contraction as needed^{2, 13}
 - Consider blood flow restriction to deter atrophy²
- Balance:
 - Proprioception with TKE control within precautions¹

Criteria for Progression to Phase 2:

- 0° EXT², ≈ 110° Flexion^{7,11}
- 20 SLR ≠ Quad Lag¹⁵

Phase 2: ROM, Total LE Strengthening & Balance (wks 3 to 6)

Goals:

- Consistent swelling resolution despite activity increases
- Proper gait mechanics by end of phase

Precautions:

- WB/Gait:
 - Refer to Dr. George's physical therapy prescription for brace and WB status for weeks 1-6
- A/AA/PROM:
 - Refer to Dr. George's physical therapy prescription for OKC and CKC ROM restrictions for week 1-6
- Activity:
 - No isolated RROM HS for 6 weeks²
 - No plyometrics in this phase^{1, 2, 8, 13}
 - Avoid pivot/twisting training until week 10²

Phase 2 Therapeutic Activities with Respect to WB/ROM Status:

- Gait:
 - Ensure proper weight shifting over involved extremity with appropriate assistance based on repair type, pain and quad control
 - Quad control as defined as 20 SLR ≠ Quad Lag¹⁵ **AND** standing march ≠ extension lag: Standing on involved knee, without UE support, patient is able to perform 10 march repetitions of uninvolved hip maintaining full knee extension on involved knee ≠ lag¹⁶
- ROM:
 - Manual & self-management for flexibility, swelling
 - Stationary bike as tolerated¹²
- Strengthening:
 - Total LE strengthening/activities aimed avoid valgus collapse and promote core strength/pelvis control²
 - Continue quad focused activity^{2, 13}
 - Double leg Mini squats <90°¹
- Balance:
 - Proprioception training progressions within precautions¹

Criteria for Progression to Phase 3:

- Normal gait mechanics without AD
- 0-125° AROM



Phase 3: Total LE Strengthening & Balance (wks 6 to 12)

Goals:

- Full flexion ROM between 6-10 weeks^{2, 8}
- **In prepubescent patients:** focus primarily on form control and movement patterns instead of muscle hypertrophy as their bodies will not put on muscle growth as in more mature patients¹⁶

Precautions:

- Avoid pivot/twisting training until week 10²

Phase 3 Therapeutic Activities:

- ROM:
 - Manual & self-management for gains in ROM, flexibility & swelling
- Strengthening & Activity:
 - Progressions of Total LE CKC & OKC 0-90° strengthening aimed avoid valgus collapse and promote core strength/pelvis control²
 - Stationary bike as tolerated¹²
 - Elliptical OK
 - Plyometric initiation¹ with cautious progressions from double leg to single leg with good valgus control
- Balance:
 - Proprioception training progressions with variable surfaces and perturbations

Criteria for Phase 4 & Running Initiation at week 8⁸:

1. Full AROM and joint girth at 100% LSI^{2, 3}
2. WB symmetry with squat form to 60°²
3. Stork test² at 75% LSI (Appendix B)
4. Isometric leg press at 60° of knee flexion LSI ≥ 75%^{2, 3} (Appendix C)
5. Isometric quad and HS LSI ≥ 75% at 60° of flexion^{2, 3} (Appendix D-E)
6. Anterior Reach ≤ 4cm difference Vs uninvolved LE^{2, 3} (Appendix F)
7. Single leg hop test LSI ≥ 70%¹⁷ (Appendix G)

Phase 4: Single Leg Strength & Plyometrics (wks 12+)

Goals:

- Increasing strength to support desired activity
- Optimize biomechanics at the hip, knee and ankle
- Address remaining barriers to RTS via KOOS-pain/KOOS-sport²²
- Establish patient specific HEP relative to resources and goals.
- Post activity soreness resolves within 24 hours¹²

Precautions:

- Ensure proper limb biomechanics with activity progressions to optimize force distribution across tibiofemoral joint

Phase 4 Therapeutic Activities:

- Begin sport specific drills/patterns at 50% effort¹⁵
- Single leg plyometric progressions without valgus¹⁵
- Ladder drills and progressive agility at 50-75% effort as tolerated¹⁵
- High level balance training
- Slow progressions of cutting/pivot & decelerating intensity as tolerated
- Continue total lower extremity strengthening based on remaining deficits

Criteria for Progression to Return to Activity Testing:

- No complaints with functional or exercise tasks
- Reports confidence with all running and jumping tasks
- Return to activity timelines vary by repair type and are based on achieving clinical criteria with return to activity testing:
 - Typical return ≈ 12-16 weeks^{3, 6}

Progression Note:

- Clinical outcomes were not affected by age, chronicity of injury, sex or concurrent ACL¹⁰
- If comorbidities create unattainable goals for discharge, discuss this with the treating physician group.



Criteria for Return to Recreational Activity:

General Ortho Patient:

- Patient meets all return to running criteria in phase 3.
- Max single leg press LSI $\geq 90\%$ ^{6, 10, 11, 19}

Recreational Athlete Sequence (includes above):

- Max Isometric Quad and HS LSI $\geq 90\%$ ¹⁸ OKC at 60° of knee flexion.
- Single leg hop test and Crossover hop test²¹ for distance: LSI $\geq 90\%$ ¹⁸

Competitive Athlete (includes above):

- Max single leg press LSI $\geq 95\%$ ¹⁸
- Max Isometric Quad and HS LSI $\geq 95\%$ ¹⁸ OKC at 60° of knee flexion
- Single Leg hop test for distance: LSI $\geq 95\%$ ¹⁸
- Side Hop test: LSI $\geq 90\%$ ¹⁹ (Appendix H)
- Crossover hop test for distance $\geq 95\%$ LSI^{18, 21} (Appendix I)

Abbreviation List:

AAROM: Active assisted range of motion	MD: Medical doctor
ABD: Abduction	NWB: Non weight bearing
AD: Assistive device	OKC: Open kinetic chain
ADL: Activity of daily Living	PA: Physician assistant
AROM: Active range of motion	PCL: Posterior cruciate ligament
BPTB: Bone patellar tendon bone	PE: Pulmonary embolism
BW: Body Weight	PLC: Posterior lateral corner
CKC: Closed kinetic chain	PROM: Passive range of motion
DVT: Deep vein thrombosis	ROM: Range of motion
ER: External rotation	RP: Resting position
EXT: Extension	RROM: Resisted range of motion
FWB: Full weight bearing	RTS: Return to sport/activity
GHJ: Gleno-humeral joint	SLR: Straight leg raise
HEP: Home exercise program	UE: Upper extremity
HS: Hamstring	TKE: Terminal knee extension
IR: Internal rotation	WB: Weight bearing
LCL: Lateral collateral ligament	WBAT: Weight bearing as tolerated
LE: Lower extremity	#: Pounds
MA: Medical assistant	≠: Absent/Without
LSI: Limb Symmetry Index = (Average score of the involved leg divided by the score of the uninvolved leg for a specific test)	≈: Approximately
	≤: Less than or equal to
	≥: Greater than or equal to

Return to Activity Test Descriptions:

Stork Balance Test²⁰: (Appendix B for diagram)

- Hands on hips. NWB foot: medial distal femur or medial proximal tibia.
- Timer starts when the patient lifts heel of the stance foot off the ground.
- Timer stops if/when the patient removes hands from hips, NWB foot from medial stance leg or the heel comes in contact with the ground.

Anterior Reach Test^{2,3}: (Appendix F for diagram)

- Stand on one leg and slide a tissue box forward with the toes of the other foot by pushing on the side of the box. Goal is to push the box as far as possible and return back to the starting upright position.
- Once contact is lost between the toes and the box the slide is over.
- Perform 6 warm up attempts per leg to diminish learning effect.
- Failed attempt = the sliding foot touches down on the floor or on top of the slide box before returning back to the starting position. Cannot kick or flick box forwards.
- Distance is measured from toe of standing foot to back edge of the box. Take the best of 3 attempts for each leg.

Single Leg Hop Test for Distance¹⁸: (See Appendix G for diagram)

- Measure patient's standing height in cm for pass/fail.
- Hands on hips to prevent arm swing momentum.
 - Arms can release for landing assistance after leaving the ground.
- 4 progressive warm up jumps $\approx 25\%$, 50%, 75% and 100% intensity.
- Patient must "stick" the landing \neq significant knee valgus.
- Use the best of 3 maximum effort jump tests.
- Distance is measured from toe of start line to shortest distanced heel.

Single Leg Timed Side Hop Test¹⁹: (See Appendix H for diagram)

- Set up: 2 parallel lines on floor, with outer edges of lines 40cm apart.
- Start position: standing on single test leg with hands on hips.
- Action: Patient hops from outside of one line to outside of the other.
- Record the total number of completed foot strikes in 30 seconds.
 - Completed foot strikes = foot lands completely outside the line, without touching the line, while maintaining hand position.

Crossover Hop Test²¹: (See Appendix I for diagram)

- Patient starts on one leg with center line just lateral to stance leg.
- Patient is instructed to maximally hop forwards 3 times on the same stance leg, alternately crossing a $\approx 15\text{cm}$ wide line.
- Distance is measured from toe of start line to heel of 3rd landed hop.



Appendix A:
KOOS-pain/KOOS-sport

Scoring KOOS Tests:
Items are scored on a 0-4 scale. Compare scores from the time of surgery to the time of return to activity to determine if Minimal Clinically Important Difference (MCID) that shows significant positive trend of RTS has been met.

Scoring KOOS-Pain:
The MCID is 9.7 points improvement for KOOS-pain²²

Scoring KOOS-Sport:
The MCID is 14.7 points improvement for KOOS-sport²²

KOOS-Pain & KOOS-Sport Knee Surveys

Today's date: ____/____/____ Date of birth: ____/____/____

Name: _____

INSTRUCTIONS: This survey asks for your view about your knee. Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

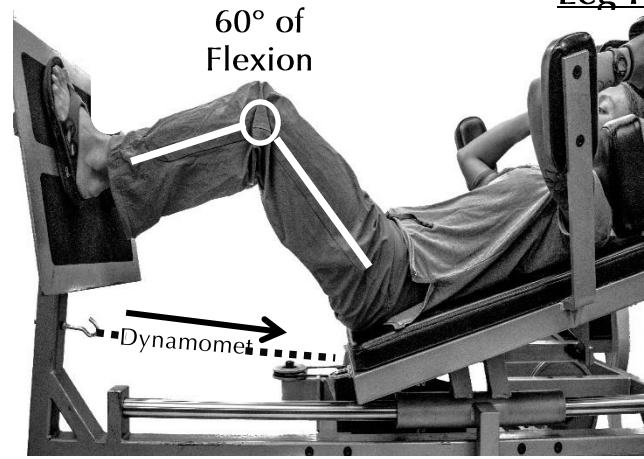
PAIN:					
	Never	Monthly	Weekly	Daily	Always
1. How often do you experience pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What amount of knee pain have you experienced the <u>last week</u> during the following activities?					
	None	Mild	Moderate	Severe	Extreme
2. Twisting/pivoting on your knee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Straightening knee fully.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Bending knee fully.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Walking on flat surface.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Going up or down stairs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. At night while in bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sitting or lying.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Standing upright.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Total Score 1-9:

SPORT:					
The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the last week due to your knee.					
	None	Mild	Moderate	Severe	Extreme
1. Squatting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Running.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Jumping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Twisting/Pivoting on your knee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Kneeling.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Total Score 1-5:

Appendix B: The Stork Test

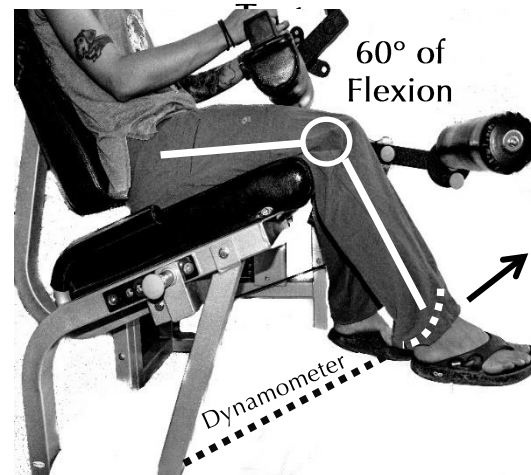


Appendix C: Isometric Single Leg Leg Press



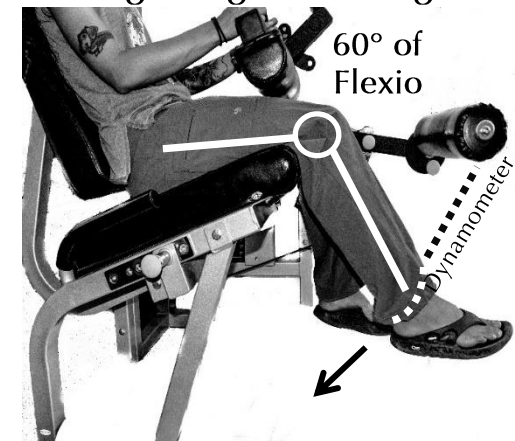
- Adjust foot and leg press position so that the knee is in 60 degrees of knee flexion when there is no slack in the dynamometer attachment.
- Perform maximal effort isometric tests per leg.
- $\text{Involved} \div \text{uninvolved} \times 100 = \text{LSI}$

Appendix D: Isometric Single Leg Quadriceps

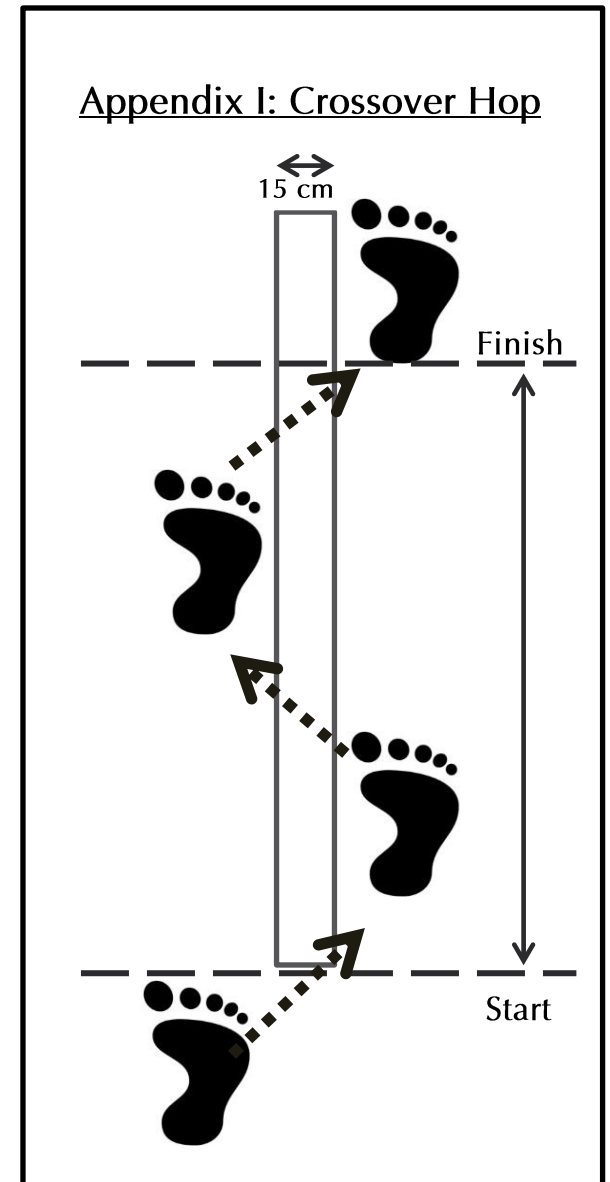
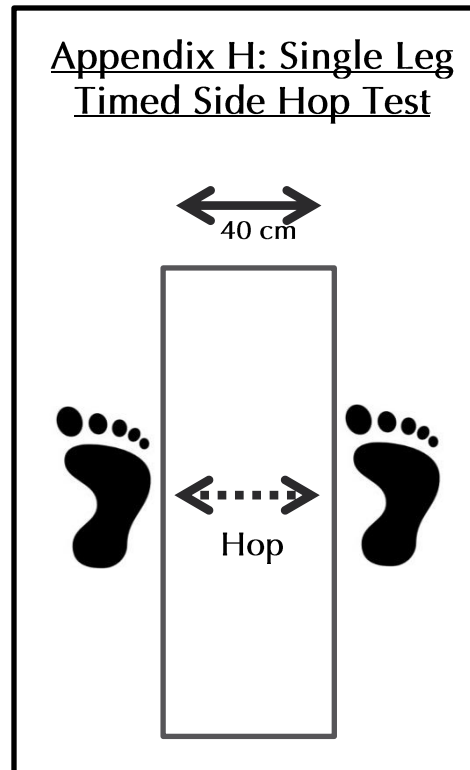
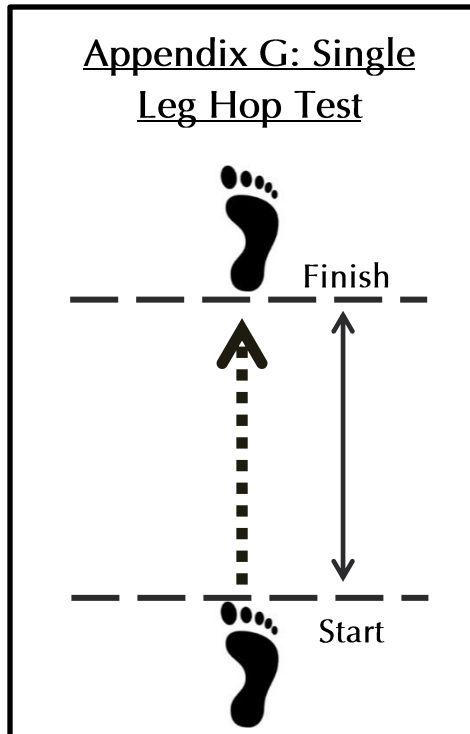
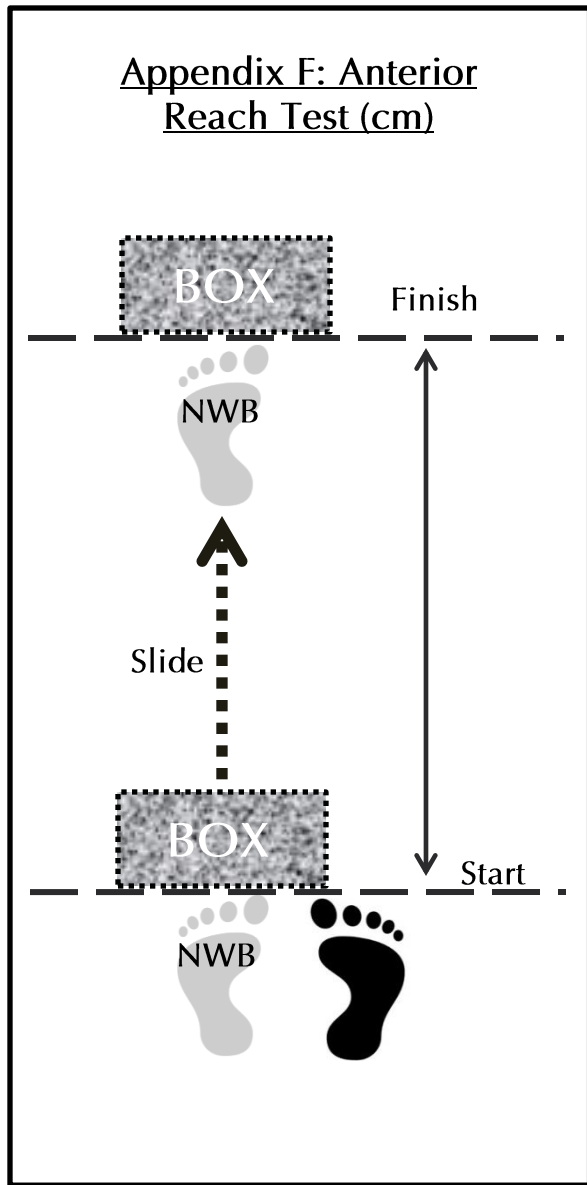


- Adjust seat position and dynamometer length so that there is no slack in the dynamometer attachment when the knee is in 60° knee flexion.
- Perform max effort isometric tests per leg.
- $\text{Involved} \div \text{uninvolved} \times 100 = \text{LSI}$

Appendix E: Isometric Single Leg Hamstring



- Adjust seat position and dynamometer length so that there is no slack in the dynamometer attachment when the knee is in 60° knee flexion.
- Perform maximal effort isometric tests per leg.
- $\text{Involved} \div \text{uninvolved} \times 100 = \text{LSI}$



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 VALLEY VIEW