



## Indiana University Health

*IU Health Physicians Orthopedics & Sports Medicine*

### **KNEE ARTHROSCOPY: MENISCECTOMY / LYSIS OF ADHESIONS / CHONDROPLASTY / FAT PAD RESECTION / PLICA RESECTION**

#### **PHYSICAL THERAPY PROTOCOL**

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**Patient Name:** \_\_\_\_\_ **Date of Surgery:** \_\_\_\_\_

**Procedure(s):**

**Right/Left Knee Arthroscopy  
Partial Meniscectomy/Debridement  
Fat Pad/Plica Debridement**

**Accessory Procedure (circled if applicable):**

**Lysis of Adhesions (LOA) with Manipulation Under Anesthesia (MUA)**



\_\_ **Evaluate and Treat – no open chain or isokinetic exercises**

\_\_ **Provide patient with home exercise program**

**Frequency:** \_\_\_\_\_x/week    x    \_\_\_\_\_weeks

\_\_ **Phase I (Weeks 1-2)\*\*\*: *Initial recovery.***

◆ **Weight bearing as tolerated without assist by 48 hours post-op.**

◆ **ROM:** Progress through passive, active and active-assisted ROM as tolerated

- Goal: Full extension by 2 weeks, 130 degrees of flexion by 6 weeks

◆ **Patellar mobilization daily**

◆ **Strengthening:** quad sets, SLRs, heel slides, etc.. No restrictions to ankle/hip strengthening.

*\*\*\*If a lysis of adhesions (LOA) and manipulation under anesthesia (MUA) was performed at the same time, patient needs to wear a knee immobilizer (or hinged knee brace, locked in extension) at all times except during PT and for hygiene. CPM is usually ordered for 2-4 hrs per day x 6wks.*

\_\_ **Phase II (Weeks 2-6 )\*\*\*: *Advance ROM and strengthening.***

◆ **ROM:** Continue with daily ROM exercises

- Goal: Increase ROM as tolerated; aggressive end-range stretching as tolerated

◆ **Strengthening:** Begin and advance closed chain strengthening to full motion arc.

- Add pulley weights, theraband, and other modalities as per PT discretion.
- Advance to wall sits, lunges, balance ball, leg curls, leg press, plyometrics as tolerated.
- Continue stationary bike and biking outdoors for ROM, strengthening, and cardio. Progress to sport-specific activities as tolerated.



- Monitor for anterior knee symptoms, modulating exercises as necessary.

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\_\_\_ **Other:**

\_\_\_ Modalities

\_\_\_ Electrical Stimulation

\_\_\_ Ultrasound

\_\_\_ Heat before/after

\_\_\_ Ice before/after exercise

\_\_\_ May participate in aquatherapy after week three, begin aqua-running week 6

**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.**

\_\_\_\_\_

**Date:** \_\_\_\_\_

**Bryan M. Saltzman, MD**