



## Indiana University Health

### IU Health Physicians Orthopedics & Sports Medicine

## **MENISCAL BODY REPAIR (ALL-INSIDE)**

### **PHYSICAL THERAPY PROTOCOL**

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

\_\_\_\_ **Evaluate and Treat** \_\_\_\_\_ **Provide patient with home program**

**Frequency:** \_\_\_\_\_ x/week x \_\_\_\_\_ weeks

	<b>WEIGHT BEARING</b>	<b>BRACE</b>	<b>ROM</b>	<b>EXERCISES</b>
<b>PHASE</b>	TTWB in Brace	Locked in full	0-90° when non-	Heel slides, quad sets, patellar



<b>I</b> 0-2 weeks	locked in extension with crutches***	extension for sleeping and all activity*  Off for exercises and hygiene	ambulatory (active/passive)	mobs, SLR, SAQ**  <b>No weight bearing with flexion &gt;90°</b>
<b>PHASE II</b> 2-6 weeks	<b>2-4 weeks:</b> TTWB in Brace unlocked 0-90°  <b>4-6 weeks:</b> Full w/ brace as above, transition to w/o brace	<b>2-4 weeks:</b> Unlocked 0-90°  Off at night  <b>4-6 weeks:</b> Full  Discontinue brace (when quad strength adequate)  Discontinue crutches when gait normalized	As tolerated within confines	Addition of heel raises, total gym (closed chain), wall sits to 90 degrees, terminal knee extensions**  Activities w/ brace until 6 weeks; then w/o brace as tolerated  <b>No weight bearing with flexion &gt;90°</b>
<b>PHASE III</b> 6-12 weeks	Full WBAT without brace	None	Full	Progress closed chain activities  Begin hamstring work, lunges/leg press 0-90°, proprioception exercises, balance/core/hip/glutes  Begin stationary bike when able
<b>PHASE IV</b> 12-20 weeks	Full	None	Full	Progress Phase III exercises and functional activities: single leg balance, core, glutes, eccentric hamstrings, elliptical, and bike  Swimming okay at 12 wks  Advance to sport-specific drills and running/jumping after 16 wks once cleared by MD

\*Brace may be removed for sleeping after week 4 postoperative

\*\*Avoid any tibial rotation for 8 weeks to protect meniscus

\*\*\*Weight bearing status may vary depending on nature of meniscus repair. Please refer to specific PT Rx provided to patient for confirmation of WB status



**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**