



OSTEOCHONDRAL ALLOGRAFT TRANSPLANTATION (OAT) WITH HIGH TIBIAL OSTEOTOMY (HTO)

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

	WEIGHT BEARING	BRACE	ROM	EXERCISES
PHASE I 0-2 weeks	Heel-touch only	Locked in full extension at all times* Off for hygiene and home exercise only	Gentle passive 0-90° CPM 6 hrs/day; begin 0-40° and advance 5-10° daily as tolerated	Heel slides, quad sets, patellar mobs, SLR, calf pumps at home
PHASE II 2-8	2-6 weeks: Heel- touch only	2-6 weeks: Locked 0-90° Discontinue	Advance as tolerated CPM continues 6	2-6 weeks: Add side-lying hip and core, advance quad set and stretching**



weeks	6-8 weeks: Advance 25% weekly until full	brace at 6 weeks	hrs/ day 0-90°	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	Full	None	Full	Progress closed chain activities Advance hamstring work, lunges/leg press 0-90° only, proprioception/balance exercises Begin stationary bike
PHASE IV 12-24 weeks	Full	None	Full	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	Full	None	Full	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.

Date: _____

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