

Patient: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

**Procedure: Right/Left Distal Triceps Tendon Repair**

**Week 1:** No formal PT. Splint and sling for 1 week to be removed either in PT or with MD guidance.

**Phase I (1-6 wks): Begin formal PT**

**Weight bearing:** <2 lb weight limit, ok for ADL use below this limit.

**Brace:** Hinged elbow brace unlocked to 50° or limit of comfort in flexion.

**Ice:** Not directly on skin, recommend as much as possible. 5x/day, 20 min/session for first 2 weeks. Then after activity at minimum.

**ROM:** Flexion - AROM and gentle PROM to a tension free endpoint. Increase about 10° per visit or to position of maximal comfort. Extension – PROM only. PROM supination/pronation at 90° of flexion. Continue shoulder and wrist ROM.

**Exercises:** Cuff/Periscapular/forearm isometrics in brace within above limits.

**Phase II (6-10 wks): Advanced motion and early strengthening**

**Weight bearing:** <5 lb weight limit, avoid resisted elbow flexion.

**Brace:** Discontinue

**ROM:** Advance active and passive elbow flexion to full (if not already achieved). Gentle passive stretching at end-ranges as tolerated. Begin gentle active elbow extension (gravity only). Continue forearm supination/pronation, shoulder and wrist ROM. Goal: full, tension-free elbow and forearm motion by 9 weeks.

**Exercises:** Avoid resisted elbow extension until 10 weeks. Progress cuff/periscapular and forearm isometrics. Modalities at PT discretion.

**Phase III (10 wks to 6 mo): Progress to sport/occupation specific activities**

**Weight bearing:** Full, recommend avoidance of heavy impact activities till after 3.5 months if possible.

**Brace:** None

**ROM:** Unrestricted active and passive stretching to end ranges of motion.

**Exercises:** Continue bands progressing to light weights (1-5 lbs). Begin resisted elbow extension and transition to closed chain upper extremity exercises. Progress to sport/occupation specific tasks.

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

**By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary.**

\_\_\_\_\_

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

**Dax Varkey MD, MPH**