This rehabilitation program is designed to return the individual to their full activities as quickly and safely as possible, following a total ankle replacement. Modifications to this guideline may be necessary dependent on physician specific instruction or other procedures performed. This evidence-based total ankle replacement guideline is criterion-based; time frames and visits in each phase will vary depending on many factors. The therapist may modify the program appropriately depending on the individual’s goals for activity following a total ankle replacement.

This guideline is intended to provide the treating clinician a frame of reference for rehabilitation. It is not intended to substitute clinical judgment regarding the patient’s post-operative care based on exam/treatment findings, individual progress, and/or the presence of concomitant procedures or post-operative complications. If the clinician should have questions regarding post-operative progression, they should contact the referring physician.

|  |  |  |
| --- | --- | --- |
| **Phase** | **Suggested Interventions** | **Goals/Milestones for Progression** |
| **Phase I**  *Date of Surgery –*  *2 – 3 Weeks* | *Immobilization:*  Cast, splint; after two-week follow-up visit, removable boot  *WB Status:*   |  | | --- | | Non-weight bearing | | *Goals of Phase:*   1. Skin healing 2. Protection of joint replacement   *Criteria to Advance to Next Phase:*   1. Sutures are removed |
| **Phase II**  *Weeks 2 – 6* | *Immobilization:*  Use of removable walker boot at all times  *WB Status:*  Weight bearing in boot as tolerated  *Therapy:*   * Beginning with gentle passive range of motion for two-weeks * Progress to active ROM: one to two times per week with focus on swelling reduction and pain control * Home care exercise instructions for motion, pain and swelling control   *ROM:*  AAROM, PROM, patient stretching and joint mobilization\*. Techniques for inversion and eversion should be minimized and may be contraindicated if the patient has had ancillary procedures such as subtalar fusion or triple arthrodesis. The distal tibiofibular syndesmosis should not be mobilized. Soft tissue techniques may be used for swelling reduction and scar tissue mobilization.  *\**Joint mobilization should focus on techniques for general talocrural distraction and facilitation dorsiflexion and plantarflexion. | *Goals of Phase:*   1. Healing 2. Protection of joint replacement   *Criteria to Advance to Next Phase:*   1. Healing appropriate for stage to move on. |
| **Phase III**  *Weeks 6 – 12*  *Rehab Program*  *Weeks 6 - 12* | *Immobilization:*  Begin transition into a regular shoe. Use of removable walker for first two-weeks.  *WB Status:*  WBAT\*  \*WB status and gait progression determined by physician and based on radiographic evidence of implant incorporation.  *Therapy:*  One to two times per week based on patient’s initial presentation. Frequency may be reduced as the patient exhibits good recovery and progress towards goals, instruction in home care and exercise to complement clinical care.  *ROM:*  APROM, PROM, patient directed stretching and joint mobilization\*. Techniques for inversion and eversion should be minimized and may be contraindicated if the patient has had ancillary procedures such as subtalar fusion or triple arthrodesis. The distal tibiofibular syndesmosis should not be mobilized.  *\**Joint mobilization should focus on techniques for general talocrural distraction and facilitating dorsiflexion and plantarflexion.  Goals: less than or equal to 10° of dorsiflexion and 30° to 40° of plantarflexion.  *Strength:*  Techniques should begin with isometrics in four directions with progression to resistive band/isotonic strengthening for dorsiflexion and plantarflexion. Due to joint fusions, eversion and inversion strengthening should continue isometrically. Band should progress to heavy resistance as tolerated. Swimming and biking allowed as tolerated.  *Proprioception:*  May begin with seated BAPS board and progress to standing balance assisted exercises as tolerated. | *Goals of Phase:*   1. Swelling reduction 2. Increase in ROM 3. Neuromuscular re-education 4. Develop baseline of ankle control and strength   *Criteria to Advance to Next Phase:*   1. Normal Gait pattern 2. Pain control 3. Edema managed |
| **Phase IV**  *Weeks 12 – 20* | *WB Status:*  Full; patient should exhibit normalized gait  *Therapy:*  One time every two to four weeks based on patient status and progression. To be discharged to an independent exercise.  *ROM:*  Patient to achieve less than or equal to 10° of dorsiflexion and 30° to 40° of plantarflexion.  *Strength:*  Progression to body weight resistance exercises with goal of ability to perform a single leg heel raise.  *Proprioception:*  Patient should be instructed in proprioceptive drills that provide both visual and surface challenges to balance.  *Agility:*  Cone/stick drills, leg press plyometrics and soft-landing drills | Goals of Phase:   1. Functional ROM 2. Good strength 3. Adequate proprioception for stable balance 4. Normalize gait 5. Tolerate full-day of ADLs/work 6. Return to reasonable recreational activities   *Criteria to Advance to Next Phase:*   1. Discharge to independent exercise program once goals are achieved 2. Patient to be instructed in appropriate home exercise program |