TWIN CITIES ORTHOPEDICS

Patellar/Trochlear Microfracture with Anteromedialization Osteotomy (AMZ)

David E. Hartigan, M.D.

Patient Name	Date of Surgery

Procedure: ☐ Right ☐ Left Knee ☐ Patellar ☐ Trochlear Microfracture with AMZ
Procedure: *(check if applicable)* ☐ ACI biopsy ☐ Lateral Release

☐ **Evaluate and Treat – no open chain or isokinetic exercises**
☐ **Provide patient with home exercise program**

☐ **Phase I (0-6 wks):** *Period of protection.*

- **Toe-Touch Weight bearing (20%) with brace and crutches.** Hinged knee brace should be worn at all times except for PT and hygiene. During ambulation, brace should be locked in extension for weeks 0-2, locked to 0-40 degrees for weeks 2-6.
- **ROM:**
  - CPM 4-6 hrs/day to 40-60 degrees as advised
  - Gentle passive ROM 0-40
  - Let knee hang to 90 degrees 3x/day for a few minutes to prevent stiffness.
- **Strengthening:** quad sets, co-contractions, isometric quad/hamstring strengthening in extension.

☐ **Phase II (6-12 wks):** *Transition phase.*

- **Transition to full weight bearing, weaning from hinged knee brace once quad control (no limp and no extension lag on SLR).** Full weight-bearing and D/C brace by week 8.
- **ROM:** D/C CPM and progress to full active and passive ROM; goal: full ROM by 8-10 weeks. Aggressive stretching at end-ranges if FROM not achieved by 10 weeks.
- **Strengthening:** Continue prior exercises, adding in SLRs. Can begin partial wall sits and then advance to other closed-chain strengthening (with knee bent no more than 40 degrees) once full weight-bearing.

☐ **Phase III (3-6 months):** *Begin more sport-focused conditioning.*

- **ROM:** Continue active and active-assisted ROM.
- **Strengthening:** Progress closed-chain patellofemoral strengthening without limits. Begin treadmill walking at a slow pace and progress to balance/proprioception.
- Light plyometrics and jogging can be initiated at 4.5 months.
- From 4.5 – 6 months, begin and advance sport-specific activities (running, agility training).
- High-impact activities (jumping, contact sports) allowed after 6 months.

☐ **Other:**

☐ Modalities
☐ Heat before/after
☐ Electrical Stimulation
☐ May participate in aquatherapy after week three, begin aqua-running week 6
☐ Ultrasound
☐ Ice before/after exercise

Frequency:_____x/week x _____weeks

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.

Physician Signature	Date
Printed Name	