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1.0 Policy Statement

1.1 It is the policy of Cappagh National Orthopaedic Hospital to provide a patient focused physiotherapy service delivered by chartered physiotherapists and support staff working in a well-equipped environment.

1.2 It is the policy of Cappagh National Orthopaedic Hospital to provide health professionals and the public with the necessary advice and guidance on physiotherapy rehabilitation.

2.0 Purpose

2.1 The purpose of this guideline is to advise health professionals and patients on the physiotherapy rehabilitation of a person undergoing an Achilles Tendon Repair.

3.0 Scope

3.1 This guideline applies to all staff involved in the care of a person undergoing an Achilles Tendon Repair, community staff involved in the pre and post-operative care of the patient, the patient and their family.

4.0 Health & Safety

4.1 There are health and safety risks involved in patient care, namely risk of physical injury to patient and staff, risk of infection.

4.2 Physiotherapists have the necessary qualifications and clinical experience to carry out this guideline and to supervise unqualified support staff.

4.3 They must be eligible for membership of their professional body, the Irish Society of Chartered Physiotherapists (ISCP).

4.4 They undertake mandatory manual handling, basic life support training, fire safety, infection prevention and control and risk management.

4.5 They complete a minimum of 100 hours continuing professional development every three years as required by the ISCP.

5.0 Responsibilities

5.1 It is the responsibility of physiotherapists to implement this guideline.

6.0 Definitions and Abbreviations

The Achilles tendon attaches the calf muscles to the calcaneus (heel bone) at the back of the ankle.

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7.0 Guideline

7.1 Pre-Operative

7.1.1 Patients should be evaluated prior to surgery, including:

7.1.1.1 Assessment of joint range of motion, muscle strength, mobility and general function.

7.1.1.2 Respiratory assessment and treatment if necessary.

7.1.1.3 Explanation of post-operative physiotherapy management, including respiratory and circulatory exercises.

7.1.1.4 Teaching independent bed mobility and transfers.

7.1.1.5 Teach mobility non weight bearing with crutches

7.2 Post-Operative

The most common method of post-operative management has traditionally been to immobilise the Achilles tendon in a plaster cast (occasionally full leg) or other type of restrictive device until the healing is considered complete and then begin range of movement and strengthening exercises. The following guidelines are for traditional rehabilitation of Achilles tendon repair.

7.2.1 Day 1

7.2.1.1 Patient cast in gravity equinus position.

7.2.1.2 Mobilise non weight bearing with crutches

7.2.1.3 Stairs practice.

7.2.1.4 Hip and knee exercises on the operated side to maintain strength.

7.2.1.5 Educate patient regarding elevation of affected limb to minimize swelling.

7.2.2 Week 2 - 6

7.2.2.1 Patient mobilises non weight bearing or partial weight bearing for 2-6 weeks, depending on Consultant.

7.2.2.2 New cast applied in more dorsiflexion with slightly more tension at weeks 2 and 4.
7.2.3 Week 6-8
7.2.3.1 Review, removal of cast.

7.2.3.2 Mobilise partial weight bearing with crutches with heel raise ½ to 1 inch to decrease stress on the tendon and ground reaction forces while ambulating.

7.2.3.3 Range of movement exercises for ankle and subtalar joints in all directions.

7.2.3.4 Gentle dorsiflexion stretches with knee flexed and extended.

7.2.3.5 Appropriate hip and knee exercises e.g. gluteus medius.

7.2.3.6 Ice and elevation as needed.

7.2.3.7 May use ultrasound, hydrotherapy and/or whirlpool.

7.2.3.8 Advice re contrast baths, home massage, home exercise programme.

7.2.4 Week 8-12
7.2.4.1 Progress to partial weight bearing with appropriate assistive device to full weight bearing independently when no pain or limp, emphasising push off.

7.2.4.2 Gastrocnemius stretches in standing.

7.2.4.3 Progress range of movement.

7.2.4.4 Isometrics of ankle all directions.

7.2.4.5 Scar massage, local electrotherapy.

7.2.4.6 Control oedema.

7.2.4.7 Resisted exercises using theraband (progressing as appropriate) all directions.

7.2.4.8 Attempt double leg eccentric heel drops, emphasising slow lowering of heels.

7.2.4.9 Step ups/downs.

7.2.4.10 Mini squats.
7.2.4.11 Proprioceptive exercises, wobble board (initiated concurrent with strengthening).

7.2.4.12 Static bicycle.

7.2.4.13 May start swimming, water walking (no running in shallow water yet).

7.2.5 Week 12-20

7.2.5.1 Should be full weight bearing, independent, no pain and no limp.

7.2.5.2 Bilateral heel raises (previously unilateral heel raise) with equal weight bearing.

7.2.5.3 Heel raising exercises should initially be performed on a level, flat surface after which the patient can progress to doing them over the edge of a stair to use the full range of movement available.

7.2.5.4 Unilateral heel raises in standing.

7.2.5.5 Advance proprioceptive exercises.

7.2.5.6 Aim for full range of movement.

7.2.5.7 Increase distance and speed of gait—may use treadmill and start gentle incline.

7.2.5.8 Progress gradually onto single-leg, eccentric heel drops over the edge of a stair if pain free.

7.2.5.9 Gentle hop with ball throwing at 16 weeks if able.

7.2.6 Week 17-20

7.2.6.1 Can begin running progression, sport specific skill development and functional activities once the patient has normal gait and full range of movement and can rapidly perform heel raises.

7.2.6.2 Plyometric exercises.

7.2.6.3 No sprinting until 20 weeks post operatively.
7.3 In sporting individuals aim for
   7.3.1 Return to sport at 6-7 months post operatively following review by Consultant.

7.4 In sedentary individuals aim for:
   7.4.1 Full weight bearing
   7.4.2 Return to previous level of function/working
   7.4.3 Double leg calf raises with minimal help for unaffected side

8.0 Related Documents
   Individual Physio tools exercise sheets

9.0 Appendices
   N/A

10.0 References
    N/A