



DR. BRIAN KLIKA & DR. ANDREW KIRKPATRICK
FLEXOR POLLICUS LONGUS (FPL) REPAIR POST-OP THERAPY PROTOCOL

Phase 1 – Maximum Protection (3-14 days)

Goals for Phase 1	Precautions for Phase 1
• Immobilize and protect repair • Initiate ROM while protecting repair • Minimize risk of scar adhesions • Pain and edema control	• Dressings to be removed for ROM exercises to ensure tight composite passive flexion to maximize tendon excursion

Splint

- Dorsal thumb blocking splint is fitted for continual wear in the following position:
 - Wrist neutral, thumb MP: 15° flexion, thumb IP: 30° flexion, thumb CMC joint: palmar abduction, digits free

PROM

- The following PROM exercises to be performed every two hours within the constraints of the splint, 25 repetitions each:
 - Passive thumb MP flexion, active extension to splint
 - Passive thumb IP flexion, active extension to splint
 - Passive composite thumb flexion, active extension to splint
 - Passive wrist flexion (the wrist is passively flexed forward out of the splint), active wrist extension to splint

Edema Management

- Light compression with Coban or compression sleeves to thumb, hand, and forearm as needed
- Elevation
- Manual Edema Mobilization (MEM)

Wound Care

- Educate patient in dressing changes



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Phase 2 – Protect Repair with Controlled ROM (2-6 weeks)

Goals for Phase 2	Precautions for Phase 2
• Continue to protect healing repair while achieving adequate tendon excursion to prevent scar adhesions • Continue scar and edema control • Progress to full controlled active and passive ROM	• In phase 2, thumb AROM exercises are initiated with the exception of thumb IP blocking exercises which should not be initiated until week 6

Splint

- Continue dorsal blocking splint between exercise sessions and at night

ROM

- Continue phase 1 exercises
- **2 weeks:** if passive motion is good and edema is well controlled, add place and hold composite thumb flexion for gentle tension
- **4 weeks:** begin AROM exercises within the constraints of the splint
 - Thumb MP flexion/extension
 - Composite MP and IP flexion/extension
 - Thumb opposition
 - CMC palmar abduction/adduction
 - Wrist flexion/extension
- **4½ weeks:** dorsal blocking splint may be removed for active thumb ROM exercises allowing full composite wrist and thumb flexion/extension

Scar Management

- Two days after suture removal, initiate scar mobilization
- Apply scar remodeling products as needed

Edema Management

- Continue phase 1 edema management



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Phase 3 – Maximum Range of Motion and Progress to Strengthening (6-12 weeks)

Goals for Phase 3	Precautions for Phase 3
• Restore full range of motion • Progress to strengthening, and return to ADL and work activities	• Educate patient that a tight sustained pinch with or without resistance greatly increases risk of tendon rupture. The patient should be using the hand for light activity only at home until 10 weeks.

Splint

- Discontinue dorsal blocking splint
- May fabricate thumb extension splint for night wear to increase thumb extension

ROM

- Begin unrestricted active and passive ROM of the thumb
- Initiate thumb IP joint blocking exercises

Modalities

- If needed, NMES may be added to enhance tendon excursion
- Apply ultrasound as needed for dense scar and/or limited tendon excursion

Strengthening

- **8-10 weeks:** begin strengthening
- **10-12 weeks:** with physician consent, a comprehensive work conditioning program for patients with high demand/heavy manual labor occupations may be appropriate

Functional Activity

- **8-10 weeks:** gradually return to functional use of the involved hand for higher level work and home management tasks
- **10-12 weeks:** patient may return to unrestricted use of the hand with physician permission