



# ORTHOPEDICS & SPORTS MEDICINE BAYCARE CLINIC®

## Dr. Brian Klika & Dr. Andrew Kirkpatrick TFCC Debridement

### Phase 1 – Initiate Motion (0-6 weeks)

#### Goals for Phase 1

- Immobilize and protect reconstruction
- Pain and edema control
- Educate patient in home program and importance of wearing splint at all times
- Educate patient to return to clinic for splint adjustments as needed to ensure comfort and compliance with splint use.

#### Other Considerations

- Patient will most often be referred to therapy for initial therapy visit after their 2-week follow-up with surgeon. Patient is usually only seen for one appointment during this initial immobilization phase. This appointment consists of splint fabrication and patient education in ROM of uninvolved joints, edema, and scar management. Patient begins therapy at 4 weeks.

#### Splint

- Muenster splint
  - Transition to wrist cock-up at 4 weeks post-op
- To be worn at all times except hygiene

#### ROM

- AROM to wrist in all planes of motion
- At 4 weeks post-op, initiate pain-free PROM to wrist and forearm to restore functional motion
- AROM to uninvolved joints (shoulder, elbow, digits)

#### Scar Management

- Begin scar massage no sooner than 2 days after suture removal after scar is fully closed with no scabbing present. Begin with light massage using lotion.
- Apply scar remodeling products as needed

#### Edema Management

- Light compression sleeves to digits, hand, and forearm
- Elevation
- Manual Edema Mobilization (MEM)

#### Functional Activity

- Splint on at all times
- Allow use of involved UE with non-resistive, light ADL/IADL only within limits of the splint.



## **Phase 2 – Maximize ROM, Strengthening (6+ weeks)**

### **Goals for Phase 2**

- Restore functional pain-free range of motion and strength
- Continue to control edema and minimize scar adhesions

### **Other Considerations**

- PROM to forearm should be performed by securing at the forearm and not distal to the wrist to avoid torsional load on the TFCC
- Although PROM is indicated for joint and soft tissue restrictions, avoid painful ROM and stretching beyond a functional range of motion. The end goal of surgery is to stabilize the wrist for pain-free function

### **Splint**

- Continue splint or Wrist Widget with heavy activities

### **ROM**

- Continue active ROM to wrist and forearm
- Continue with PROM of wrist in all planes of motion

### **Strengthening**

- Initiate hand, wrist, and forearm strengthening
- Initiate isotonic strengthening including weighted wrist and forearm exercises and gentle grip and pinch strengthening with putty
- Proprioceptive/stabilization - wrist alphabet with 1# hand weight, oscillation with flex bar, gyroball
- Scapula stabilization and proximal upper extremity strengthening

### **Manual Therapy**

- Continue scar and edema management
- Desensitization, as needed

### **Modalities**

- Fluidotherapy for heat, ROM, and desensitization, as needed
- Paraffin may be used for deep heat, as needed

### **Functional Activity**

- Continued use of involved upper extremity with ADL/IADL within physical activity restrictions

### **Work Conditioning**

- After 8-10 weeks and with MD consent a comprehensive work conditioning program for patients with high demand/heavy manual labor occupations may be appropriate

This protocol was reviewed and updated by Brian Klika, MD, Andrew Kirkpatrick, MD, and the ABMC Occupational Therapy Department on December 10<sup>th</sup>, 2025.

## **References**

1. Cannon, Nancy M. et. al. Diagnosis and Treatment Manual for Physicians and Therapists, 5<sup>th</sup> Ed. The Hand Rehabilitation Center of Indiana. Indianapolis, Indiana. 2021.