UL Health Sports Medicine
Official Health Care Provider of the Louisville Cardinals

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Procedure: PCL Reconstruction with Meniscus Repair

Description of Procedure: PCL reconstruction using an Achilles tendon allograft in addition to a meniscus repair using all-inside (AI) or inside-out (IO) techniques.

PT Frequency: 3-4x wkly 0-3 mo, physician/therapist discretion afterwards. Home exercises daily.

Important Note: Please *heavily* emphasize early ROM to avoid arthrofibrosis.

	Weight Bearing	**Brace**	**ROM**	**Therapeutic Exercises**
Phase I: 0-4 wks	Toe touch weight bearing (TTWB) with crutches with brace locked in extension.	PCL "Jack" Brace preferred. If unable to acquire, use regular hinged knee brace with a stack of towels behind tibia to provide anterior force to prevent posterior sag. Locked in full extension for sleeping and all WB. Unlock to 0-90° for NWB exercises. Off **only** for hygiene. Dressing: PT may perform dressing change as needed. Leave steri-strips in place. Ok to shower with or without dressing. No tub bathing/ soaking until wound fully healed.	0-90° passive when NWB and in prone position. Emphasize extension. Goal of full extension and 90° passive flexion by 2 weeks. **Healing is dependent on the vascularity of the tear site and stability of the repair construct. Meniscal motion is greatest past 60 degrees. Twisting should be avoided.	Quad sets, patellar mobilization, SLR with brace locked in extension, seated SAQ sets. **Avoid isolated hamstring exercises.** If concurrent MCL or PLC procedures, avoid varus/ valgus stresses.
Phase II: 4-12 wks	**4-6 wks:** Quickly progress to weight bearing as tolerated (WBAT). Dual crutch use→single crutch use in opposite	**4-6 wks:** PCL "Jack" Brace unlocked **6-12 wks:** discontinue	Progress to full. Goal of 120° flexion by 6 weeks. No weight bearing with flexion >90°.	Progress through passive, active, and resisted ROM. Extension board and prone hang with ankle weights (up to 10 lbs), posterior leg stretch (legs up against a wall), seated wall sits (back against wall, legs flat on ground). Stationary bike with no resistance for knee flexion (alter seat height as ROM

Continued on Back

	Weight Bearing	Brace	ROM	Therapeutic Exercises
	arm→no crutch use. **6 wk onward:** WBAT			increases). Encourage frequent ankle ROM. **Initiate BFR** when quadriceps activity returns. SAQ sets (seated first, progress to standing), SLRs with knee locked in extension. Standing glut sets. **Avoid hamstring resistance exercises.** Closed chain work (mini-squats/weight shifts, gentle leg press 0-90° arc) once full weight bearing. Wall sits. Progress proprioception training. Initiate Step-Up program. No restrictions to ankle/hip strengthening Modalities PRN
Phase III: 12 wks onward	WBAT	None	Full	**12-18 wks:** Progress exercises and functional activities (single leg balance, core, glutes. Advance strengthening as tolerated, continue closed chain exercises. Increase resistance on equipment. Begin forward treadmill running program when 8" step down is satisfactory (No sooner than 12, preferably 16 weeks). Begin plyometrics and increase as tolerated. **18-24 wks:** Initiate sport-specific agility drills and functional testing. Advance plyometric program starting at 22 weeks. Advance agility program at 22 weeks (Z cuts, backward

	Weight Bearing	Brace	ROM	Therapeutic Exercises
				to forward running, footwork drills, double leg power jumps, alternate single leg jump rope). FSA at 6-8 mo.

Typical follow up frequency is 2 wks with mid-level then with Dr. Richards at 4-6 wks, 3 mo, 6 mo, 8-9 mo for RTP discussion, 1 yr, 2 yr, and 5 yr. Long term follow up is kindly requested for data collection. Frequency is subject to change pending patient progress. Progression back to sport is dependent on case-by-case basis and determined by Dr. Richards. If significant pain or swelling occurs, patient is expected to stop causative activity and follow up with our office. On call providers are always available.