

Distal Triceps Repair Rehab Protocol

Rupture of the biceps tendon may be either an acute or chronic injury. Treatment may be either surgical or non-surgical, however, it is generally agreed, that young, active patients tend to have better outcomes with surgical repair. With conservative, or non-surgical, treatment, loss of flexion and supination strength has been reported to be 20-50% and 30-50% respectively.

Early repair within two to three weeks has been documented to have better outcomes, although later repair is possible. With an acute repair, the tendon typically has minimal scarring and can be easily reattached to its point of insertion on the bone either through drill holes, with suture anchors, or with a metal button. The surgeon may use a single incision in the crease of the elbow or two incisions, with an additional incision on the side of the forearm.

Patients are placed in a well padded splint for the first two weeks to allow incisions to heal and are then transitioned into a hinged elbow brace to gradually increase range of motion while allowing the tendon to heal. Therapy is often prescribed to assist with regaining range of motion and to help regain muscle strength.

Important post-operative signs to monitor include:

- Swelling of the elbow or upper arm and surrounding soft tissue
- Abnormal pain response, hypersensitive-an increase in night pain
- Severe range of motion limitations

Return to activity requires both time and clinical evaluation. To most safely and efficiently return to normal or high level functional activity, the patient requires adequate strength, flexibility, and endurance. Functional evaluation including strength and range of motion testing is one method of evaluating a patient's readiness to return to activity. Return to intense activities following an open distal biceps repair requires both a strenuous strengthening and range of motion program along with a period of time to allow for tissue healing. Symptoms such as pain, swelling and stiffness should be closely monitored by the patient.

	Range of Motion	Brace	Therapeutic Exercise
Phase I 0-2 Weeks	None	Splint in neutral	Gentle shoulder ROM
Phase II 2-4 Weeks	None except in therapy	Worn at all times (including therapy) Locked at 0-30 except in therapy	- PROM for extension and pronation (with elbow at 0-30) - Assisted ROM for flexion and supination (at 0-30)
Phase III 4-6 Weeks	Active flexion to 45 in brace	Worn at all times (including therapy) 0 to 45 flexion Remove for hygiene	- Begin AAROM for extension and progress to active - Continue AAROM for flexion and progress to passive flexion to 90
Phase III 6-8 Weeks	Active extension to 90 in brace	Worn at all times (including therapy) 0 to 90 flexion Remove for hygiene	- Active motion as tolerated - May begin combined motions (ie flexion with supination) - Sub max pain free triceps isometrics in neutral
Phase IV 8-10 Weeks	Gently advance to tolerance	None if adequate motor control	Progressive strengthening program—5 lbs x 3 sets of 10 every other day
Phase V 10-12 Weeks	Gently advance to tolerance	None	10 lbs x 3 sets of 10 every other day
Phase VI 12 wks - 5 months	Full and pain free	None	- May add five pounds a week if pain free - May begin light upper extremity weight training
Phase VII 5 months and beyond	Full and pain free	None	Return to full activity

