TFCC Central Tear-Debridement

This protocol is intended to provide the clinician with a guideline for the postoperative rehabilitation course of a patient who has undergone ***TFCC Repair***. General time frames are given for reference to the average, but individual patients will progress at different rates depending on their age, comorbidities, pre-surgical range of motion, strength, health/functional status, rehabilitation compliance, learning barriers and complications. Specific time frames, restrictions and precautions are given to protect healing tissues and surgical reconstruction.

The central TFCC is avascular, and therefore not reparable. This portion of the articular disc may be debrided through either open repair or arthroscopic. During surgery, special care is taken to maintain the volar and dorsal radioulnar ligaments.

If debridement is performed along with ulnar shortening osteotomy, HIT procedure, Sauve-Kapanji, or TFCC repair, defer to those more protective post-operative protocols.

Postoperative Guidelines

Surgical Indication

- Lesions to central TFCC
- Chronic ulnocarpal pain

Return to Work

The timeline for returning to work can vary depending on the type of work performed, various accommodations that may be available within your work environment, and any postoperative complications. Your surgeon will discuss the timeline for returning to work after consideration of these factors.

Overall goals of surgery: pain-free, functional wrist. Avoid aggressive stretching and strengthening; patient needs to stay within pain-free range of motion and exertion.

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Phase I (7-14 days after surgery)

Rehabilitation appointments	• Physician appointment at 10-14 days post op • One Rehabilitation appointment with an Occupational Therapist following the physician 10-14 days post op appointment • Once per week, 30-minute visits for up to 6 weeks
Rehabilitation goals and priorities	• Instruct on post-operative precautions • Protect in custom orthosis • Instruct on wound healing

Suggested therapeutic exercises	• Home exercise program: 25 slow repetitions, 3-4 times a day
	  ○ AROM to address any limitations in shoulder, elbow, fingers and/or thumb PRN as needed
	  ○ Mid-range AROM for wrist flexion/extension and forearm rotation
	• Edema management
	• Scar mobilization once incisions fully healed

Precautions	• No lifting/pushing/pulling
Orthoses	• Off-the-shelf OR Custom wrist-hand orthosis positioning wrist in slight extension • Orthosis is for comfort only • Orthosis off for hygiene, light daily activities and exercises

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Phase II (3-4 weeks post-operative)

Rehabilitation appointments	• Once a week
Rehabilitation goals and priorities	• Continue protection; progress pain-free ROM

Suggested therapeutic exercises	• Home exercise program: 25 slow repetitions, 3-4 times a day
	  ○ AA/PROM to address any limitations in shoulder, elbow, fingers and/or thumb as needed
	  ○ A/AAROM for wrist and forearm in all planes with gentle end-range stretch
	• Use of heat prior to exercises
	• Continue scar and edema management

Precautions	• No lifting/pushing/pulling
Orthosis	• At 4 weeks begin to wean from orthosis, off for an hour 3-4 times per day during light ADL

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Phase III (5-6 weeks post-operative)

Rehabilitation appointments	• Depending on pain and ROM, frequency varies from once per week to twice per month
Rehabilitation goals and priorities	• Light functional use of hand • Progress strength as tolerated
Suggested therapeutic exercises	5 weeks: • Progress to PROM for wrist flexion/extension, held at end range for 30 seconds • May begin weighted exercises if needed to increase wrist flexion/extension PROM • May initiate isometric strengthening for wrist and forearm in supination. This position promotes distal / dorsal translation of the radius, relatively "lengthening" the radius to minimize ulnocarpal abutment. • If grip is limited, may begin rubber band hand exerciser or putty strengthening in supination. • Continue scar management 6 weeks: • Initiate pain-free UE strengthening with hand-held weights. Consider wrist widget or Modabber to support as needed • Avoid torque at wrist (no forearm rotation with resistance)
Precautions	• No lifting/pushing/pulling until cleared by MD
Orthosis	• Orthosis off during the day for light ADL; on for heavy or painful tasks • May discontinue orthosis if pain-free

TFCC Debridement

References

1 Cannon, N. M. (2020). *Diagnosis and treatment manual for physicians & therapists: Upper extremity treatment guidelines*. Hand Rehabilitation Center of Indiana.

2 Kleinman, W. (2007) Stability of the distal radioulna joint: biomechanics, pathophysiology, physical diagnosis, and restoration of function. What we have learned in 25 years. *Journal of Hand Surgery, 32(7),* 1086-1106.

3 Demino, C., Morales-Restrepo, A., Fowler, J. (2019). Surgical management of triangular fibrocartilage complex lesions: a review of outcomes. *Journal of Hand Surgery,* Online 1(1), 32-38.

These rehabilitation guidelines were developed collaboratively between UW Health and UnityPoint Health - Meriter Rehabilitation and the UW Health Orthopedic Surgeons.