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REHABILITATION PROTOCOL

# Modified Broström / Lateral Ankle Ligament Reconstruction

Postoperative Rehabilitation Protocol

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> This protocol is a general guideline and does not replace individualized medical advice. Timelines vary with the procedure performed, healing, and individual factors. Always follow the specific instructions from your surgeon and physical therapist, which take precedence over this document.

Rehabilitation following lateral ankle ligament reconstruction varies depending on associated procedures, including peroneal tendon surgery, osteotomies, cartilage procedures, or use of augmentation (e.g., suture-tape/internal brace). This protocol outlines a general guideline. Progression may be modified based on intraoperative findings, individual healing response, and surgeon discretion. Please contact our office with any questions regarding your specific rehabilitation plan.

## Phase I: Protection & Healing

Weeks 0–2

### IMMOBILIZATION / WEIGHT BEARING

- Non-weight bearing
- Short leg splint at all times

### PRECAUTIONS

- No ankle inversion
- Protect surgical repair

### GOALS

- Minimize swelling
- Protect ligament reconstruction
- Promote wound and skin healing

### RECOMMENDED CARE

- Strict elevation (foot above heart level)
- Ice and swelling control modalities as tolerated
- Gentle toe motion

## Phase II: Early Motion & Progressive Weight Bearing

Weeks 2–6

### IMMOBILIZATION / WEIGHT BEARING

- Transition from splint to **CAM walking boot at 2 weeks**
- Begin **progressive weight bearing as tolerated** in the boot
- Boot worn for ambulation and sleeping unless otherwise instructed

### PRECAUTIONS

- **No inversion stretching**
- Avoid unstable surfaces (no wobble board or uneven terrain)

### GOALS

- Restore sagittal plane ankle motion
- Maintain stability of the repair
- Improve neuromuscular control

### PHYSICAL THERAPY FOCUS

- Edema and scar management
- Controlled ankle motion
- Gait training

### RANGE OF MOTION

- Plantarflexion and dorsiflexion only
- Target by end of phase:
  - ≥10° dorsiflexion

### EXERCISES

- Stationary cycling
- Active and active-assisted ankle dorsiflexion/plantarflexion

- ~30° plantarflexion

- Isometric peroneal activation
- Multi-angle isometrics within allowed ROM
- Seated rocker board (sagittal plane only)
- Rhythmic stabilization (DF/PF)
- Upper body strengthening as tolerated

## Phase III: Strengthening & Proprioception

**Weeks 6–12**

### BRACING

- Discontinue CAM boot
- Transition to ankle brace:
  - ASO ankle brace or
  - Tayco ankle brace, based on comfort and activity level

### PRECAUTIONS

- Gradual reintroduction of inversion after 6 weeks, under PT guidance

### GOALS

- Restore full ankle range of motion
- Improve strength, balance, and neuromuscular control
- Prepare for higher-level functional activity

### PHYSICAL THERAPY FOCUS

- Full active ankle ROM in all planes
- Progressive strengthening
- Balance and proprioceptive training

### EXERCISES

- Resistance band ankle strengthening
- Double- and single-limb calf raises
- Static and dynamic balance training
- BAPS board (levels 1–2)
- Step-ups and functional closed-chain exercises
- Treadmill walking
- Stationary cycling
- Wall squats and lower extremity strengthening

## Phase IV: Return-to-Sport Progression

**Weeks 12+**

### BRACING

- Continue ankle brace for higher-risk activities and sports
- Brace use is recommended for 3–6 months, or for the first season after return to sport

### GOALS

- Restore sport-specific strength, agility, and confidence
- Safe and durable return to athletic participation

### PHYSICAL THERAPY FOCUS

- Plyometrics
- Agility and cutting drills
- Sport-specific training

### EXERCISES

- Interval running progression
- Single- and double-limb plyometrics
- Agility ladders and shuttle runs
- Box jumps and hopping drills
- Sport-specific movement patterns

## Return-to-Sport Criteria

Return to sport is typically allowed at the earliest around 12 weeks, but is **criteria-based, not time-based**. Clearance requires:

- Clearance by physical therapy and surgeon

- Minimal to no swelling following activity
- Full or near-symmetric ankle range of motion
- Functional strength appropriate for sport demands
- Good dynamic balance and neuromuscular control
- Ability to perform 10 single-leg hops on the operative side:
  - Without pain
  - Without instability
  - Without compensatory movement patterns

While some patients may meet criteria near 12 weeks, full unrestricted competitive play often occurs closer to 3–5 months, particularly for cutting and pivoting sports. Associated cartilage procedures or osteotomies may delay return further.

## Special Considerations

- **Cartilage procedures (OCD/microfracture):** Return to sport may be delayed
- **Peroneal tendon repair or osteotomy:** Progression may be slower
- **Augmented repairs (e.g., suture-tape/internal brace):** May allow accelerated progression at surgeon discretion

## References


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