Distal Triceps Repair or Reconstruction

Postoperative Rehabilitation Guidelines

Autograft or Allograft Procedures

Note: Revision surgery, chronic tears, or cases involving autograft/allograft tendon reconstruction may require modifications to the below guideline. Additional restrictions or modifications will be listed in the operative report and postoperative therapy instructions.

The intent of this protocol is to provide the clinician/therapist with a guideline of the postoperative rehabilitation course for a patient who has undergone distal triceps reconstruction. It is not intended to be a substitute for clinical decision-making regarding progression based upon individual findings, progress, tissue quality, fixation strength, and postoperative complications. If a clinician or therapist has questions regarding progression, they should consult with Dr. Eichinger.

Josef K. Eichinger, MD

General Information

- Total recovery time is generally 6-9 months depending upon chronicity of injury, tissue quality, graft type, patient age, activity demands, and associated procedures.
- Adherence to rehabilitation restrictions is critical to protect the tendon reconstruction during biologic incorporation and healing.
- Progression should be based on protection of the repair rather than restoration of motion.

Immobilization

- Posterior splint with elbow in approximately 30°-45° of flexion for 10-14 days, unless otherwise indicated by the surgeon.
- Transition to hinged elbow brace at first postoperative visit.
- Hinged elbow brace is maintained for a minimum of 8 weeks.
- Brace should be worn at all times except for hygiene and prescribed therapy exercises.

Personal Hygiene / Showering

- Avoid getting splint wet following surgery.
- Avoid submersion in baths, pools, lakes, or hot tubs for a minimum of 4 weeks after surgery.

Expectations for Outcomes

Acute distal triceps reconstructions generally heal reliably; however, chronic injuries requiring autograft or allograft reconstruction require a prolonged period of protection to permit biologic graft incorporation. Premature active extension or resisted extension can result in elongation or failure of the reconstruction.

The following are general rehabilitation management concepts:

Joint Protection

- No active elbow extension or triceps contraction for a minimum of 8 weeks.
- No pushing, lifting, transfers, or weight-bearing through the operative extremity during the protection phase.
- Therapist-assisted stretching into flexion is prohibited during the first 8 weeks.

Triceps Function and Range of Motion

- The triceps is the primary elbow extensor and places significant stress on the reconstruction.
- During the first 8 weeks, elbow flexion is performed actively while elbow extension is performed passively.
- Active extension against gravity is prohibited during this period.
- Progression of elbow motion is designed to gradually increase flexion while protecting the repair from excessive tension.

Method of Repair

- Distal triceps reconstruction may be performed utilizing autograft or allograft tissue.
- Fixation methods may include suture anchors, transosseous tunnels, cortical button fixation, or a combination thereof.
- Rehabilitation progression may be adjusted based upon fixation quality and intraoperative findings.

Postoperative Rehabilitation – Distal Triceps Reconstruction with Autograft/Allograft

Immobilization / Range of Motion

Weeks 0–2

- Posterior splint maintained.
- No elbow ROM.
- Hand, wrist, and shoulder ROM as tolerated.

- Avoid shoulder resisted extension activities.

Week 2

- Transition into hinged elbow brace.
- Brace set at:
    - 0° extension
    - 30° flexion

Hinged Brace Flexion Progression

Brace settings may be adjusted at surgeon discretion based on tissue quality and repair integrity.

- Week 2: 0°-30°
- Week 3: 0°-45°
- Week 4: 0°-60°
- Week 5: 0°-75°
- Week 6: 0°-90°
- Week 7: 0°-105°
- Week 8: 0°-120° to full flexion as tolerated
- Week 8+: Discontinue brace if adequate motor control and healing are demonstrated

Range of Motion Exercises (Within Brace Limits)

Weeks 2-8

- Active elbow flexion only.
- Passive elbow extension only.
- Forearm pronation/supination with elbow at 90° flexion.
- Shoulder ROM as tolerated.
- No active elbow extension.
- No resisted extension.
- No weight-bearing through the operative extremity.

Week 8

- Initiate active elbow extension.
- Progress to full active ROM.
- Gradual restoration of functional motion.

Weeks 10-12

- Full active ROM expected.
- Gentle stretching may be initiated if deficits remain.

Strengthening Program

Weeks 0-8

- Grip strengthening.
- Wrist and forearm strengthening.
- Scapular stabilization and postural exercises.
- Rotator cuff strengthening with elbow protected.
- **No triceps activation.**
- **No elbow extension strengthening.**

Weeks 8-10

- Initiate active triceps recruitment.
- Submaximal triceps isometrics.
- Light closed-chain proprioceptive activities below shoulder level.

Weeks 10-12

- Begin progressive resisted elbow extension.
- Theraband resistance program.
- Light functional strengthening.

Weeks 12-16

- Progress upper extremity strengthening.
- Initiate machine and free-weight strengthening as tolerated.
- Advance endurance activities.

Weeks 16-24

- Progressive return to work and recreational activities.
- Begin sport-specific conditioning when strength and motion criteria are met.

Months 6-9

- Return to unrestricted athletic participation and heavy labor activities after clearance by the surgeon.

Precautions

- No active elbow extension before 8 weeks.
- No resisted triceps strengthening before 10 weeks.

- No pushups, dips, bench press, or heavy lifting before 4 months.
- No unrestricted sporting activity before 6 months.
- Any sudden increase in pain, loss of extension strength, or palpable defect should prompt immediate surgeon evaluation.

This mirrors the layout and terminology of your distal biceps protocol while emphasizing the prolonged protection required for triceps graft incorporation.