Campbell Clinic ORTHOPAEDICS

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Patient Name:_____ Diagnosis:_____ PT Duration:_____/ Week _____ Weeks

Phase	Precautions	Treatment Recommendations	Emphasize
Phase 1: Acute/High Irritability Phase *Criteria for Advancement:* *-Minimize antalgia and use of assistive devices during gait* *-Pain and swelling controlled*	▪ Screen patient for fractures with the Ottawa Ankle/Foot Rules ▪ Assess for severity of injury to supporting structures, e.g. peroneal tendon, flexor hallucis longus ▪ Maintain MD precautions if applicable	▪ Swelling management o Protect, Rest, Ice, Compression, Elevation (PRICE), modalities ▪ Gait and stair training o Focus on optimal loading and early weight bearing o Encourage symmetrical gait pattern o Train in use of assistive device if necessary o Taping/bracing as needed ▪ A/AA/PROM of the ankle o Do not overload involved tissues o Focus on non-weight bearing (NWB)/limited weight bearing interventions ▪ Balance/proprioception o Seated multi-directional rocker board minimizing stress to injured tissues ▪ Pain-free ankle/foot strengthening o Isometrics progressing to isotonics o Intrinsic strengthening ▪ Low-grade joint mobilizations focusing on the distal tibiofibular, talocrural and subtalarjoints, e.g. posterior talar glides and mobilizations with movement ▪ Proximal LE and core strengthening, UE strengthening as needed	▪ Pain-free exercise ▪ Swelling management ▪ Limit motions which stress healing tissues o Anterior talofibular ligament (ATFL) limit: Inversion (INV) and Plantarflexion (PF) o Calcaneofibular ligament (CFL) and posterior talofibular ligament (PTFL) limit: INV o Deltoid ligament limit: Eversion (EV) o High ankle sprain limit: Weight-bearing (WB) INV/EV
Phase 2: Subacute/Moderate Irritability Phase *Criteria for Advancement:* *-Gait normal without assistive device* *-Pain and swelling self-managed as activity increases* *(continued)*	▪ Premature return to activity ▪ Avoid stretching of injured ligaments	▪ Swelling management o Consider compression sleeve ▪ Gait and stair training o Encourage symmetrical gait pattern ▪ A/PROM of the ankle o Address persisting deficits ▪ Neuromuscular training ▪ Weight bearing balance/proprioception o Progression from bilateral to unilateral o Progression from static to dynamic o Sagittal progressing to multidirectional o Progression from level ground to compliant surfaces -Multi-directional rockerboard, proprioceptive foam, hemispheric balance trainer ▪ Weight bearing strengthening o Heel rise progression - Track directly to 1st/2nd metatarsals ▪ Progressive joint mobilizations targeting on distal tibiofibular, talocrural and subtalar joints ▪ ADL specific training o Progressive community ambulation ▪ Heel and toe walking ▪ Negotiate down stairs ▪ Squats	▪ Pain-free exercise ▪ Swelling control ▪ Tripod contact pattern of foot to floor ▪ Limit motions which stress healing tissues o ATFL: INV/PF o CFL/PTFL: INV o Deltoid: EV o High Ankle: WB INV/EV

Ankle Sprain Rehabilitation Protocol

Joseph D. Lamplot, M.D.

Phase 2: Subacute/Moderate Irritability Phase (continued)		▪ Transitions onto and off of the floor o Front and side planks o Kneeling/half kneeling exercises ▪ Resume cardio activities if not symptomatic	
Phase 3: Chronic/Low Irritability Phase *Criteria for Discharge:* *-Full ankle ROM and strength* *-Heel rise strength 90-100% equal to the contralateral side and/or 20 heel rises on involved side (see Hebert-Losier reference for age specific norms)* *-Ability to perform task and sport specific interventions with no instability or increase in symptoms* *-Patient appropriate functional testing, e.g. drop vertical jump vs. 6-minute walk test*	▪ Premature return to activity	▪ Swelling management o Consider compression sleeve A/PROM of the ankle o Address persisting deficits in range of motion and joint mobility ▪ Weight bearing balance/proprioception o Progress to unilateral and dynamic stabilization ▪ Multi-directional rockerboard, foam, hemispheric balance trainer ▪ Sport specific balance/proprioception ▪ Perturbations ▪ Reactionary drills emphasizing directional and speed changes ▪ Weight bearing strengthening o Heel rise progression o Eccentric control o Increase load (reintroduce previously symptomatic movements) o Endurance training ▪ Incorporate instability into progression ▪ Work on inclines/declines/sport specific terrain ▪ Loaded squat variations o Bilateral/unilateral ▪ Progress to single leg side planks ▪ Running, plyometrics, agilities, hopping o Deceleration and cutting exercises	▪ Weight bearing stability ▪ Task specific training ▪ Gait duration/distance/step count ▪ Tripod contact pattern of foot to floor in high level activities

Protocol adapted from Hospital for Special Surgery Rehabilitation ankle sprain guidelines