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Outpatient Physical Therapy Following Surgical Debridement Of Osteochondritis Dissecans Of The Talar Dome: A Case Report

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1 Outpatient Physical Therapy Following Surgical
2 Debridement of Osteochondritis Dissecans of the
3 Talar Dome: A Case Report
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7 Angela Serrani
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36
37 The patient signed an informed consent allowing the use of medical information for this report
38 and received information on the institution’s policies regarding the Health Insurance Portability
39 and Accountability Act.

40
41 The author acknowledges Mike Fillyaw, PT, MS for assistance with case report
42 conceptualization.
43

44 **Abstract**

45 *Background:* Osteochondritis Dissecans (OCD) is an alteration of subchondral bone with
46 possible disruption of the surrounding articular cartilage. Hypothesized causes of the chondral
47 defect include repeated trauma or vascular disruption within the joint. Surgical treatment may be
48 used to relieve symptoms of OCD and improve function.

49 *Purpose:* The purpose of this paper is to describe physical therapy treatment and outcomes for
50 a patient following surgical debridement of OCD of the talar dome.

51 *Case Description:* The patient was a 27 year old female with a history of frequent ankle
52 sprains. She reported a specific incident earlier this year that led to increased right ankle pain.
53 She had radiographs and an MRI following the incident which revealed OCD of her right talar
54 dome. She underwent surgical debridement of her talar dome and was referred to physical
55 therapy for post surgical care, evaluation, and treatment.

56 *Outcomes:* During the episode of care, the patient did not make large improvements in
57 strength, range of motion, swelling, or pain. The patient benefited from physical therapy by
58 maintaining her strength and ROM during a period of decreased activity.

59 *Discussion:* It was suspected that the patient had a tibialis posterior tendon rupture, and that
60 was greatly contributing to her lack of progress in physical therapy. Physical therapy was put on
61 hold for this patient until further imaging could be taken and she could be assessed by a foot and
62 ankle specialist physician.

63 *Manuscript Word count:* 3,210

64

65

66 **Background and Purpose**

67 Osteochondritis Dissecans(OCD) is an alteration of subchondral bone with possible
68 disruption of adjacent articular cartilage.¹ The cause of a chondral defect is unknown but several
69 hypotheses exist. Hypothesized causes include repetitive microtrauma disturbing the vascularity
70 of the talus or non-traumatic disruption of the subchondral blood supply.¹ Although the exact
71 incidence of OCD is unknown, it is suspected that chondral injury may occur in as many as 50%
72 of ankle instability episodes.¹

73 The goal of treatment for OCD is to relieve symptoms and improve function.² Non-
74 surgical treatment options for patients with OCD of the talus include rest, cast immobilization,
75 and use of non-steroidal anti-inflammatories.² Surgical treatment options include excision of the
76 lesion, excision and cutterage, excision combined with cutterage and microfracturing, filling the
77 defect with bone graft, antegrade transmalleolar drilling, retrograde drilling, fixation, and other
78 techniques such as osteochondral transplantation and autologous chondrocyte implantation.²
79 Outcomes following microfracture surgery for this condition yield satisfying results.³ In this case
80 report, the patient was treated with surgical debridement of the defects in her talus following her
81 diagnosis of OCD.

82 The purpose of this paper is to describe physical therapy treatment and outcomes for a
83 patient following surgical debridement of OCD of the talar dome. Physical therapists will
84 benefit from this case report by learning through my experience of treating this patient with a
85 unique diagnosis. I will add to the body of knowledge in physical therapy by outlining the
86 treatment of a patient with OCD of the talus and her subsequent outcomes and I will make a
87 reasonable assessment of how her outcomes were related to the treatment provided.

88

89 **Case Description**

90 **Patient History**

91 The patient was a 27 year old female with a history of frequent sprains of either ankle and
92 intermittent bilateral ankle pain over the past 8 years. She reported that in the beginning of
93 March 2014 she “turned the wrong way” while bowling and immediately experienced increased
94 right ankle pain. She had radiographs and an MRI following the initial incident. The radiographs
95 were negative for fracture and the MRI showed an osteochondral defect on her right talar dome.
96 She initially presented to her orthopedic surgeon with complaints of right ankle pain and
97 instability and difficulty maintaining a normal gait pattern. Her medical diagnosis was OCD of
98 the right talar dome. She underwent surgical debridement of the defects in her talus in mid April,
99 2014 and was referred to physical therapy for post surgical care, evaluation, and treatment of her
100 right ankle. During surgery, the patient’s distal tibia was fractured and the ligaments on the
101 lateral side of her ankle were sprained purposely to allow the surgeon to access her talar dome.
102 Following surgery, more radiographs were taken to ensure proper alignment of her fractured tibia.
103 The patient was non weight bearing on her right lower extremity with the use of crutches for two
104 weeks after the surgery. She then transitioned, for a short period of time, to the use of a walking
105 boot for long distance ambulation. When she presented to physical therapy, she reported use of a
106 short lace up brace at all times when ambulating.

107 The patient lived on a farm with her husband and 4 children; ages 12, 8, 3, and 1. She had
108 family and friends living near by who were available to help with child care following her
109 surgery. The patient’s home had stairs to enter and exit which did not have a functional railing
110 and a full flight of stairs inside which were necessary to access the patient’s living environment.

111 She was able to use stairs successfully but with increased ankle pain and an abnormal sideways
112 stepping pattern.

113 The patient had exercised induced asthma, seasonal allergies, and reported a significant
114 weight gain since the surgery due to inactivity. She reported smoking 7-10 cigarettes per day,
115 drinking alcohol infrequently, and no family history of OCD or frequent ankle sprains. The
116 patient's medications included Tylenol as needed, Buspar and Citrapram daily.

117 The patient's goals were to be able to return to her every day activities including caring
118 for her household, 4 children, and animals, to be able to walk without pain, and to be
119 comfortable driving.

120 **Systems Review**

121 *Integumentary:* Non pitting edema was present in right foot and ankle. Surgical incision at
122 medial right ankle was fully closed, with no stitches, and no detectable adhesions.

123 *Musculoskeletal:* Right ankle active range of motion (AROM) was limited in all directions.

124 Right ankle strength was limited in all motions. Patient also exhibited an antalgic gait pattern.

125 *Cardiovascular and neuromuscular* systems were not examined.

126 **Clinical Impression 1**

127 This patient reported a significant history of ankle sprains. Repeated trauma from ankle
128 instability is a hypothesized cause for the formation of osteochondral lesions,¹ leading me to
129 believe that this patient's OCD of the talus was likely caused by her frequent episodes of ankle
130 instability. Surgical correction of the chondral defects in the talus caused trauma to the
131 surrounding structures including bones and ligaments. This surgery and trauma were followed
132 by a period of ankle immobilization. Inflammation, swelling, and pain were likely due to
133 surgery related trauma and decreased ankle strength and range of motion were likely due to the

134 subsequent period of immobilization. Her poor gait mechanics were likely caused by a
135 combination of factors including habit, pain, decreased strength, and inflammation.

136 This patient was chosen as the subject of this case report because her diagnosis is less
137 common than many of the others we see in the outpatient orthopedic setting. She was also
138 selected because she is a relatively young, healthy person without known comorbidities, making
139 it less likely that a concurrent condition would interfere with treatment and outcomes. This
140 patient was slightly overweight, but reported that the weight gain was recent and due to her
141 inability to return to pre surgery activity levels. Her weight was not enough to cause concern
142 about increased forces through her ankle and I presumed that when she was able to increase her
143 activity levels she would also return to her previous weight. The patient's cigarette smoking may
144 have contributed to increased bone healing time.⁴

145 Potential complications of this surgery include the possibility soft tissue damage such as
146 tendon rupture, as well as the possibility that the chondral defect was not effectively repaired
147 during the surgery.

148 Planned examination procedures include:

- 149 • strength assessment of the lower extremities
- 150 • range of motion assessment of the lower extremities
- 151 • assessment of swelling in right lower extremity using circumferential measurements
- 152 • gait assessment
- 153 • Lower Extremity Functional Scale (LEFS)

154

155

156 **Examination**

157 **Tests and Measures**

158 *Strength:* Specific muscle strength of this patient's non-affected left ankle was assessed using
159 manual muscle testing (MMT). Initially, her right ankle strength was not assessed due to
160 tenderness and inflammation but it was assessed upon discharge. The reliability of MMT
161 increases with the experience level of the practitioner but is reliable and the concurrent validity
162 of MMT is also high.⁵

163 *Range of motion:* AROM of the patient's ankles was assessed using goniometry. As long as
164 standardized measurement practices are used within a clinic, goniometry is a reliable way to
165 measure range of motion (ROM) of a joint.⁶ Goniometry is valid for measuring the ROM of a
166 joint but can not be used to infer the factors contributing to the joint.⁶

167 *Integumentary:* Visual and tactile inspection of the integument surrounding the area of the
168 surgical incision was conducted.

169 *Circumferential Measurement:* Circumferential measurements of her ankles were taken to assess
170 the swelling that was present. The patient was supine on the exam table with her foot and ankle
171 in a neutral position and a measuring tape was used. The four measurements taken were figure 8,
172 malleoli, forefoot, and metatarsal heads. A figure 8 ankle measurement has high inter-rater and
173 intra-rater reliability.⁷ This measurement has better accuracy when the landmarks are marked
174 and the same examiner carries out the measurements.⁷ Ankle circumference measurement has
175 high inter-examiner agreement and excellent reliability.⁸ Circumferential measurements are
176 quicker and easier to complete in the clinic than other methods of ankle edema measurement
177 such as water displacement.⁸

178 *LEFS*: The LEFS is a written 20 item questionnaire that assesses the patient's ability to perform
179 everyday tasks.⁹ It can be used to evaluate impairment of a patient with a lower extremity
180 musculoskeletal impairment, to measure progress and outcomes, and to set functional goals.⁹
181 Refer to Appendix 1 for the LEFS form.

182 *Gait assessment*: The patient's gait was assessed by observing her walking without an assistive
183 device for 20 feet back and forth several times. She was instructed to walk at a self selected pace
184 and was observed from front, back, and each side. Excessive toe out, lack of plantarflexion, and
185 lack of push off on the right side were notable findings.

186 All measurements and assessment was taken by the same therapist for the sake of reliability.

187 Refer to table 1 for results of Tests and Measures.

188 **Clinical Impression 2**

189 The findings of weakness, decreased range of motion, impaired gait pattern, pain, and
190 inflammation upon examination are consistent with this patient's post surgical status. This
191 patient remains an appropriate candidate for this case report. According to the Guide to Physical
192 Therapy Practice, her PT diagnosis is practice pattern 4I: Impaired Joint Mobility, Motor
193 Function, Muscle Performance, and Range of Motion Associated With Bony or Soft Tissue
194 Surgery.¹⁰

195 This patient's impairments include decreased muscle strength in all motions of the right
196 ankle, limited right ankle ROM, poor gait pattern, right lower extremity pain, and inflammation.
197 Her functional limitations are inability to walk, stand, run, drive, bathe, squat, and use stairs.
198 Her disabilities include inability to ambulate in the community and inability to care for her
199 household and children. Her prognosis for improvement is good given adherence to plan of care.
200 This is based on her motivation to get back to her prior level of function, lack of factors that

201 might interfere with her recovery, having a supportive family nearby to help her, and her young
202 age. There is an overall clinical outcome of “good and excellent” in 79% of patients treated with
203 surgical correction of OCD,¹¹ leading me to believe that this patient also has a very good chance
204 of having a favorable outcome following her surgery. At this time no referral or consultation is
205 necessary. Consultation with her surgeon may be called for if progress is not as expected with
206 physical therapy treatment.

207 Additional tests and measures planned include MMT of the right ankle and more extensive
208 gait analysis. Functional movement analysis may be used once she has begun to make progress.
209 A Lower Extremity Functional Scale will be administered every 12 visits and at discharge.

210 The initial procedural intervention plan of care was 2 visits per week for 6 weeks.
211 Planned interventions included exercises to increase weight bearing ability, balance, and
212 proprioception, stretching, gait training, and strengthening of her lower extremity to improve gait.
213 Manual therapy techniques planned included soft tissue mobilization, joint mobilizations, PROM,
214 stretching, and ice massage. Other possible modalities for use included electric stimulation,
215 vasopneumatic compression device, and cryotherapy.

216 *Short term goals (3 weeks):*

- 217 • worst right ankle pain in the past two days less than or equal to 5/10
- 218 • right ankle active range of motion (AROM) in dorsiflexion(DF) greater than or equal to 0° and in
219 plantarflexion (PF) greater than or equal to 55°
- 220 • right ankle strength DF and PF than or equal to 4-/5
- 221 • ability to perform step up leading with right foot onto a 4 inch step without pain
- 222 • Independence with home exercise program.

223 *Long term goals (6 weeks):*

- 224 • ability to stand for an entire shower without pain

- 225 • ability to walk on uneven ground without pain
- 226 • ability to complete household care tasks for 30 minutes at a time without pain
- 227 • ability to ascend and descend stairs reciprocally without railing without pain
- 228 • ability to ambulate community distances with equal step length on each foot using a normal gait pattern

229 This patient will be discharged from physical therapy upon meeting all of her long term
230 goals or upon gaining the maximum benefit from physical therapy.

231 **Interventions**

232 *Coordination, Communication, and Documentation*

233 Each visit was documented in the form of a SOAP note with accompanying flow sheets
234 to record exercises performed. At the 12th and 19th visits a reevaluation was performed and
235 recorded. Reevaluations and progress notes were faxed to the patient's surgeon before her
236 scheduled follow up visits. Communication with her surgeon also took place in the form of
237 phone calls and voice messages. Communication about treatment choices also took place
238 between my self and several other physical therapists at the clinic.

239 *Patient Related Instruction*

240 The patient was given a home exercise program (HEP) with handouts including pictures
241 of the exercises. (Figure 1). The patient reported complete compliance with her HEP. I also
242 discussed with the patient the importance of proper foot wear. Recommendations were made
243 about the type of supportive sneakers she should be wearing and she was educated about how to
244 choose an appropriate pair of sneakers. The patient also received instructions to ice her ankle
245 and elevate her foot as often as possible and to avoid walking long distances and spending
246 extended periods of time on her feet. She reported that she was as compliant with rest, ice, and
247 elevation as she could be while caring for four young children.

248 *Procedural Interventions*

249 Procedural intervention for this patient changed focus several times over the course of her
250 treatment based on changes in her condition. (Table 2). During visits 1 through 5 the patient
251 was still experiencing inflammation due to her postsurgical status and weakness due to her
252 postsurgical period of immobilization. The focus of treatment during this phase was to decrease
253 inflammation, improve ROM and strength, and improve her abnormal gait pattern. During this
254 phase, progress in gait pattern, decreased inflammation, and improved strength and ROM were
255 expected. Manual interventions of soft tissue mobilization, joint mobilizations, and PROM were
256 provided to reduce inflammation and pain and increase ROM. Therapeutic exercises were used
257 to help build strength and improve gait, with a goal of the patient being able to ambulate with a
258 normal, pain free pattern. Through visit 5 the patient was making progress as expected.

259 At visit 6 the patient presented with increased inflammation and pain in her ankle. It was
260 assumed that the pain and inflammation were a result of the gains in ROM the patient had made
261 and the increased weight bearing through the injured ankle. At this time, interventions were
262 focused on reducing pain and inflammation through the use of manual therapy techniques
263 including soft tissue mobilization, joint mobilizations, and ice massage. During visits 7 through
264 10 the same types of manual therapy were used but the exercise program was increased to
265 include ROM, balancing, and weight bearing practice. Although the patient's ankle was still
266 inflamed and painful at each visit, exercises were still performed to prevent further loss of
267 strength and ROM. During visits 11 through 13 manual therapy remained the same, balancing
268 exercises were progressed and eccentric calf lowering was added. Rock Tape¹² was applied in
269 overlapping fan patterns for swelling reduction.

270 At visit 14, it became more evident that the patient was not able to maintain a correct foot
271 position in a weight bearing position. She fell in to a position of flattened longitudinal arch with
272 all weight bearing activities. It was suspected that weight bearing with her foot in a flattened
273 position contributed to her pain and inflammation. Thus, during visits 14 through 19, the
274 exercises remained the same but other treatment techniques were altered. Manual therapy was
275 reduced to gentle soft tissue mobilization to assist with swelling reduction. Modalities including
276 electrical stimulation, ice, and vasopneumatic compression were used for swelling reduction and
277 pain control and low dye taping¹³ was used to support the patient's longitudinal arch and correct
278 foot position during weight bearing.

279 **Outcome**

280 The patient made minimal progress with regards to reduced swelling and pain and
281 increased ROM during the initial phase of treatment. Following the 6th visit progress was
282 minimal and she continued to regularly experience increased swelling and pain. Swelling was
283 essentially unchanged from evaluation to visit 19. Ankle strength upon MMT was improved
284 from evaluation to visit 19 but the patient was still lacking fully functional ankle strength. (Table
285 1). Improvement made in AROM was likely due to increased joint mobility and muscle length
286 after the patient's period of immobilization.

287 None of the patient's long term goals were met. After the 19 visits she still reported
288 fluctuating pain levels and decreased functional mobility. Her physician suspected she might
289 have a partial or complete tibialis posterior tendon rupture and he sent her for an MRI to examine
290 the condition of the tendon. The patient reported to us at a later date that the metal hardware in
291 her ankle created an artifact on the MRI, obscuring a clear view of the tendon in question and
292 that she was referred to a foot and ankle specialist for more detailed imaging procedures. Due to

293 the traumatic nature of her initial ankle surgery, it is likely that the tendon rupture was a result of
294 the surgery. The signs of tendon rupture were not initially evident because the patient was
295 immobilized and wearing an ankle brace after surgery.

296 **Discussion**

297 This case highlights the importance of doing detailed assessment and reassessment of
298 patients who have had any type of traumatic surgery. While the purpose of this case report was
299 fulfilled, it is difficult to assess the effectiveness of PT treatment for this patient because of the
300 suspected tendon injury. The patient's inability to weight bear with a normal foot and ankle
301 position remained a limiting factor in progressing her gait pattern through out PT treatment.

302 Due to her surgical status and suspected tendon injury, it is possible that without the PT
303 treatment, her pain and swelling would have been worse and she would have continued develop
304 weakness in the affected ankle and lower extremity. She also benefited from the communication
305 between her physical therapist and doctor in returning for a follow up visit when her healing was
306 not progressing as planned. The patient did demonstrate a 14 point increase in her LEFS score,
307 showing a slight improvement in her functional abilities. The minimally clinically important
308 difference for the LEFS is 9 points,⁹ meaning that her improvement on the test correlates to a
309 clinical improvement in function. Another benefit of PT for this patient was the emotional
310 support of her physical therapist. Having someone who was truly concerned about not just the
311 status of her ankle, but also about how she was functioning on a daily basis was important to this
312 patient as she dealt with the challenges of having such a life affecting injury.

313 Maintaining contact with the patient through out her upcoming imaging, specialist
314 consultation and possible surgery will remain important even though her PT treatment is on hold

315 at the time of writing this report. She will likely benefit from continued PT in the future,
316 following treatment provided by her foot and ankle specialist.

317 I suggest more research in the area of conservative management of OCD. Because this
318 patient had such difficulty with surgery complications I think it would be beneficial if patients
319 could be offered non surgical options, but only if those options can be proven effective at
320 treating OCD.

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393 longitudinal arch and reduce excessive pronation. *J Athl Train.* 1995;30(3):266-8.
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396 Table 1. Results of tests and measures.
 397

	Initial	At visit 19
LEFS score	13/80	27/80
Right ankle active range of motion		
Dorsiflexion	-15°	-7°
Plantarflexion	46°	45°
Inversion	18°	10°
Eversion	6°	18°
Right ankle circumferential measurements		
Figure 8	52 cm	51.5 cm
Malleoli	27 cm	26.75 cm
Forefoot	23 cm	22 cm
Metatarsal heads	23.5 cm	23 cm
Right ankle strength (MMT)		
Dorsiflexion	3-/5	5/5
Plantarflexion	3-/5	5/5
Inversion	Not Tested	3+/5
Eversion	Not Tested	4+/5

398
 399 Lower Extremity Functional Scale (LEFS), Manual Muscle Testing (MMT)
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424 Table 2. Procedural interventions.

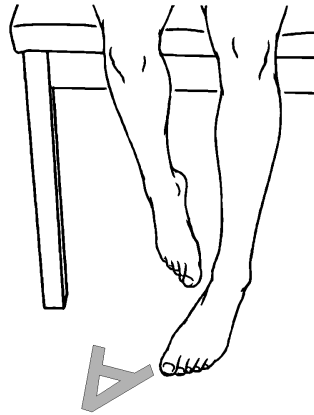
	Visits 1-5	Visit 6-10	Visit 11-13	Visit 14-19
Manual Therapy	<ul style="list-style-type: none"> • STM to ankle, foot, gastroc/soleus • Joint mobilizations: AP glide talus on mortise, 1st ray in PF and DF, cuneiforms and cuboid in PF and DF, distraction • PROM R ankle in DF and PF 	<ul style="list-style-type: none"> • STM to Achilles, gastroc/soleus, foot, and ankle, Efflourage to medial knee, leg, and foot • Joint mobilizations: AP glide talus on mortise, cuneiforms and cuboid in PF and DF, 1st TMT in PF and DF, calcaneus inversion and eversion, distraction with PF and DF 	<ul style="list-style-type: none"> • STM to Achilles, gastroc/soleus, foot, and ankle, Efflourage to medial knee, leg, and foot • Joint mobilizations: AP glide talus on mortise, cuneiforms and cuboid in PF and DF, 1st TMT in PF and DF, calcaneus inversion and eversion, distraction with PF and DF 	<ul style="list-style-type: none"> • STM to Achilles, gastroc/soleus, foot, and ankle, Efflourage to medial knee, leg, and foot
Tape			<ul style="list-style-type: none"> • Rock Tape, 2 interwoven fans to anterior and lateral ankle 	<ul style="list-style-type: none"> • Low dye taping for arch support • Rock Tape, 2 interwoven fans to anterior and lateral ankle
Modalities		<ul style="list-style-type: none"> • Ice with foot elevated 	<ul style="list-style-type: none"> • Ice with foot elevated 	<ul style="list-style-type: none"> • E-stim • Ice with foot elevated • Vasopneumatic compression system
Therapeutic Exercises	<ul style="list-style-type: none"> • Gait training • Recumbent bike • BAPS board • Weight shifting • Treadmill • Mini squats 	<ul style="list-style-type: none"> • Recumbent bike • BAPS board • DF stretch on wedge • Weight shifting seated on PB • Eccentric calf lowering • Tandem stance on foam • Ankle TB x4 	<ul style="list-style-type: none"> • Recumbent bike • BAPS board • DF stretch on wedge • Eccentric calf lowering • Tandem stance on foam • Ankle TB x4 • Balancing on 2 dynadiscs 	<ul style="list-style-type: none"> • Recumbent bike • BAPS board • Balancing on 2 dynadiscs • Eccentric calf lowering • Ankle alphabet • Ankle TB x4 • DF stretch on wedge
Home Exercises	<ul style="list-style-type: none"> • Ankle alphabet • Towel scrunches • Standing gastroc/soleus stretch 	<ul style="list-style-type: none"> • Ankle alphabet • Towel scrunches • Standing gastroc/soleus stretch 	<ul style="list-style-type: none"> • Ankle alphabet • Towel scrunches • Standing gastroc/soleus stretch 	<ul style="list-style-type: none"> • Ankle alphabet • Towel scrunches • Standing gastroc/soleus stretch

425 Soft tissue mobilization (STM), Anterior/posterior (AP). Passive range of motion (PROM), Dorsiflexion (DF), Plantarflexion (PF), Tarsal metatarsal
426 joint (TMT), Physioball (PB), Therabands (TB)

ANKLE / FOOT - 9 Ankle Alphabet

ANKLE / FOOT - 10 Toe Curl: Unilateral

Using left ankle and foot only, trace the letters of the alphabet. Perform A to Z.



Repeat _____ times per set.
Do _____ sets per session.
Do _____ sessions per day.



With right foot resting on towel, slowly bunch up towel by curling toes.

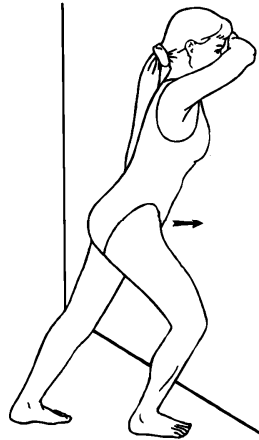
Repeat _____ times per set. Do _____ sets per session.
Do _____ sessions per day.

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LOWER LEG - 9 Achilles / Gastroc

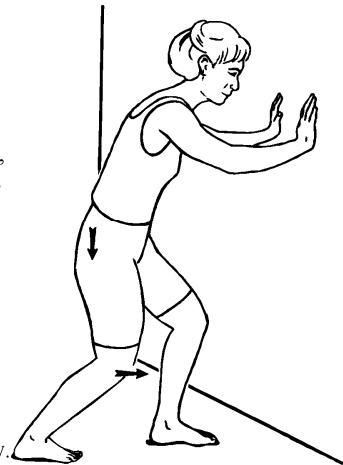
LOWER LEG - 10 Achilles / Soleus

With back leg straight, move hips forward until stretch is felt. Hold _____ seconds. Repeat with other leg.



Repeat _____ times.
Do _____ sessions per day.

With back foot flat and toes turned slightly inward, lower hips and bend knees until stretch is felt. Hold _____ seconds. Repeat with other leg.



Repeat _____ times.
Do _____ sessions per day.

428

429

Figure 1. Diagrams of patient's home exercises.

430 Ankle alphabets were performed with the right ankle, 2 times per set, 1 set per session, 2 sessions

431 per day. Toe curl was performed with the right foot, 20 times per set, 2 sets per session, 2

432 sessions per day. Both lower leg stretches were performed with right leg behind body, held for

433 30 seconds, repeated 3 times, 2 sessions per day.

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446 Appendix 1. Lower Extremity Functional Scale.
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We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
a. Any of your usual work, housework, or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
Column Totals:					

SCORE: _____/80

Error (single measure): ±5 scale points
MDC: 9 scale points
MCID: 9 scale points