

TENDON TRANSFER PROTOCOL DETAILS FOR SPECIFIC OPERATIONS

Revere Health – Dr. Daniel Hoopes, Orthopedic Lower Extremity Surgeon

Procedure	Indication	Pre-op	Post-op	2 weeks	6 weeks	12 weeks	5 months
Tendon transfers:	Alignment, stability and gross movement are goals. Object: to move a tendon that is causing a deformity to a location where it can perform a useful function.	Rarely isolated procedures. Be aware of accompanying procedures. <u>Precautions default to the most restrictive protocol.</u> Most tendon transfers: WBAT in CAM walker 6 weeks. (If “high risk” then first 2 weeks NWB)	Bed “rest” with leg elevated 8-10 inches. Bed exercises joints above and below surgical sites. Avoid tensioning or stretching transferred tendon (except as indicated)	Splint→Cast/boot, Edema control. Scar massage. If no cast, AROM non-transferred tendons. At 3 weeks post-op, passive movement <i>only</i> in direction of transferred tendon musculature (agonist). Gentle AROM of antagonist to return to neutral. Gentle isometrics in cast/neutral OK.	AROM transferred tendon if cleared by MD. Scar massage. General healing by 7-10 weeks. Yellow theraband OK around 9 weeks post op.	OK to push strengthening More vigorous strengthening by 3-4 months.	May take 6 months for complete tendon reattachment, full muscle activity.
Girdlestone –Taylor: FDL to extensor hood	Hammer/claw toes	Will no longer have distal phalangeal flexion (FDL is on dorsum of proximal phalanx).	CAM. WBAT POD 1. Gentle AROM ankle/STJ . Gentle AROM toes OK for Hansen patients, not for Sangeorzan (wait 6 weeks).				
Extensor subs.—EDL to EDB, EDL to P. tert	Claw toes with extrinsic extensor overdrive		CAM. WBAT POD 1 AROM OK Similar to gastroc slide except in CAM boot for 4 weeks during day Hansen, , 6 weeks at night				
Peroneus longus to Peroneus brevis	P.L. overdrive/cavus	Stops “pull down” of 1 st ray. Maintains eversion	Cast or CAM. WBAT POD 1. Avoid eversion/inversion		Cast off 7-10 weeks, then OK to PROM/AROM eversion & inversion	Vigorous strengthening after 3-4 months.	
FHL to base of proximal phalanx	Clawed hallux from weak Tibialis Anterior	Won’t have IP flexion	CAM. WBAT POD 1. FWB after 1 st week-casted 6-8 weeks				
Post Tib augmentation with FDL	Post. Tib insufficiency	Deeper procedure, more swelling. NWB/TDWB to protect arch.	Splint. Rest until POD 3. Avoid supination/inversion		WBAT 6-8 weeks post-op PROM/AROM eversion & inversion		
EHL to Tib Ant	deficient Tib Ant/CMT		Splint. Rest until POD 3. Avoid dorsiflexion	WBAT (Could be WBAT POD 3 if isolated)	Cast until 6 weeks post op		
P. Tib to dorsum of foot or to EDL or Tib Ant.	Deficient Tibialis Anterior		Splint. Rest until POD 3. WBAT 2 nd POD Avoid dorsiflexion		@ 8 weeks, ortho shoe or removable cast/cam		Vigorous exercise 4-6 mos. Post-op
FHL to achilles	Deficient Achilles. Note: If done isolated and achilles is non-functional, this has a very long/slow recovery.		Splint. Rest until POD 3. Hansen patients WBAT, Sangeorzan NWB until 2 weeks post op. Can be outpatient if isolated procedure. Walking cast for 6 weeks		No heel raises	Double-leg heel raises	Single-leg heel raises
P.L. to Achilles	Augment deficient Achilles		Splint. Rest until POD 3, then WBAT. Immobilized for 6-8 weeks	Cast, WBAT	Boot WBAT	Out of boot	
P.L. to dorsum of foot	Improve dorsiflexion, reduce cavus (CMT)		Splint. Rest until POD 3, then WBAT.	Cast, WBAT	Boot, WBAT	Boot at night	
Drop foot correction: FHL to P.B. FDL to P.Tib. P. Tib divided 2/3 to Tib Ant, 1/3 to EHL/EDL.	Foot Drop	Extensive procedure	Splint, NWB	CAM Boot, Gentle PROM. WBAT in <i>static stance</i> , continue TDWB in gait.	AROM if OK’d by MD. WBAT>FWB in gait with boot on 2 more weeks	In night splint for at least 6 months, maybe forever.	
SPLATT-split anterior tib tendon	Reduce over-pull of tib ant, particularly excessive inversion.		Cast. NWB 2-6 weeks				

Peroneus Longus and Tibialis anterior are antagonists. Unopposed Tib Ant elevates the 1st ray and flattens the arch.

Peroneus Brevis and Tertius are antagonists to Posterior Tibialis. Unopposed Peroneus longus leads to medial cavus—raised medial arch and plantarflexed 1st ray.

Peroneus brevis abducts forefoot, everts entire foot and elevates lateral border to assist with dorsiflexion.