KANSAS JOINT & SPINE SPECIALISTS
EXCEPTIONAL ORTHOPAEDIC CARE BEGINS HERE

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TRICEPS REPAIR

INDICATIONS

- Partial (>50%) or complete triceps rupture
- Partial (>50%) or complete triceps laceration

The only exception to a repair would be an extremely sedentary patient.

SURGICAL PROCEDURE

A posterior incision is made curving radially over the olecranon. The triceps tendon is identified and scar tissue is freed from the muscle belly. Degenerative tissue and bony fragments are excised. Drill holes are made through the olecranon. Sutures are passed through the drill holes and are tied with elbow in full extension. The tendon repair is reinforced by suturing the repaired tendon to the intact triceps muscle. Extra drill holes and sutures are also used to strengthen the repair. A drain is placed in the wound and a bulky compressive dressing is applied with the elbow between 20°- 30° of flexion and the forearm in neutral.

Strauch, RJ: Biceps and triceps injuries of the elbow. In Rosemwasser, MP and Strauch, RJ (eds.) The Orthopedic Clinics of North America: Elbow trauma and reconstruction. Philadelphia, WB Saunders, 1999, pp 95-107.

POSTOPERATIVE REHABILITATION

5 Days Postop

The bulky compressive dressing is removed. A light compressive dressing is applied to the hand, forearm, elbow and upper arm. Note: Elastic stockinette is not indicated until elbow range of motion allowed as it is difficult to apply and remove.

Active and gentle PROM exercises are initiated to the wrist and forearm 6-8 times a day.

A static elbow splint or long arm splint with elbow in 30° of flexion is fabricated to wear between exercise sessions and at night. Note: A clam-shell splint will provide the optimal immobilization.

10-14 Days Postop

Within 48 hours following suture/staple removal, scar retraction, scar massage with lotion and the use of Otoform K™, Elastomer™, or Rolyan 50/50™ may be initiated.
Note: It may be difficult for the patient to apply a scar pad secondary to the posterior location of the incision.

4-6 Weeks Postop

Gravity-assisted active and passive elbow extension may be initiated 6-8 times a day.

AROM exercises are initiated for elbow flexion. Initially, the AROM is from 0° to 30° of flexion. As the flexion is increased 20° each week in the elbow splint, the active elbow flexion may increase 20° as well. A prefabricated, locking hinged elbow splint may be used in place of a custom made splint.

8-12 Weeks Postop

The patient may begin to wean out of splints as comfort allows.

Full active and PROM exercises are initiated to elbow 6-8 times a day.

Dynamic splinting for elbow flexion may be initiated as necessary.

An upper extremity strengthening program may be initiated, on an every other day basis.

CONSIDERATIONS

To begin AROM of the elbow at 4 weeks in common. Some physicians, depending on surgery, may opt to wait until 6 weeks postop.

CONSERVATIVE MANAGEMENT – THERAPY

Conservative management is initiated for patients who are not interested in repair or who are completely sedentary. The therapy program for conservative management is as follows:

- Edema control is initiated as necessary
- The patient is immobilized in a LAS or static elbow splint in 20° - 30° of flexion for 4-6 weeks.
- Between 4 and 6 weeks, the patient may begin to wean out of splint and begin full AROM of the elbow and gradually progress to strengthening by 8 weeks. The splint is worn for comfort only.