NYU Hospital for Joint Diseases
NYU LANGONE MEDICAL CENTER

Laith M. Jazrawi, MD
Associate Professor of Orthopaedics
Chief - Division of Sports Medicine
Tel: (646) 501-7223

INSTRUCTIONS FOR SURGERY

In order to make your admission and hospital stay smooth and more pleasant, please comply with the following instructions:

☐ If your surgery is on **MONDAY**, please report to:

NYU Hospital for Joint Diseases
301 East 17th Street
New York, NY 10003

If indicated by your physician, schedule your pre-surgical testing, located at

303 2nd Avenue, 1st Floor Suite 16
New York, NY 10003

☐ If your surgery is on **FRIDAY**, please report to:

NYU Langone Outpatient Surgery Center
339 East 38th Street
New York, NY 10016

If indicated by your physician, please call 212-263-5985 to schedule your pre-surgical testing, located at

240 East 38th St.
New York, NY 10016
Mezzanine Level

***One business day prior to your surgery, hospital staff will contact you to finalize your surgery time.**

A. Bring jogging/warm-up pants, shorts/skirt if having knee surgery.

B. Bring a shirt/blouse that buttons open in front instead of a pullover if having shoulder/elbow surgery.

C. If you own crutches, bring them with you, if having knee, ankle or hip surgery.

D. Bring all medications or a list of current medications you are taking with you. Also bring a list of any allergies.

E. Blood pressure medication should be taken as usual with a sip of water the morning of surgery. **DO NOT** take a diuretic or fluid pill. Seizure medications may be taken before surgery.

F. **DO NOT** take oral diabetes medications (pills) the night before or the day of surgery. If you are on insulin, **DO NOT** use insulin the morning of surgery unless you are a "problem diabetic" in which case you need to consult your physician regarding the proper insulin dose for you to use prior to surgery.

NYU Hospital for Joint Diseases
NYU LANGONE MEDICAL CENTER

Laith M. Jazrawi, MD
Associate Professor of Orthopaedics
Chief - Division of Sports Medicine
Tel: (646) 501-7223

G. Please **DO NOT** wear makeup or nail polish the day of surgery. You will need to remove contact lens (including extended wear), denture, or bridges prior to surgery. Please bring your own containers for storage.

H. Leave all jewelry and valuables at home. The hospital will not take responsibility for lost or missing items.

I. You need to report any skin irritation, fever, cold, etc., to Dr. Jazrawi.

J. You will need to bring your insurance card/information with you.

K. DO NOT eat, drink (including water), chew gum, candy, smoke cigarettes, cigars, use smokeless tobacco, etc., after midnight the night before surgery or the morning of your surgery. The only exception is a sip of water to take necessary medications the morning of surgery.

L. You must arrange someone to drive you home when ready to leave the hospital. You will not be allowed to drive yourself home after surgery. We can assist you if you need transportation to the airport or hotel, however, you need to let us know in advance (if possible) so we can make the arrangement.

M. NOTE: DO NOT take any aspirin, aspirin products, anti-inflammatories, Coumadin or Plavix at least 5 days prior to surgery. You are allowed to take Celebrex up to your day of surgery. If your medical doctor or cardiologist has you on any of the above medications. Please check with him/her before discontinuing the medication. You may also take Tylenol or Extra-Strength Tylenol if needed.

Nonsteroidal Anti-Inflammatory (Arthritis) Medications:

Some of the most common names for frequently used NSAID's include: Motrin, Indocin, Nalfon, Naprosyn, Naprelan, Arthrotec, Tolectin, Feledene, Voltaren, Clinoril, Dolobid, Lodine, Relafen, Daypro, Advil, Aleve, Ibuprofen.

Your first follow up appointment is usually scheduled for approximately 2 weeks after your surgery at the 333 East 38th street office. The date and time of your follow-up is _____.

If you cannot make this appointment or need to change the time, please contact the office.

If you have any questions regarding your surgery, please contact the office at 646-501-7223 option 4, option 2 or via the internet at www.newyorkortho.com

NYU Hospital for Joint Diseases
NYU LANGONE MEDICAL CENTER

Laith M. Jazrawi, MD
Associate Professor of Orthopaedics
Chief - Division of Sports Medicine
Tel: (646) 501-7223

Home Supplies For Your Surgery
Laith M. Jazrawi M.D.

Open Surgery

A. Open knee surgery (ACL reconstructions, ALL (Anterolateral ligament) reconstructions, Autologous Chondrocyte Implantation, PCL reconstructions, High tibial osteotomy, Distal femoral osteotomy, Posterolateral corner reconstruction, MCL reconstruction, OATS (osteochondral autograft), Osteochondral allograft,)
   a. You will need 4x4 Tegaderm waterproof dressings for fourteen days. Also, a box of 4" by 4" gauze sponges if there is bleeding at the incision site. **Dressing changes for open knee surgery done post-op day #3.**

B. Open shoulder surgery , (Biceps Tenodeis, Latarjet, Open capsulorrhaphy, Glenoid reconstruction using Distal tibial allograft):
   a. You will need 4x4 Tegaderm waterproof dressings for fourteen days. Also, a box of 4" by 4" gauze sponges if there is bleeding at the incision site. **Dressing changes for open shoulder surgery are done post-op day #3.**

C. Open Ankle Surgery (Achilles Tendon Repair, Os Trigonum Excision, Ankle OCD, Modified Brostrom-Gould Procedure, Peroneus Longus/Brevis Repair)- You do not have to worry about dressing changes as your leg will be in splint/cast for the first two weeks

D. Open Elbow surgery (Distal Biceps Repair, LCL Reconstruction, Radial Head or Capitellum ORIF, Radial Head Replacement/Resection, Triceps Repair, UCL Reconstruction – Tommy John Surgery)- You do not have to worry about dressing changes as your leg will be in splint/cast for the first two weeks

E. Hamstring repair You will have a special dressing placed on at the time of surgery that can be removed at post-operative day #5. You will then need 4x4 Tegaderm waterproof dressings until your first f/u in 2 weeks . Also, a box of 4" by 4" gauze sponges if there is bleeding at the incision site.

Arthroscopic Surgery

A. For Arthroscopic shoulder, elbow, knee, or ankle surgery:
   a. Small size (~2x2) Tegaderm waterproof dressings can be used for arthroscopic portals x 2 weeks.
   b. If biceps tenodesis was performed, use 4x4 Tegaderm dressings on wounds.
   c. In general, dressing changes for arthroscopy are done on post operative day 3

Post-Operative Medication Administration

Knee Arthroscopy

- **Pain- Percocet (Oxycodone/Acetaminophen) 10/325; One tab every 6 hours as needed.**
- **DVT prophylaxis- Aspirin 325mg; One tab daily x 10 days**
- ******Aspirin starts post-operative day #1**
- **Patients on birth control or history of clotting; Xarelto 10mg x 14 days followed by Aspirin 325mg daily x 28 days (Xeralto starts POD #1)**

Knee Ligament Reconstruction

- **Pain- Percocet (Oxycodone/Acetaminophen) 10/325; One tab every 6 hours as needed.**
- **Breakthrough Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.**
- **Antibiotic – Keflex 500mg; One tab 4 times daily x 4 days**
    - **Keflex allergy – Clindamycin 300mg; One tab twice daily x 7days.**
- **Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.**
- **DVT prophylaxis- Aspirin 325mg; One tab daily x 10 days**
    - **Patients on birth control or history of clotting; Xarelto 10mg x 14 days followed by Aspirin 325mg daily x 28 days**
- ******Antibiotics and Xeralto or Aspirin start post-operative day #1**

Non-weight bearing Lower Extremity Surgery

- **Antibiotic – Keflex 500mg; One tab 4 times daily x 4 days**
    - **Keflex allergy – Clindamycin 300mg; One tab twice daily x 7days.**
- **Pain- Percocet (Oxycodone/Acetaminophen)10/325; One tab every 6 hours as needed.**
- **Adjunctive Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.**
- **Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.**
- **DVT prophylaxis- Xarelto 10mg; One tab daily x 14 days followed by Aspirin 325mg daily x 28days.**
- ********Antibiotics and Xeralto or Aspirin start post-operative day #1**

Shoulder/Elbow Surgery

- **Antibiotic – Keflex 500mg; One tab 4 times daily x 4 days**
    - **Keflex allergy – Clindamycin 300mg; One tab twice daily x 7days.**
- **Pain- Percocet (Oxycodone/Acetaminophen)10/325; One tab every 6 hours as needed.**
- **Adjunctive Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.**
- **Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.**

Ankle fracture surgery

- **Antibiotic – Keflex 500mg; One tab 4 times daily x 4 days**
    - **Keflex allergy – Clindamycin 300mg; One tab twice daily x 7days.**
- **Pain- Percocet (Oxycodone/Acetaminophen)10/325; One tab every 6 hours as needed.**
- **Adjunctive Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.**
- **Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.**
- **DVT prophylaxis- Xarelto 10mg; One tab daily x 14 days followed by Aspirin 325mg daily x 28days.**
- ******Antibiotics and Xeralto start POD #1**

Ankle arthroscopy +/- Microfracture and Achilles repair

- **Pain- Percocet (Oxycodone/Acetaminophen) 10/325; One tab every 6 hours as needed.**
- **DVT prophylaxis- Aspirin 325mg; One tab daily x 10 days**
- ******Aspirin starts post-operative day #1**
- **Patients on birth control or history of clotting; Xarelto 10mg x 14 days followed by Aspirin 325mg daily x 28 days (Xeralto starts POD #1)**

Hamstring repair

- **Antibiotic – Keflex 500mg; One tab 4 times daily x 4 days**
    - **Keflex allergy – Clindamycin 300mg; One tab twice daily x 7days.**
- **Pain- Percocet (Oxycodone/Acetaminophen)10/325; One tab every 6 hours as needed.**
- **Adjunctive Pain – Dilaudid (Hydromorphone) 2mg; 2-3 tabs every 8 hours as needed for adjunctive pain.**
- **Constipation – Docusate (Colace) 100mg; 1 tab twice daily as needed.**
- **DVT prophylaxis- Xarelto 10mg; One tab daily x 14 days followed by Aspirin 325mg daily x 28days.**
- ******Antibiotics and Xeralto start POD #1**

Laith M. Jazrawi, MD
Associate Professor of Orthopaedics
Chief, Division of Sports Medicine
Tel: (646) 501-7223

NYU Langone MEDICAL CENTER

Post-Operative Instructions
Glenoid Reconstruction using Fresh Distal Tibial Allograft

Day of Surgery

A. Relax. Diet as tolerated.
B. Icing is important for the first 5-7 days post-op. While the post-op dressing is in place, icing should be done continuously. Once the dressing is removed on the first or second day, ice is applied for 20-minute periods 3-4 times per day. Care must be taken with icing to avoid frostbite.

You will be contacted by Gotham surgical brace company regarding an ice compression unit to be used after surgery. This helps with pain and swelling but typically is not covered by insurance. The cost is $200-300 for a 2-week rental. Alternatively, ice gel packs with a shoulder or knee sleeve can be provided by the hospital for a minimal charge.

C. Pain medication as needed every 6 hours (refer to pain medication sheet)

First Post-Operative Day

A. Continue ice pack everyone to two hours while awake and pain meds as needed or cryocuff or gameready. Ice cuff as per instructions.

Second Post-Operative Day

A. Continue ice pack up to post op day 2-5 and utilize after physical therapy sessions.

Third Post-Operative Day

A. You may remove surgical bandage and shower this evening. Apply Tegaderm (transparent medical dressing) to wounds prior to showering and remove and apply fresh Tegaderms after shower is complete
B. You will need to keep your incisions covered with Tegaderms when taking a shower for the first 2 weeks

Physical Therapy

A. Physical Therapy should begin at 4 weeks. Please call your preferred facility to make an appointment.
B. Pendulum exercises should begin after the first postoperative follow-up visit.

** Tegaderms may be purchased at local pharmacies.*
**Note: Your shoulder will be very swollen. It may take a week or longer for this to go away. It is also common to notice burning around the shoulder as the swelling resolves. If excessive bleeding occurs, please notify Dr. Jazrawi.*

Call our office @ 646-501-7223 option 4, option 2 to confirm your first postoperative visit, which is usually about 1-2 weeks after surgery. If you are experiencing any problems, please call our office or contact us via the internet at www.newyorkortho.com.

NYU Hospital for Joint Diseases
NYU LANGONE MEDICAL CENTER

Laith M. Jazrawi, MD
Associate Professor of Orthopaedics
Chief --- Division of Sports Medicine
Tel: (212) 598---6784

Anterior Stabilization of the Shoulder: Distal Tibial Allograft

Name: _____ **Date:** _____

Diagnosis: _____ **Date of Surgery:** _____

Phase I – Immediate Post Surgical Phase (approximately Weeks 1- 3)

Goals:

- Minimize shoulder pain and inflammatory response
- Protect the integrity of the surgical repair
- Achieve gradual restoration of passive range of motion (PROM)
- Enhance/ensure adequate scapular function

Precautions/Patient Education:

- No active range of motion (AROM) of the operative shoulder
- No excessive external rotation range of motion (ROM) / stretching. Stop at first
- end feel felt
- Remain in sling, only removing for showering. Shower with arm held at side
- No lifting of objects with operative shoulder
- Keep incisions clean and dry
- Patient education regarding limited use of upper extremity despite the potential
- lack of or minimal pain or other symptoms

Activity**:**

- Arm in sling except when performing distal upper extremity exercises
- (PROM)/Active-Assisted Range of Motion (AAROM)/ (AROM) elbow and wrist/hand
- Begin shoulder PROM (do not force any painful motion)
- Forward flexion and elevation to tolerance
- Abduction in the plane of the scapula to tolerance
- Internal rotation (IR) to 45 degrees at 30 degrees of abduction
- External rotation (ER) in the plane of the scapula from 0-25 degrees; begin at
- 30-40 degrees of abduction; respect anterior capsule tissue integrity with ER range of motion; (seek guidance from intraoperative measurements of external rotation ROM)
- Scapular clock exercises progressed to scapular isometric exercises
- Ball squeezes
- Sleep with sling supporting operative shoulder; place a towel under the elbow to prevent shoulder hyperextension
- Frequent cryotherapy for pain and inflammation
- Patient education regarding posture, joint protection, positioning, hygiene, etc.

NYU Hospital for Joint Diseases
NYU LANGONE MEDICAL CENTER

Laith M. Jazrawi, MD
Associate Professor of Orthopaedics
Chief --- Division of Sports Medicine
Tel: (212) 598---6784

Milestones to progress to phase II:

- Appropriate healing of the surgical repair
- Adherence to the precautions and immobilization guidelines
- Achieved at least 100 degrees of passive forward elevation and 30 degrees of passive external rotation at 20 degrees abduction
- Completion of phase I activities without pain or difficulty

Phase II – Intermediate Phase/ROM (approximately Week 4-9)

Goals:

- Minimize shoulder pain and inflammatory response
- Protect the integrity of the surgical repair
- Achieve gradual restoration of (AROM)
- To be weaned from the sling by the end of week 4-5
- Begin light waist level activities

Precautions:

- No active movement of shoulder till adequate PROM with good mechanics
- No lifting with affected upper extremity
- No excessive external rotation ROM / stretching
- Do not perform activities or strengthening exercises that place an excessive load on the anterior capsule of the shoulder joint (i.e. no pushups, pec flys, etc..)
- Do not perform scaption with internal rotation (empty can) during any stage of rehabilitation due to the possibility of impingement

Early Phase II (approximately week 4):

- Progress shoulder PROM (do not force any painful motion)
- Forward flexion and elevation to tolerance
- Abduction in the plane of the scapula to tolerance
- IR to 45 degrees at 30 degrees of abduction
- ER to 0-45 degrees; begin at 30-40 degrees of abduction; respect anterior capsule tissue integrity with ER range of motion; seek guidance from intraoperative measurements of external rotation ROM)
- Glenohumeral joint mobilizations as indicated (Grade I, II) when ROM is significantly less than expected. Mobilizations should be done in directions of limited motion and only until adequate ROM is gained.
- Address scapulothoracic and trunk mobility limitations. Scapulothoracic and thoracic spine joint mobilizations as indicated (Grade I, II, III) when ROM is significantly less than expected. Mobilizations should be done in directions of limited and only until adequate ROM is gained.
- Begin incorporating posterior capsular stretching as indicated
- Cross body adduction stretch

NYU Hospital for Joint Diseases
NYU LANGONE MEDICAL CENTER

Laith M. Jazrawi, MD
Associate Professor of Orthopaedics
Chief--- Division of Sports Medicine
Tel: (212) 598---6784

- Side lying internal rotation stretch (sleeper stretch)
- Continued Cryotherapy for pain and inflammation
- Continued patient education: posture, joint protection, positioning, hygiene, etc.

Late Phase II (approximately Week 6):

- Progress shoulder PROM (do not force any painful motion)
  - Forward flexion, elevation, and abduction in the plane of the scapula to tolerance
  - IR as tolerated at multiple angles of abduction
  - ER to tolerance; progress to multiple angles of abduction once >/= 35 degrees at 0-40 degrees of abduction
- Glenohumeral and scapulothoracic joint mobilizations as indicated (Grade I-IV as appropriate)
- Progress to AA/AROM activities of the shoulder as tolerated with good shoulder mechanics (i.e. minimal to no scapulathoracic substitution with up to 90-110 degrees of elevation.)
- Begin rhythmic stabilization drills
  - ER/IR in the scapular plane
  - Flexion/extension and abduction/adduction at various angles of elevation
- Continue AROM elbow, wrist, and hand
- Strengthen scapular retractors and upward rotators
- Initiate balanced AROM / strengthening program
  - Initially in low dynamic positions
  - Gain muscular endurance with high repetition of 30-50, low resistance 1-3 lbs)
  - Exercises should be progressive in terms of muscle demand / intensity, shoulder elevation, and stress on the anterior joint capsule
  - Nearly full elevation in the scapula plane should be achieved before beginning elevation in other planes
  - All activities should be pain free and without substitution patterns
  - Exercises should consist of both open and closed chain activities
  - No heavy lifting or plyometrics should be performed at this time
    - Initiate full can scapular plane raises to 90 degrees with good mechanics
    - Initiate ER/IR strengthening using exercise tubing at 0° of abduction (use towel roll)
    - Initiate sidelying ER with towel roll
    - Initiate manual resistance ER supine in scapular plane (light resistance)
    - Initiate prone rowing at 30/45/90 degrees of abduction to neutral arm position
- Continued cryotherapy for pain and inflammation
- Continued patient education: posture, joint protection, positioning, hygiene, etc.

Milestones to progress to phase III:

- Passive forward elevation at least 155 degrees
- Passive external rotation within 8-10 degrees of contralateral side at 20 degrees abduction
- Passive external rotation at least 75 degrees at 90 degrees abduction
- Active forward elevation at least 145 degrees with good mechanics

Laith M. Jazrawi, MD
Associate Professor of Orthopaedics
Chief -- Division of Sports Medicine
Tel: (212) 598---6784

- Appropriate scapular posture at rest and dynamic scapular control with ROM and functional activities
- Completion of phase II activities without pain or difficulty

Phase III - Strengthening Phase (approximately Week 10 – Week 15)

Goals:

- Normalize strength, endurance, neuromuscular control
- Return to chest level full functional activities
- Gradual and planned buildup of stress to anterior joint capsule

Precautions:

- Do not overstress the anterior capsule with aggressive overhead activities / strengthening
- Avoid contact sports/activities
- Do not perform strengthening or functional activities in a given plan until the patient has near full ROM and strength in that plane of movement
- Patient education regarding a gradual increase to shoulder activities

Activity:

- Continue A/PROM as needed/indicated
- Initiate biceps curls with light resistance, progress as tolerated
- Initiate gradually progressed strengthening for pectoralis major and minor; avoid positions that excessively stress the anterior capsule
- Progress subscapularis strengthening to focus on both upper and lower segments
  - Push up plus (wall, counter, knees on the floor, floor)
  - Cross body diagonals with resistive tubing
  - IR resistive band (0, 45, 90 degrees of abduction
  - Forward punch

Milestones to progress to phase IV:

- Passive forward elevation WNL
- Passive external rotation at all angles of abduction WNL
- Active forward elevation WNL with good mechanics
- Appropriate rotator cuff and scapular muscular performance for chest level activities
- Completion of phase III activities without pain or difficulty

Phase IV - Overhead Activities Phase / Return to activity phase (approximately Week 16-20)

Goals:

- Continue stretching and PROM as needed/indicated
- Maintain full non-painful AROM
- Return to full strenuous work activities
- Return to full recreational activities

Precautions:

NYU Hospital for Joint Diseases
NYU LANGONE MEDICAL CENTER

Laith M. Jazrawi, MD
Associate Professor of Orthopaedics
Chief--- Division of Sports Medicine
Tel: (212) 598---6784

- Avoid excessive anterior capsule stress
- With weight lifting, avoid tricep dips, wide grip bench press, and no military press or lat pulls behind the head. Be sure to "always see your elbows"
- Do not begin throwing, or overhead athletic moves until 4 months post-op or cleared by MD

Activity:

- Continue all exercises listed above
  - Progress isotonic strengthening if patient demonstrates no compensatory strategies, is not painful, and has no residual soreness
- Strengthening overhead if ROM and strength below 90 degree elevation is good
- Continue shoulder stretching and strengthening at least four times per week
- Progressive return to upper extremity weight lifting program emphasizing the larger, primary upper extremity muscles (deltoid, latissimus dorsi, pectoralis major)
  - Start with relatively light weight and high repetitions (15-25)
- May do pushups as long as the elbows do not flex past 90 degrees
- May initiate plyometrics/interval sports program if appropriate/cleared by PT and
- MD
- Can begin generalized upper extremity weight lifting with low weight, and high repetitions, being sure to follow weight lifting precautions.
- May initiate pre injury level activities/ vigorous sports if appropriate / cleared by
- MD

Milestones to return to overhead work and sport activities:

- Clearance from MD
- No complaints of pain or instability
- Adequate ROM for task completion
- Full strength and endurance of rotator cuff and scapular musculature for task completion
- Regular completion of continued home exercise program