Rehabilitation of the Arthrofibrotic Knee

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Abstract
This paper describes the postoperative rehabilitation of the arthrofibrotic knee, with specific emphasis on modern rehabilitation techniques. The significance of prevention and early recognition is discussed. The importance of early motion and patellar mobility is emphasized and specific exercises to prevent and treat stiffness are described. Continuous passive motion, bracing, and exercise—on the stationary bicycle, on the treadmill, and in water—are adjuncts in the program. Strengthening is added when motion is re-established and there is no swelling or pain. Sport-specific activities are added if progress is satisfactory and motion is maintained. If pain, swelling, or stiffness develops, exercises should be discontinued. Modalities such as cryotherapy, ultrasound, electrical stimulation, rest, and manipulation can be used judiciously. Anti-inflammatory and analgesic medications should be used to prevent inflammation, to control pain, and to allow more aggressive rehabilitative exercises.

Rehabilitation of the arthrofibrotic knee is among the toughest challenges in orthopedics. Care must be coordinated appropriately to achieve optimum results. Arthrofibrosis is a process that occurs when diffuse scar tissue or fibrous adhesions form within or about a joint. In the knee, such periarticular scarring can occur as a localized or a global process that can restrict flexion, extension, or patellofemoral mobility. Fibrosis of the suprapatellar pouch, as well as the medial and lateral gutters, is typical. The scarring may also occur in the anterior compartment and frequently in the posteromedial and posterolateral joint capsule. A thickened, fibrotic capsule is characteristic and, in its most severe forms, can completely prohibit joint motion.

Sprague and colleagues were among the first to describe the phenomenon of arthrofibrosis in the knee. Since that time, several reports have discussed the clinical outcomes after both arthroscopic and open surgical treatment. Millett and colleagues recently reported good outcomes after open surgery and aggressive rehabilitation in a series of patients with profound motion loss of the knee secondary to advanced arthrofibrosis.

Arthrofibrosis can be caused by a variety of factors, such as prolonged immobilization, infection, or graft malposition after ligament reconstruction. Historically, anterior cruciate ligament (ACL) reconstruction has been the major culprit, although there are many other situations in which arthrofibrosis may occur. Fortunately, a better understanding of the causes has led to improved prevention strategies and earlier recognition, which has resulted in a decrease in both the incidence and the sequelae of arthrofibrosis. Because arthrofibrosis can be so difficult to treat, prevention is clearly the best approach. Appropriate surgical indications, surgical techniques, and rehabilitation can decrease the incidence. These topics are discussed elsewhere in the literature.

When arthrofibrosis does develop, it needs to be recognized early and treated appropriately. Physical therapy and rehabilitation are essential to a good outcome. Currently, there are no reports that deal specifically with the rehabilitation of the arthrofibrotic knee. Therefore, the purpose of this paper is to discuss this topic, emphasizing modern rehabilitative techniques.

Initial Management
Prevention and Early Detection
Primary prevention of arthrofibrosis is the best management strategy. For knees with ACL injuries, arthrofibrosis can be prevented by avoiding surgery when the knee lacks full motion, by using proper surgical technique with meticulous graft placement and avoidance of bleeding, and by instituting an early and appropriate rehabilitation program.
When motion problems do occur, early detection allows for the prompt intervention that can decrease long-term morbidity. In the immediate postoperative period after any knee surgery, but particularly after ligament reconstruction, monitoring knee motion is critical. We systematically assess both flexion and extension and compare motion with that of the uninvolved, contralateral side. By serially measuring prone heel hangs, or having a 2-week goal of full extension and 120° of flexion, we can detect motion problems early and modify our rehabilitation program accordingly. In patients with arthrofibrotic knees who are treated surgically, we also carefully monitor knee motion and its progression. In this way, we can alter our physical therapy, bracing, and other modalities as needed.

Patellar mobility is important for proper knee function, and loss of this mobility is invariably involved in arthrofibrosis. We always examine the mobility of the entire extensor mechanism—the patella, the patella tendon, and the quadriceps tendon. Decreased mobility, in either the medial-lateral direction or the superior-inferior direction, can lead to patellofemoral overload with pain and poor outcomes. Scarring and adhesions in the anterior interval (pretibial recess) or suprapatellar pouch will increase patellofemoral contact forces, alter patellofemoral tracking, and cause pain.5,10

When motion loss is detected, a careful systematic evaluation should help establish the correct cause, allowing for targeted treatment. Magnetic resonance imaging (MRI) may assist in evaluating the soft tissues; often, an ACL nodule, fat pad scarring, or adhesions can be noted. Suprapatellar scarring can be felt on exam and seen on MRI as the suprapatellar pouch becomes compartmentalized and abnormally shortened. This leads to a decreased excursion of the extensor mechanism and patellar entrapment. Patellar height should also be assessed. By carefully measuring patellar height both on exam and with radiographs, patella baja may be detected.

Other potential causes of motion loss after reconstructive knee surgery include an ACL nodule or reflex sympathetic dystrophy. By palpation, the examiner may be able to detect the subcutaneous or “clunk” of an ACL nodule.11 The clinician should be alert for the possibility of reflex sympathetic dystrophy in patients who develop pain out of proportion to the diagnosis maneuvers, alldynia, or trophic or sudomotor changes.12

Early recognition and intervention are essential to prevent the sequelae of arthrofibrosis, which include patella baja and progressive joint degeneration. Noyes and colleagues13 found that by placing patients with early motion problems into an aggressive rehabilitation program that included serial casting and aggressive motion exercises, outcomes could be improved.

**Surgical Management**

**Arthroscopic or Open?**

A detailed description of the specific techniques of surgical treatment for arthrofibrosis can be found elsewhere in the literature.6,7,14-16 Briefly, to outline our approach, we treat the majority of patients who develop arthrofibrosis with an arthroscopic procedure, distending the capsule and releasing scar tissue, adhesions, and other surgically correctable lesions.15,16 Particular attention is paid to mobilizing the extensor mechanism by re-establishing the suprapatellar pouch, releasing the medial and lateral retinacula, maintaining the pretilibial recess, and inspecting the notch for impingement. Restoring mobility to the extensor mechanism is key to decreasing anterior knee pain and to restoring knee function. In certain instances in which the motion loss is severe, open releases may be necessary to accomplish this goal.2,13 A systematic 9-step evaluation to the surgical management of the arthrofibrotic knee should be undertaken (Table).3 Whenever surgery of the arthrofibrotic knee is undertaken, an appropriate rehabilitation and pain management protocol must follow in order to achieve optimal results.

**The Role of Manipulation**

In certain instances, such as in those patients with relatively mild involvement, a nonoperative approach can be initiated. This consists of physical therapy and possibly a manipulation of the knee under anesthesia. Although manipulation under anesthesia can be used to improve motion in the arthrofibrotic knee,13 we generally recommend an arthroscopic release to libe- rate the tight capsular tissues and to remove adhesions.17 We believe surgical intervention can address the offending contracted tissue more precisely, helping to avoid collateral damage and minimize bleeding. To our knowledge, there is no data that

<table>
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<tr>
<th><strong>Table. 9-Step Surgical Evaluation of the Arthrofibrotic Knee</strong></th>
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<tr>
<td>1. Suprapatellar pouch—free adhesions/mobilize</td>
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<tr>
<td>2. Medial gutter—free adhesions/mobilize</td>
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<tr>
<td>3. Lateral gutter—free adhesions/mobilize</td>
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<tr>
<td>4. Infrapatellar fat pad/pretilibial recess—re-establish normal anterior interval of the knee</td>
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<td>5. Lateral retinaculum—perform lateral retinacular release if tight or scarred</td>
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<tr>
<td>6. Medial retinaculum—perform medial retinacular release if tight or scarred</td>
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<tr>
<td>7. Intercapsular notch—peel off scar tissue; in severe cases release ACL and/or PCL</td>
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<tr>
<td>8. Tibial insertion of posterior capsule—inspect capsular recess, medial and, if necessary, lateral capsulotomies</td>
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<td>9. Femoral insertion of posterior capsule—release if necessary</td>
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specifically addresses the timeframe during which a manipulation would be most effective. Our experience treating patients with postoperative or posttraumatic arthrofibrosis indicates that immature scar tissue can be successfully broken up by manipulation but that mature scar tissue cannot. Exactly when scar tissue becomes mature is a subject of contention; we estimate the timeframe to be 3 to 4 months.

Because of the unpredictability and danger of manipulation, we rarely, if ever, perform an isolated manipulation in a chronically stiff knee. Instead, we prefer a more controlled surgical release, and this can usually be accomplished arthroscopically. Forceful manipulation of the stiff knee can cause excessive joint compression leading to articular cartilage damage or even fracture.

Other authors, however, have reported manipulation to be a successful and useful adjunct. Dodds and colleagues reported the results of manipulations of 42 knees with persistent flexion or extension deficits after intra-articular ACL reconstructions. At manipulation, average flexion increased from 95° to 136°, and average extension from 11° to 3°. At final follow-up, average flexion was 127° and average extension was 4°. Final range of motion (ROM) was not affected by time to manipulation, severity of flexion deficit, or concomitant arthroscopic débridement of adhesions. However, knees with pre-manipulation extension deficits of greater than or equal to 15° achieved significantly less final extension than knees with lesser pre-manipulation deficits. The authors concluded that manipulations were a safe and effective method for improving both flexion and extension in knees that had restricted motion after ACL reconstructions.

Our use of manipulation is summarized in the box below.

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### OUR APPROACH TO USING MANIPULATION SUMMARIZED

We view manipulation as an option that works best for flexion deficits in milder and early cases of arthrofibrosis, when the scar tissue is relatively immature. Generally, we prefer to avoid manipulation as a first-line treatment and instead advocate arthroscopic surgical releases. Formal lesions, such as ACL nodules, malpositioned grafts, or dense adhesions, respond better to surgery. When manipulation is chosen, it should be performed gently so as not to overload the chondral surfaces and cause further degeneration. With forceful manipulation, one also must be careful to avoid rupturing the quadriceps or tearing the muscle, which can lead to myositis. The optimum timeframe for performing a manipulation is unclear, but we do not recommend manipulation in long-standing or chronic cases of arthrofibrosis.

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### Analgesia and Anti-inflammatory Medications

After surgery, pain control is essential, as it allows rehabilitation to begin without undue discomfort. Analgesia may be achieved with oral or injectable opioids, but in many cases we prefer to utilize indwelling epidural catheters for a few days postoperatively. This permits total analgesia and allows for more aggressive motion exercises. Collaborating with pain management specialists or anesthesiologists is often helpful. We also advocate the use of anti-inflammatory medications in conjunction with epidural analgesia in the immediate postoperative period. We routinely use nonsteroidal anti-inflammatory drugs and, in severe cases, may consider a short course of intravenous corticosteroids.

### Rehabilitation

#### Early Motion

Early motion is key for the successful rehabilitation of the postoperative arthrofibrotic knee. We have known for some time that prolonged immobilization has detrimental effects on periarticular cartilage, bone, and soft tissues and can lead to motion loss. Therefore, modern rehabilitation programs have stressed early motion and weight-bearing, resulting in fewer motion problems and better outcomes. Several researchers have shown that patients recovering from ACL reconstruction who participated in early motion and weight-bearing had a decreased incidence of motion loss and regained extension more quickly. We also advocate early motion after surgery for knee arthrofibrosis. Poor rehabilitation, whether due to lack of motivation or lack of instruction, will adversely affect the ultimate outcome.

While knee ROM varies from individual to individual, most normal knees have some degree of hyperextension (average, 5° in males, 6° in females). Hyperextension not only allows the normal "screw home" mechanism to occur but also permits the quadriceps to relax during stance phase. Normal knee flexion is approximately 140° in men and 143° in women, and while small flexion deficits typically do not alter gait, most readily notice a unilateral or asymmetric loss of flexion, particularly those involved in running or jumping sports.

Our motion goals are determined at the conclusion of surgery for knee arthrofibrosis. Although restoring full motion is the ultimate goal, avoiding damage to the quadriceps and patellar tendons is also crucial. Passive ROM can be done by wall slides, by seated flexion and extension exercises, by prone flexion exercises, or by heel slides. Hamstring and calf muscle strengthening is also performed to stretch the posterior capsule and soft tissues. To encourage knee
extension, we instruct patients to prop up their heels when resting supine or to hang their legs off the table.
a splint that applies a series of increasing incremental displacements over a constant period of time. This method theoretically causes plastic deformation of the soft tissues by the displacement, which the brace then maintains. The brace is used 2 to 3 times daily for 30 minutes, and the patient is instructed to increase the stretch every 5 minutes.

While many brace options exist, they nevertheless must be used properly. Improper use can cause excess compressive loads on the chondral surfaces, leading to unnecessary cartilage wear and joint degradation.

**Stationary Bicycle**

The stationary bicycle is utilized for restoring normal joint kinematics, soft tissue mobility, and muscle re-education. The bicycle has classically been used to increase ROM. We have also found the repetitive motion of the bike helpful to loosen and mobilize the soft tissues. We set the seat height so that patients have approximately 10° of knee flexion at the bottom of the pedal stroke.

While the bicycle may be introduced in the first postoperative week, often we delay its use until postoperative day 14 to decrease the incidence of swelling or joint irritation. In most cases, patients spin without any resistance for the first 6 weeks. After 6 weeks, patients are permitted to increase the revolutions per minute and to add resistance, provided there is no loss of motion, sign of heat, or swelling. At approximately 3 months postoperatively, advanced speed intervals can be utilized for low-load strengthening.

**Treadmill**

The treadmill can be used to improve cardiovascular and muscle endurance and is introduced as early as 1 week postoperatively. A 7% to 12% incline minimizes patellofemoral contact stresses and is beneficial to the soft tissues and muscles of the knee. At 6 weeks, backward treadmill walking can be added. This is an excellent exercise for quadriceps conditioning that places relatively low stress on the patellofemoral joint. Time spent walking backwards can be increased every 2 weeks as tolerated by the patient.

**Aquatherapy**

Deep water jogging is begun when the surgical incisions have healed. From weeks 2 to 6, deep water running in a fashion that mimics jogging is done 2 to 3 days per week, for 20 to 30 minutes per session. At 6 to 8 weeks postoperatively, aquatherapy can be advanced by the addition of training fins that increase resistance. The patient performs a ‘flutter kick’ and uses a kickboard to help isolate the lower body. We have found the flutter kick to be particularly useful and safe for the patellofemoral joint.

**Figure 2. Elastic resistance exercises.** An elastic resistance cord is used to perform each of these exercises. The patients initially start with high repetitions and low resistance to build endurance. Over time, resistance can be increased by altering the cord. (A) The double knee bend, a closed-chain exercise that strengthens both the quadriceps and hamstring muscle groups. Notice that the patient does not bend more than 30°-40° to decrease patellofemoral contact stresses. (B) The “carpet drag,” which strengthens the hamstring muscles. (C) The seated leg press, which strengthens the quadriceps muscle group.

**Elastic Resistance Strengthening**

The first phase of strengthening is started with elastic resistance exercises, concentrating on high repetitions with moderate resistance. Our goal is maintaining mobility while regaining strength and endurance. The first 3 exercises are the double knee bend, the “carpet drag,” and the leg press (Figure 2). More advanced exercises such as forward or backward jogging, single knee bends, and side-to-side lateral agility can be added as tolerated. If proper knee mobility is maintained, advanced strength exercises are performed to increase the load on the muscle. Any exercises that cause stiffness or swelling in the knee joint or extensor mechanism are immediately discontinued.
**TYPICAL POSTOPERATIVE PROTOCOL**

Our typical postoperative protocol is multifaceted:

- **Weight-bearing as tolerated.**
- **Continuous passive motion (CPM)**
- **Hyperextension to 90°, increase as tolerated.**
- **Dynamic splint for 1 hour after physical therapy.**
- **Night.**
- **Full passive, active, and active-assisted ROM.**
- **Patellar and extensor mobilizations.**
- **Exercise bike—both legs start within first week as tolerated.**
- **Treadmill—2 weeks postoperatively.**
- **Sport cord—wait until 2 weeks postoperatively.**
- **Water exercises when incisions are healed.**
- **Daily outpatient physical therapy for 1 week.**
- **Continue outpatient physical therapy 6 times per week for 6 to 8 weeks.**

Before surgery, we carefully document the motion loss, and determine the specific cause. In the operative suite, the knee capsule is stretched with saline to stretch the thickened capsule and to disrupt the intra-articular adhesions. Subsequently, the arthroscope is inserted; the arthroscopic examination, if performed (Table, page 32), and appropriate surgical treatment is performed, as described elsewhere. After surgery, patients are typically hospitalized for 24 to 48 hours, but in severe cases may remain hospitalized for 4 to 6 days. When there is global arthrofibrotic involvement of the knee or when extensive surgical releases are performed, we use indwelling epidural catheters for the first 48 to 72 hours to provide pain relief. Analgesia of the affected extremity is extremely important as it allows us to mobilize the limb without undue discomfort to the patient. A nonsteroidal anti-inflammatory medication, such as ketorolac, is also administered for both its anti-inflammatory and analgesic effects.

**Modalities**

**Cryotherapy**

Cryotherapy is a simple and successful means to control swelling, pain, and inflammation. Ice can be used liberally after each exercise session and as needed when not exercising. Our protocol is 20 minutes “on,” with at least 1 hour between sessions.

**Ultrasound**

Ultrasound has been shown to increase the elasticity of soft tissues, which may be beneficial in suppressing scar tissue formation. This can be used as early as 2 weeks postoperatively.

**Electrical Stimulation**

Electrical stimulation can be used for swelling reduction and muscle re-education. In severe cases of arthrofibrosis, the quadriceps muscle may be shut down due to excessive scarring or swelling. An external electrical stimulation device may be indicated in such instances. A variety of currents can achieve an adequate muscle contraction.

**When Motion May Do Harm**

In certain instances, rest and observation are the best methods of treatment for the stiff knee.

The “Hot Knee”

A knee that is acutely inflamed with soft-tissue swelling and loss of motion, the so-called “hot knee,” should not be treated forcefully. Rest, ice, and anti-inflammatory agents are necessary to avoid further inflammation and motion loss. This can occur after any surgical or traumatic insult to the knee.
In such knees, tissue injury has led to the release of cytokines and growth factors that result in inflammation, scar tissue formation, fibrosis, and joint contractures. Active manipulation at this time will only accelerate the process. When a "hot knee," which is caused by inflammation, RSD has a poorly defined neurogenic cause. Pain out of proportion to the stimulus, allodynia, and skin changes are common features. RSD can cause stiffness from swelling, which is usually extra-articular or from increased sensitivity to pain. Gentle and appropriate rehabilitation can hasten recovery while overzealous or aggressive treatment may only exacerbate the underlying complex regional pain syndrome. Recognition is key. The management of such knees, however, is beyond the scope of this paper.

Myositis

Another uncommon cause of motion loss is myositis, which can be severely disabling owing to pain and stiffness. In suspected cases, radiographs should be carefully reviewed for soft tissue calcifications, which may be seen as early as 6 weeks after injury but often require 3 months or more to develop. If calcifications are noted, aggressive attempts at restoring motion should be avoided. With time, the soft tissue insult will clear and motion will return. However, pain can persist over the calcified area for months. On occasion, extensive periarticular calcifications can result in severe loss of motion, and surgical excision and release may be indicated.

Summary

Rehabilitation of the arthrofibrotic knee is among the most difficult challenges in orthopedics. Physical therapy is usually a first-line approach to any postoperative problem with motion about the knee and is essential after surgical treatment of the arthrofibrotic knee. In this paper, we have outlined our standard protocol for the postoperative rehabilitation of the arthrofibrotic knee.

The first step is to recognize and diagnose arthrofibrosis accurately. Then, a rational approach that focuses on maintaining and regaining motion can be implemented. In the early postoperative period we stress ROM exercises and patellar mobility. We utilize the CPM machine, gentle manipulation, and the stationary bike as rehabilitative aids. We avoid stimulating inflammation and are careful to rest the "hot knee." If increased swelling, inflammation, or pain occur, it is best to rest the knee and allow this phase to pass. Ice and anti-inflammatory agents are used liberally to prevent inflammation and to provide analgesia. Once motion is established, we slowly begin strengthening with elastic resistance exercises, aqua jogging, and the treadmill. Eventually we allow sport-specific rehabilitation and a return to full activities.

Acknowledgments

The authors wish to thank Lottie Applewhite for her help in preparing this manuscript.

References

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