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ORTHOPAEDIC SPORTS MEDICINE

POST-OPERATIVE INSTRUCTIONS

Tibial Plateau Fracture Repair

What to do, what to expect, and when to call — for the first two weeks after surgery.

At a glance

Dressing	Multi-layer bandage with brace. Outer layers off on day 3; small white tape strips stay on.
Brace	Locked in full extension for the first week. Unlocked at your post-op visit.
Weight bearing	Non-weight bearing (NWB) — no weight through the operative leg. Crutches or walker at all times.
Motion machine (CPM)	If prescribed: ~4 hours/day. Start at 30°, advance 10°/day. Return at 100°.
DVT prophylaxis	Aspirin 81 mg twice daily while on crutches.
First post-op visit	5–10 days after surgery.

Diet

Begin with clear liquids — Jell-O, broth, Gatorade — along with light foods like crackers or toast. Once you tolerate these without nausea, gradually progress to your normal diet over the following day.

Wound care

You will leave the operating room with a multi-layer dressing. From the outside in: a stretchy tan elastic bandage (ACE wrap), then a soft white cotton wrap (Webril), then white gauze pads and a yellow ointment-coated mesh (Xeroform), and small white tape strips (Steri-Strips) directly on the skin. Keep this dressing clean and dry for the first **3 days**.

On day 3, remove the dressing in this order:

1. Unclip or remove the brace if wearing one.
2. Unwrap or cut off the stretchy tan outer wrap.
3. Pull apart the soft white cotton wrap — it tears easily with your fingers.
4. Remove and discard the white gauze pads and yellow mesh beneath them.
5. **Leave the small white tape strips on your skin.** They will lift off on their own over 1–2 weeks. Do not pick at them.

Once incisions are dry for 24 hours, you may shower — let water run over them, pat dry, do not scrub. **No baths, pools, hot tubs, or ocean until cleared at follow-up.**

Understanding your pain

Some pain after surgery is normal and expected. Pain in the 0–4 range is generally well-managed by the scheduled non-opioid regimen below. If your pain rises above a 4, the breakthrough oxycodone is available. If pain feels uncontrolled, unrelenting, or getting worse rather than better, call the office.

Multimodal pain regimen

Your post-operative pain plan is based on multiple recent randomized controlled trials.[1–5] These studies show that a scheduled regimen of non-opioid medications provides equal or better pain control than opioids, with fewer side effects. Take these medications even if you feel comfortable — they work best taken consistently. Take with food when possible.

DAYS 1–5

MEDICATION	MORNING	NOON	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	—	1 tab
Gabapentin 300 mg	1 tab	1 tab	1 tab	—
Methocarbamol 750 mg	1 tab	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab	—

DAYS 6–7 · GABAPENTIN TAPER BEGINS

MEDICATION	MORNING	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	1 tab
Gabapentin 300 mg	1 tab	—	1 tab
Methocarbamol 750 mg	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab

DAYS 8–9 · GABAPENTIN TAPER CONTINUES

MEDICATION	MORNING	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	1 tab
Gabapentin 300 mg	1 tab	—	—
Methocarbamol 750 mg	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab

DAYS 10–14 · MAINTENANCE

MEDICATION	MORNING	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	1 tab
Methocarbamol 750 mg	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab

BREAKTHROUGH OXYCODONE — 15 TABLETS PRESCRIBED

Many patients do not need any oxycodone. If your pain rises above a 4, take 1 tablet of

oxycodone 5 mg. Use only as needed, for as short a time as possible.

DRIVING AND OPERATING MACHINERY

Three medications in this regimen — **gabapentin** (days 1–9), **methocarbamol** (days 1–14), and **oxycodone** if taken for breakthrough pain — can cause drowsiness, dizziness, or impaired coordination. While taking any of these, do not drive, operate heavy machinery, or make important financial, legal, or major life decisions. Plan to have someone else drive for at least the first week, and do not drive until you have stopped gabapentin, are off oxycodone, and feel the methocarbamol is no longer affecting your alertness.

Journavx (suzetrigine) — optional

Journavx is a non-opioid FDA-approved analgesic (2025) comparable to hydrocodone/acetaminophen without addiction risk, sedation, or driving impairment.[6,7] Ask the office for a prescription if interested. **Cost:** ~$15/pill, often not insurance-covered. **First dose:** 100 mg on an empty stomach; then 50 mg every 12 hours with or without food. No grapefruit.

DRUG INTERACTIONS — READ BEFORE REQUESTING

Do not take with: ketoconazole, itraconazole (Sporanox), voriconazole (Vfend), posaconazole (Noxafil), clarithromycin (Biaxin), ritonavir/cobicistat medications (Paxlovid, Norvir, Kaletra, Stribild, Genvoya, Symtuza, Evotaz, Prezcobix), nefazodone, carbamazepine (Tegretol), phenytoin (Dilantin), phenobarbital, rifampin, rifabutin, or St. John's wort.

Contact your prescribing physician before taking if you take: fluconazole (Diflucan), erythromycin, ciprofloxacin (Cipro), diltiazem (Cardizem/Tiazac), verapamil (Calan/Verelan), fluvoxamine (Luvox), or efavirenz (Sustiva).

Hormonal contraception: Use backup non-hormonal method if your contraceptive contains a progestin other than levonorgestrel or norethindrone — during treatment and 28 days after stopping.

Blood clot prevention

Take one 81 mg aspirin ("baby aspirin") twice daily for as long as you are using crutches. Stop once walking comfortably without crutches.

DO NOT START ASPIRIN IF ANY OF THE FOLLOWING APPLY — CALL THE OFFICE FIRST

- Allergy to aspirin
- Active stomach ulcer or recent gastrointestinal bleeding
- Already taking a blood thinner (warfarin, Eliquis, Xarelto, Pradaxa, Plavix, etc.) or known bleeding disorder

If you already take aspirin daily for cardiac reasons, call the office to discuss the appropriate dose.

Brace and activity

Use crutches or a walker at all times. **Keep the operative leg completely off the ground — no weight at all.** The tibial plateau is the top surface of the shin bone; bearing weight before healing can cause the repair to fail.

The brace is locked in full extension for the first week — remove only for showering, exercises, and the CPM. **Do not place pillows behind the knee.** Elevate the leg to chest level when resting.

> **NON-WEIGHT BEARING IS STRICTLY ENFORCED**
> Even briefly touching the foot down to catch yourself counts as bearing weight and can displace the repair. Use crutches or a walker for all movement, including to the bathroom at night.

Ice and cold therapy

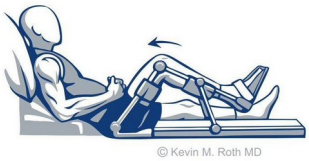
Begin icing immediately after surgery. **Bagged ice or gel packs:** 20 minutes at a time, no more than once per hour, with a cloth between ice and skin. **Cold-therapy devices (Game Ready, Polar Care, Breg, etc.):** use for 20–30 minutes at a time, up to 4 times per day, with a thin cloth between the pad and your skin — or follow the specific instructions for your device if different. If you had a nerve block, the limb may be numb for 12–72 hours — watch the clock carefully.

Exercises

Begin exercises 24 hours after surgery, at least **3 times per day.** Try to perform 3 sets of 10 repetitions initially; you may increase to 15 repetitions if tolerated. Formal physical therapy starts after your first post-op visit. Do ankle pumps throughout the day to minimize blood clot risk.

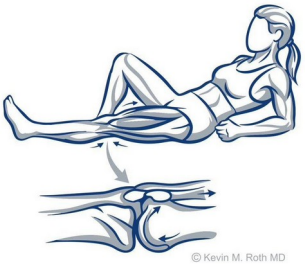
Continuous passive motion (CPM)

If a motion machine (CPM) was prescribed, use it approximately 4 hours per day. It is fine to sleep in the CPM. Remove the brace before getting in. Start at 30° and advance 10° per day; once you reach 100°, you may return the unit. When not in the CPM, elevate the leg to chest level whenever possible to reduce swelling.



Quadriceps sets

Lie or sit with leg fully extended. Tighten the front thigh muscle to flatten the knee against the bed or floor.



Heel props

Heel on a rolled towel or armrest, nothing behind the knee, let it relax and straighten. A 2–5 lb weight on the thigh can help.

Prone heel hangs

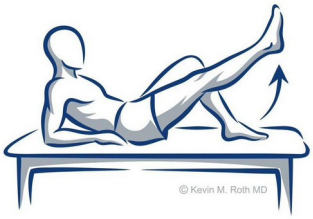
Stomach on a bed, knee at the edge, foot hanging off. Let gravity straighten the knee.

Heel slides

Slide heel toward thigh to bend the knee, hold, then straighten.

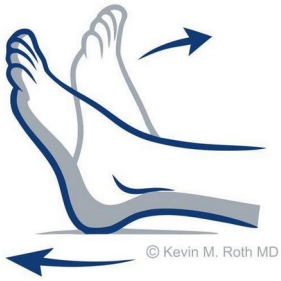
Straight leg raises

Tighten quad, lift heel 4–6 inches with knee straight, lower slowly.



Ankle pumps

Foot up and down like a gas pedal — 20–30 reps every few hours.



No tobacco or nicotine

Do not use tobacco or nicotine products for at least 3 months after surgery. Nicotine significantly increases the risk of infection, wound healing problems, and failure of the repair. For help quitting, call **1-800-QUIT-NOW**.

BLOOD CLOT WARNING SIGNS

Lower extremity surgery combined with reduced activity increases the risk of a blood clot forming in the leg. Know these warning signs:

Signs of a blood clot in the leg (DVT):

- Swelling in the calf or thigh — can occur on either the operative or non-operative side
- Pain or tenderness in the calf, especially behind the knee
- Redness, warmth, or bluish discoloration of the leg

Signs of a blood clot in the lung (pulmonary embolism — a medical emergency):

- Sudden shortness of breath
- Sharp chest pain, especially with deep breathing
- Rapid heart rate
- Unexplained cough, sometimes with blood-tinged mucus

If you have DVT symptoms, call **(650) 853-2943** or go to the nearest ER. **If you have PE symptoms, call 911 immediately.**

When to call

Call **(650) 853-2943** for any concern, day or night.

- Pain not controlled by the regimen above, or getting worse rather than better
- Numbness lasting more than 24 hours, or longer than expected from your nerve block
- Fever above 101 °F
- Increasing redness, warmth, or tenderness around the incisions
- Persistent or increasing drainage or bleeding from the incision
- Calf pain or swelling
- Color change in the operative limb
- Blistering of the skin
- Any other concern

GO TO THE NEAREST EMERGENCY ROOM IMMEDIATELY FOR

- Difficulty breathing
- Severe chest pain
- Loss of consciousness
- Pain that is completely uncontrollable

Follow-up

If you do not already have a follow-up appointment, call **(650) 853-2943** to schedule. Most follow-up visits are 5–10 days after surgery.

REFERENCES

1. Moutzouros V, et al. A multimodal protocol to diminish pain following common orthopedic sports procedures. *Arthroscopy.* 2020;36(8):2249–2257.
2. Moutzouros V, et al. Can we eliminate opioids after ACL reconstruction? *Am J Sports Med.* 2021;49(14):3794–3801.
3. Jildeh TR, et al. Multimodal nonopioid pain protocol following meniscus surgery. *Arthroscopy.* 2021;37(7):2237–2245.
4. Jildeh TR, et al. Multimodal nonopioid protocol following arthroscopic rotator cuff surgery. *Arthroscopy.* 2022;38(6):1077–1085.
5. Syed UAM, et al. Effect of preoperative education on opioid consumption. *J Shoulder Elbow Surg.* 2018;27(6):962–967.
6. Bertoch T, et al. Suzetrigine, a nonopioid NaV1.8 inhibitor: two phase 3 trials. *Anesthesiology.* 2025;142(6):1085–1099.
7. Alvarez-Aguilar P, Picado-Loaiza S. Suzetrigine versus placebo for acute postoperative pain. *Medicine.* 2026;105(10):e47877.

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