KEVIN M. ROTH, MD
ORTHOPAEDIC SPORTS MEDICINE

POST-OPERATIVE INSTRUCTIONS

Distal Biceps Tendon Repair

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

At a glance

Dressing	Plaster splint over the surgical dressing — keep clean and dry. Removed by Dr. Roth's team at your first post-op visit.
Splint → sling	Splint for about the first week. At your first post-op visit it comes off and you transition to a sling, which you wean out of over weeks 2–4 as comfort allows.
The 1-pound rule	Nothing heavier than a coffee cup in the operative hand for the first 6 weeks. No lifting, carrying, pushing, pulling, or twisting against resistance.
Forearm numbness	A patch of numbness or tingling on the thumb-side of the forearm is common after this surgery and usually resolves on its own — see the numbness section below.
Driving	No driving until discussed with Dr. Roth.
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.

Splint care

Your operative extremity is in a plaster splint after surgery. Keep it clean and dry until your follow-up appointment when Dr. Roth's team will remove it.

To shower, place a large garbage bag over the splint and seal it above the splint with duct tape. A rubber band alone will not create a tight enough seal.

Do not attempt to remove or adjust the splint yourself.

If the splint feels too tight or you cannot get comfortable, call the office immediately.

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 — 10 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.

Protecting the repair — the 1-pound rule

The biceps tendon has been reattached to the bone of your forearm. Until it heals, the two motions that pull directly on the repair are **bending the elbow against resistance** and **rotating the palm upward against resistance** (like turning a stiff doorknob or opening a jar). Protecting the repair from those loads matters far more than protecting it from gentle motion.

THE 1-POUND RULE — FIRST 6 WEEKS

For the first 6 weeks, do not lift, carry, push, or pull anything heavier than a **coffee cup** with the operative arm. In addition:

- No twisting against resistance — jars, doorknobs, screwdrivers, bottle caps
- No carrying bags, groceries, or a briefcase in the operative hand
- Do not use the operative arm to push yourself up from a chair or bed

Gentle motion is good for the elbow and will be started early — loading is what must wait.

Splint, sling, and activity

You will leave the operating room with your elbow in a plaster splint at roughly a right angle. The splint stays on until your first post-op visit (5–10 days), when Dr. Roth's team removes it. You will then transition to a **sling for comfort and protection**, which you may wean out of gradually over weeks 2–4 as comfort allows. Unlike older protocols, you will not be locked in a brace for six weeks — recent high-quality studies show that starting protected motion early leads to better function without increasing the risk of re-tear, and your repair was performed with strong fixation designed to allow it.

Gentle elbow motion begins once the splint is removed, guided by your physical therapist — formal physical therapy starts after your first post-op visit and follows Dr. Roth's distal biceps therapy protocol, including a temporary limit on how far you straighten the elbow that is relaxed week by week.

Keep the operative elbow **elevated above shoulder level** whenever you are sitting or resting for the first 1–2 weeks — this significantly reduces swelling. You may return to sedentary work or school **3–4 days after surgery** if tolerable and not taking opioids. No driving until discussed with Dr. Roth.

Exercises

While the splint is on, there is no elbow exercise — the elbow rests. Keep the rest of the arm moving:

- **Fingers and wrist.** Straighten and bend your fingers and make a full fist at least 4 times per day for 5–10 minutes each session. This maintains circulation and prevents stiffness in the hand.
- **Shoulder.** Gentle shoulder motion — shrugs, shoulder blade pinches, and letting the arm dangle and sway while bending forward — keeps the shoulder from stiffening while the elbow is protected.
- **Walk.** Get up and walk for a few minutes at least once every few hours while awake — this minimizes blood clot risk from prolonged rest.

Elbow and forearm motion begin when the splint comes off at your first post-op visit, and your physical therapist will progress them from there.

Ice and cold therapy

Because you have a splint, use gel ice packs or bags of frozen vegetables — **the splint must not get wet.** Apply for 20–30 minutes at a time, up to 4 times per day. If you had a nerve block, your arm may be numb for up to 24–72 hours — watch the clock carefully when icing.

Numbness on the forearm — usually expected

> **A NUMB PATCH ON THE THUMB-SIDE FOREARM IS COMMON — AND USUALLY TEMPORARY**
>
> The incision for this surgery is near a small skin-sensation nerve (the lateral antebrachial cutaneous nerve). Numbness or tingling over the **thumb-side of the forearm** occurs in a meaningful share of patients, and in the large majority it resolves on its own over weeks to a few months. It does not affect the strength of the repair. Mention it at your post-op visits so it can be followed — but on its own it is not a reason to worry.
>
> **Different — and worth a same-day call:** new **weakness** straightening your fingers or lifting your wrist upward. Call the office if you notice this.

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**.

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
- New weakness straightening the fingers or lifting the wrist upward
- Numbness that is spreading or worsening (the stable thumb-side forearm patch described above is expected)
- Fever above 101 °F
- Increasing redness, warmth, or tenderness around the incision
- Persistent or increasing drainage or bleeding from the incision
- Color change in the operative limb
- Blistering of the skin
- The splint feels too tight, or you cannot get comfortable in it
- 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

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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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