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St. Charles Center for ORTHOPEDICS & NEUROSURGERY

Rehabilitation Protocol
Primary Reverse Total Shoulder Arthroplasty

Phase 1: *Hospital to 1st Follow up – Protect Subscapularis (0 to 2 weeks)*

- Patients may shower on Post op day #3 - over plastic, waterproof dressing
- Waterproof dressing will be removed by surgeon at 1st post-op visit
- Sutures are all underneath the skin and will dissolve on their own
- **Sling should be worn at all times** except for showering and while performing shoulder exercises
- While lying supine, the distal humerus/elbow should be supported by a pillow or towel roll to avoid shoulder extension
- Therapist should teach the following in hospital on POD1 to be performed 3 times per day starting immediately:
  - Elbow, forearm, and hand AROM
  - Supine passive ROM – flexion to 130, ER to 20

    ****Supine exercises should be performed with a small towel placed behind the elbow to avoid shoulder hyperextension and anterior capsular stretch****
  - Emphasize home program

Phase 2: *Protect the Subscapularis (2 to 6 weeks)*

- Sling should be worn at night, ok to remove abduction pillow. Remove the sling during the day with the following restrictions:
  - Limit ER to 20
  - No resisted IR, and **no PROM/AAROM into IR beyond neutral (0°)** — early stretch into IR tensions the healing subscapularis repair and is a likely contributor to the late anterior stiffness pattern this revision targets
  - Avoid extension of shoulder
  - Avoid reaching behind the back
  - Do not lift anything greater than 2 to 3 lbs with the involved hand
  - While lying supine, the distal humerus/elbow should be supported by a pillow or towel roll to avoid shoulder extension
- Continue Phase 1 exercises with the addition of:
  - Pendulums
  - AAROM - Pulleys into scapular plane elevation to 130, ER to 20
  - Supine AAROM into flexion and ER with above limits
  - Emphasize home program

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Phase 3: *(6 weeks – 10 weeks)*

Lifting restriction of 10 pounds remains

- **New:** Initiate PROM/AAROM into internal rotation in the scapular plane (arm supported at the side, elbow near 90°) — begin gently and advance as tolerated. Do **not** combine IR with extension or adduction (i.e., no hand-behind-back stretching) until 8 weeks, to protect the maturing subscapularis repair
- Advance AROM and PROM as tolerated
  - Maintain ER limit of 30 until 10 weeks
  - Advance elevation as tolerated
- Scapular stabilizer strengthening
- Strengthen rotator cuff and shoulder musculature (Isometrics, Theraband, dumbbell, etc). AVOID RESISTED IR OR EXTENSION UNTIL 10 WEEKS.
- **New:** At each visit, document functional IR by spinal landmark reached (e.g., sacrum, L3, T12) — this creates an early trend line so a stalling IR trajectory is caught well before the 3–4 month mark

Phase 4: *(>10 weeks)*

- Advance shoulder ER range of motion as tolerated (Light stretching only)
- May initiate subscapularis strengthening (resisted IR and extension)
- Advance shoulder and rotator cuff strengthening as tolerated
- Incorporate low level functional activities at 3 months (swimming, water aerobics, light tennis, jogging)
- Start higher-level activities at 4 months (tennis, light weight training, and golf)
- Initiate functional progression to sports specific activities at 4 months

New — Anterior Capsule / Extension Mobility Progression (begin once above criteria are met, ~10–12 weeks):

Rationale: functional (hand-behind-back) IR requires >40° of shoulder extension. Months of protective extension avoidance allow the anterior capsule/subscapularis to adaptively shorten — this progression directly re-lengthens those structures once the repair has matured.

- Progressive doorway/corner anterior capsular stretch into horizontal abduction and extension, advancing arm position weekly as tolerated
- Progressive towel- or wand-assisted hand-behind-back stretch (combined extension + IR + adduction), 2–3x/day, gentle end-range hold
- Thoracic extension mobility (foam roller or wall thoracic extensions) — improves the trunk-extension contribution to functional IR
- Cross-body adduction stretch for the posterior capsule — lateralized glenosphere designs can over-tension the posterior capsule, which also restricts IR
- Functional task practice: simulated toileting, dressing, and hygiene tasks to reinforce combined-motion IR carryover

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Red Flag / Escalation Criteria — refer back to surgeon if:

- No improvement in functional IR spinal landmark over a **4-week** period by the **12-week** visit
- Active or passive IR remains substantially restricted at the **3-month** visit despite consistent home program adherence
- Marked asymmetric loss of passive extension or anterior capsular end-feel (firm/capsular, non-painful block) on exam

Early referral allows consideration of manipulation under anesthesia, targeted anterior capsular mobilization, or formal PT re-evaluation *before* soft tissue matures into a fixed contracture