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Shoulder Hemiarthroplasty / Total Shoulder Rehabilitation Protocol

TYPE I - FIXATION AND STABILITY GOOD

PHASE I (2nd Day to 4th Week Postop)

2-5 Days Postop

- Early passive ROM's & active assisted ROM's
  - Supine position
    - Forward elevation passive and assisted
    - External rotation with arm at side - no more than 30°

5 Days - 4 Weeks

- Continue above ROM's
- Pendulum exercises
- Assisted extension
- Assisted internal rotation - posterior to trunk
- Assisted external rotation - arms clasped behind neck
- 3rd Week – Start Isometrics:
  - External rotation
  - Extensors, flexors, abductors

PHASE II (4-6 Weeks to 3 Months): Active Exercise Program

- Supine forward elevation
- Standing forward elevation assisted by other extremity
- Continue rotational exercises
  - Add internal rotation isometrics
- Controlled self-stretching

6th Week

- Convert isometrics to resistance exercises: use various grades of elastic tubing
- Strengthen in internal rotation, external rotation, forward flexion, abduction and extension

PHASE III (After 3 Months)

- Residual deficiencies in range of motion and strength can be addressed by stretching and continued strengthening
- Light weights or progressive resistance tubing for strengthening

TYPE II - POOR FIXATION, MUSCLE OR BONE DEFICIENCIES

In subjects with poor fixation or muscle or bone deficiencies, it will be necessary to alter the rehabilitation goals to maintain stability and prevent tendon, muscle or bone disruption. This is a limited-goals category of rehabilitation. Examples include 1) large repaired rotator cuff tears, 2) poor stability due to inherent tissue problems, 3) when glenoid or humeral bone grafts are needed to fill bony deficiencies.

In this setting, initiation of exercises are delayed and the extent of passive or assisted early motion is reduced. Typically, elevation should be limited to 90° and external rotation to 20°. Most of these patients will be in an abduction splint or pillow, and passive elevation and external rotation should be carried out with the splint on, thus not allowing the arm to fall to the patient's side. After the initial 4 weeks, the total shoulder protocol, Type I (good fixation and stability) should be initiated. Individualized rehabilitation protocols for the above group of patients are very common and are dependent on the pathology noted and repaired at surgery.