

Reverse Total Shoulder Arthroplasty (Primary OA) Rehabilitation Protocol

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Patient: _____ **DOS:** _____

Surgeon Parameters

Subscapularis Tenotomy: ☐
Subscapularis Repair: ☐

Osteoporosis / Dislocation Risk: ☐

Other Precautions:

Checkboxes above are patient-specific and supersede the general timeframes below; if more than one applies, follow the most protective track. **Sling duration, PROM limits, and AROM timing differ by track.** Therapist to use clinical judgment to individualize exercise selection and pace within each phase.

Phase	Goals	Precautions	Treatment Focus
Phase 1 Weeks 0–6	Goals - Protect implant (± subscapularis repair); control pain/swelling - Early PROM per track to prevent stiffness - Maintain elbow/wrist/hand mobility - Initiate deltoid and scapular activation	Precautions - Sling per track; out for PT, hygiene, and elbow/wrist/hand motion - No lifting, weight bearing, or pushing up from chair/bed with operative arm - Dislocation precautions: avoid combined extension + adduction + IR (no hand-behind-back); pillow under elbow when supine If subscapularis repaired: padded abduction sling 4 wks; immediate gentle PROM with ER advanced slowly from 4-6 wks; no active/resisted IR; AROM begins at sling discontinuation (≈4 wks) If subscapularis tenotomy: sling for comfort; immediate PROM as tolerated, avoid dislocation positions; gentle AROM may begin immediately in PT If osteoporosis / dislocation risk: sling 6 wks; gentle therapist-directed PROM only; no AROM until 6 wks	Treatment Focus - Pendulums; PROM elevation (scapular plane) and ER per track - AAROM → AROM (supine → upright) once permitted by track - Submax deltoid isometrics and scapular setting, per track - AROM elbow/wrist/hand daily - Ice/modalities PRN pain-swelling
► Advance to Phase 2 when: wound healed, pain controlled, PROM progressing, sling discontinued per track.			
Phase 2 Weeks 6–10	Goals - Discontinue sling (all tracks) - Restore PROM, then AROM equal to PROM - Restore scapulohumeral rhythm - Typical targets by 12 wks: ≈120–140° elevation, ≈30–45° ER at side, functional IR	Precautions - Continue dislocation precautions through 12 wks - Lifting ≤1–2 lbs; no weight bearing through operative arm - Progress by response, not calendar If subscapularis repaired: no resisted IR until 10 wks; advance ER gradually without overpressure If osteoporosis / dislocation risk: begin AROM and more aggressive PROM at 6 wks; new point tenderness over acromion/scapular spine → notify surgeon	Treatment Focus - AAROM → AROM all planes (pulley, cane, wall slides); supine → upright progression - PROM/stretching toward targets - Deltoid and ER isometrics → light band as tolerated - Scapular stabilization and closed-chain (table slides), 2–3x/wk
► Advance to Phase 3 when: AROM ≈ PROM with good mechanics (no shrug), pain-free daily activities.			

Phase	Goals	Precautions	Treatment Focus
Phase 3 <i>Weeks 10–24</i>	Goals • Restore deltoid and periscapular strength/endurance • Maximize functional ROM • Return to functional, work, and recreational activities	Precautions • Strengthening begins at 12 wks; light load, high reps; keep hands in front of body • Avoid heavy overhead pressing and impact loading • Acromial/scapular spine pain → hold loading and notify surgeon	Treatment Focus • Band/light dumbbell strengthening: deltoid, cuff (incl. IR), scapular stabilizers, 2–3 sets x 10–15 • Closed-chain progression (wall push-up → counter) • Stretching all planes as tolerated • Functional/recreational drills; golf ≈3–4 months, tennis ≈4–6 months • Transition to home program
► Full Release (typically 4–6 months / 16–24 wks): functional pain-free AROM, strength adequate for goals, no instability symptoms, cleared by physician.			

Special Considerations

- Expected ROM after RTSA is less than anatomic TSA; IR behind the back is often limited — emphasize function over end range
- Lifelong avoidance of heavy overhead lifting and impact loading; long-term lifting limit per surgeon

Thank you for taking care of our patient.

This protocol serves as a general guideline and outline only. Our team defers to the clinical judgment and expertise of the treating physical therapist to make appropriate adjustments and modifications based on the individual patient's presentation, progress, and response to treatment. For any questions regarding this protocol, please contact Dr. Wollenman directly at (561) 215 – 0184.