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REVERSE TSA REHABILITATION PROTOCOL

(TO BE GIVEN TO YOUR PHYSICAL THERAPIST)

PHASE I:	SLING	ROM/EXERCISE

Week 0-3	• All times except
	  • Exercise
	  • Dressing
	  • Eating
	  • Showering
		• When supine, keep elbow forward of midline to reduce arm falling into extension (risk factor for dislocation)
		• Maximum ER to neutral
		• Pendulums and Codman's exercises independently performed by patient
		• Maintain hand strength
		• Maintain normal motion at the elbow and wrist
		• Do not use arm to push up out of chair/bed

Week 3-6	• Wean • Wear at night and when out of house	• Supine AAROM (FF 90, ER neutral) • FLEX, ABD, ADD, IR with towel, start ER at 6 weeks (minimize reps 5-10) • Pool for PROM and AAROM (water is assistance) • Use combined motions and teach fluidity of movement • 10 reps with combined movement in pool • Light scapular strengthening (i.e. scapular setting, gentle MR scap protraction and retraction) • Do not use arm to push up out of chair/bed
PHASE II:		
Week 6-12	• Discontinue sling	• Continue with PROM • Increase AAROM on land - Progress from SUPINE to SEATED, then to STANDING position • At 6 weeks begin AROM on land, against gravity (straight planes only, no combined motions) • Pool – continue AAROM and AROM • Progress to some light closed-chain proprioceptive exercises (wall washing) • Arm bike with no resistance
PHASE III:		

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Week 12-18	• None	• Begin AROM with combined motions at 12 weeks (on land, against gravity) • Begin light strengthening – lats, rhomboids, biceps, triceps, pecs, deltoids • Pool – continue and use floats and paddles for light resistive work in water

General Guidelines:

- Maintain surgical motion early, but don't push it.
- Strengthening the surrounding musculature-this can start anytime.
- Alternate between pool and land therapy.
- No pulleys in first 6 weeks.
- Most reverse patients are sent to outpatient therapy at 6 weeks postop. Dislocation is a concern during first 12 weeks: Avoid extension of arm during this period.
- The reverse prosthesis is a semi-constrained device, and normal range of motion is not often achieved, especially to internal rotation.
- Passive (therapist hands on) manipulation of a reverse total shoulder is not recommended.

This is a gradual progression, not a stepped progression.

Goals:

Active forward flexion goal is 130. f the posterior rotator cuff is intact, active ER goal is 30-45.Without a posterior rotator cuff and following a latissimus dorsi tendon transfer, active ER to neutral can be expected. Internal rotation is typically less than an anatomic total shoulder, and patient may only achieve reach to lower lumbar spine.

External rotation strength is dictated by the integrity of the posterior rotator cuff. If the posterior rotator cuff is completely torn and a tendon transfer is NOT performed, the patient will not have strength to external rotation, and therefore cannot perform theraband exercises in external rotation. In addition reaching the face and head may be impossible.

The reverse total shoulder arthroplasty is a salvage procedure, meaning it is intended to treat shoulder rotator cuff tears with arthritis, which are NOT reconstructable. The failure rates at this juncture are higher than an anatomic prosthesis, and therefore the lifting limit is set lower, specifically 15 lbs.