Inland Orthopaedic Surgery & Sports Medicine Clinic

Kyle J. Hazelwood, M.D.

REVERSE TOTAL SHOULDER ARTHROPLASTY
POST-OPERATIVE INSTRUCTIONS AND REHABILITATION PROTOCOL

Reverse total shoulder arthroplasty is performed for those patients that have both a rotator cuff tear and arthritis in the shoulder, and in some cases, for patient with isolated massive irreparable rotator cuff tears. The ball and the socket are reversed from an anatomic (standard) shoulder replacement, which relies on different muscles to move the shoulder compared to an anatomic shoulder replacement, which relies on an intact rotator cuff. Physical Therapy may begin around one week from the date of surgery. Your rehabilitation will be a supervised program by a physical therapist and a home program as directed by your therapist. Your therapist will help guide your rehab, teach you what movements and activities to avoid as well as what movements/arm positions are safe, and will advance and progress your rehab based off this protocol.

I. <u>POST-OP INSTRUCTIONS</u>

a. The abduction brace/sling is used for 4 weeks after surgery, unless you are directed otherwise. It is ok to remove the sling for bathing/grooming and to do your exercises. It is best to wear the sling while sleeping for the first few weeks after surgery. Most patients find this most comfortable to do in a reclined position.

b. May **remove bandage post-op day 3** and clean shoulder with alcohol and gauze. Keep steri-strips/sutures in place. Keep the incision covered with dry gauze for 10 days. **Ok to shower the day after surgery, but keep the shoulder covered and as dry as possible**. Either bathe, keeping the shoulder dry or cover shoulder with saran wrap and tape in shower.

c. After removing dressing on 3rd day, do not scrub over incisions while in shower. Just let soap/water drain over shoulder and pat dry. Do not submerge incisions in bath or pool until fully healed (~5 weeks)

d. If you had a **nerve block at the time of surgery, it usually wears off around 2 days post-operatively**. It is normal to have some numbness in the shoulder/arm the first few days after surgery as a result. **The first night after surgery take pain medication before going to bed as the nerve block will often wear off during the night.**

e. Take the prescribed pain medications as directed. You can supplement your pain control with ice if needed. Place a towel over the shoulder if using ice to protect the skin.

f. Decrease the frequency of your pain medicine as your symptoms allow. Although everyone is different, generally patients are able to be off of pain medicine around 1 week post-op.

g. There is no conclusive data about when it is safe to return to driving after shoulder replacement surgery. You cannot drive while taking pain medications. In general, you should be able to lift your arm overhead, be out of the sling and have minimal pain in the shoulder before returning. Return to driving is highly individualized and is generally guided by your ability to drive safely and your ability to make evasive maneuvers if that was required.

h. The risk of blood clots is extremely low after surgery of the shoulder or upper extremity. However, certain conditions may increase your risk including smoking, family or personal history of blood clots or birth control pills. If any of these situations apply, please let Dr. Hazelwood know and take 1 tablet of aspirin (325 mg) per day for 2 weeks after surgery.

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II. REHABILITATION PROTOCOL WEEKS 0-4
MAXIMAL PROTECTIVE PHASE

a. Continue **Sling x 4 weeks**. Remove your sling for exercises, bathing and grooming
b. 2-3 times per day work on pendulum exercises and table slides (see below)
c. Work on range of motion of your wrist, elbow and grip strength **DAILY** beginning the day after surgery
d. **No External Rotation of the shoulder beyond zero degrees (neutral abduction) x 4 weeks**
e. Active Assisted forward elevation in scapular plane up to 130 degrees, abduction to 90 deg
f. No extension/internal rotation (behind back)
g. **No weight bearing through the operative arm**
    i. **No pushing off of a chair with the operative arm (risk of dislocation)**
    ii. **Avoid activities requiring external rotation, e.g. closing heavy door**
h. No lifting with your operative arm exceeding 5 lbs
i. Modalities, ice as needed. Place a towel or covering between your skin and the ice to protect your skin. Maximum 20 minutes/per hour. Gradually wean off ice as swelling/discomfort decreases.
j. Education in ADLs

II. REHABILITATION PROTOCOL WEEKS 4-6
MODERATE PROTECTIVE PHASE

a. Can begin to wean out of sling. Some patients may be comfortable to remain in sling for walking outside the home
b. Continue to work on pendulums, table slides and wrist/elbow ROM, grip strength
c. **Can begin external rotation of the shoulder to 30 degrees**
d. Initiate gentle internal rotation of the shoulder
e. Progress AAROM forward flexion in scapular plane as tolerated
f. Weight restrictions: 5 lbs
g. Begin isometric scapular strengthening exercises
h. If range of motion comes along faster than above timeframes, reinforce protection phase and discourage “overdoing it.”

III. REHABILITATION PROTOCOL WEEKS 6-12
INITIAL STRENGTHENING PHASE

a. **Progress External Rotation as tolerated**
b. Initiate Active Range of Motion (AROM)
    i. **GOAL: Functional range of motion by 8-10 weeks**
c. Weight Restrictions: 10 lbs
d. Progress scapular strengthening
e. **At 8 weeks, can begin light rotator cuff strengthening exercises, in protective ROM only**
f. Deltoid isotonics in plane of scapula, only after positive rotator cuff strength is determined
g. Avoid “internal rotation strengthening”

IV. REHABILITATION PROTOCOL WEEKS 12+
RETURN TO ACTIVITY

a. Progress range of motion without restriction, progress strengthening (deltoid, rotator cuff, scapular stabilizers)

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b. Return to normal everyday activity, low impact sports, light weight machines if good ROM, ADL strength

c. **Activities to avoid:**
   i. Activities that would cause high stress to implant
   ii. Activities with high risk of injury or high-energy fall

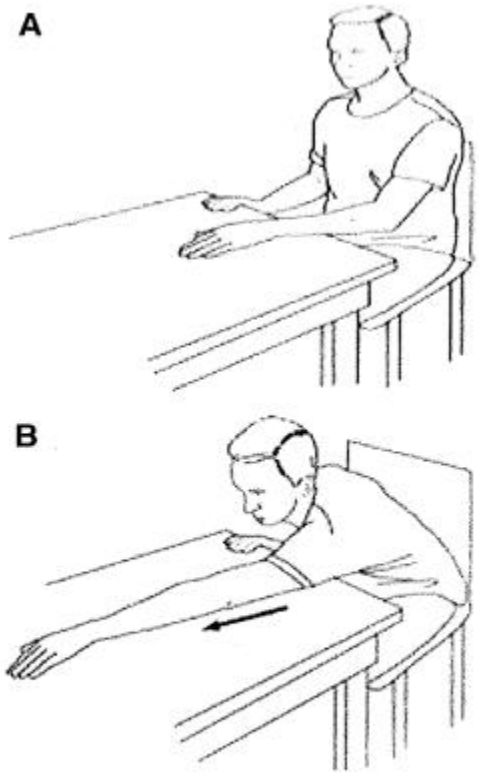

FIGURE 1. Table slide. (A) Starting position. While seated at a table, the patient places the hand of the affected shoulder on a sliding surface (e.g., a magazine that slides over a smooth table surface). (B) Ending position. The patient slides the hand forward, maintaining contact with the table, while the head and chest advance toward the table.