Indiana University Health

IU Health Physicians Orthopedics & Sports Medicine

LATISSIMUS REPAIR

PHYSICAL THERAPY PROTOCOL

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Patient Name: _____ **Date of Surgery**: _____

___ **Evaluate and Treat** ___ **Provide patient with home program**

Frequency: _____**x/week x** _____**weeks**

_____**Weeks 0-1:**

- Patient to do Home Exercises given post-op (pendulums, elbow ROM, wrist ROM, grip strengthening)
- Patient to remain in shoulder immobilizer for 6 weeks

_____**Weeks 1-6:**

- True PROM only! The tendon needs to heal back into the bone.

- ROM goals: 90º FF/30º ER at side; ABD max 40-60 without rotation
- No resisted motions of shoulder until 12 weeks post-op
- Grip strengthening
- No canes/pulleys until 6 weeks post-op, because these are active-assist exercises
- Heat before PT, ice after PT

_____**Weeks 6-12:**

- Begin AAROM → AROM as tolerated
- Goals: Same as above, but can increase as tolerated
- Light passive stretching at end ranges
- Begin scapular exercises, PRE's for large muscle groups (pecs, lats, etx)
- Isometrics with arm at side beginning at 8 weeks

_____**Months 3-12:**

- Advance to full ROM as tolerated with passive stretching at end ranges
- Advance strengthening as tolerated: isometrics → bands → light weights (1-5 lbs); 8-12 reps/2-3 sets per rotator cuff, deltoid, and scapular stabilizers
- Only do strengthening 3x/week to avoid rotator cuff tendonitis
- Begin eccentrically resisted motions, plyometrics (ex. Weighted ball toss), proprioception (es. body blade)
- Begin sports related rehab at 4 ½ months, including advanced conditioning
- Return to throwing at 4 months, begin with light toss
- Return to throwing from the pitchers mound at 6 months
- Return to full competition 9-12 months

Comments:

____Functional Capacity Evaluation ____Work Hardening/Work Conditioning ____ Teach HEP

Modalities

___Electric Stimulation ___Ultrasound ___ Iontophoresis ___Phonophoresis ____ Heat before/after ____Ice before/after ___Trigger points massage ___TENS ___ Other _____ ____ Therapist's discretion

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary. This patient __ would __would not benefit from social services.

_____ **Date:**_____

Bryan M. Saltzman, MD