PROXIMAL HUMERUS OPEN REDUCTION INTERNAL FIXATION (ORIF)

PHYSICAL THERAPY PROTOCOL

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

Procedure: **Right / Left Proximal Humerus ORIF**

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

Frequency: _____x/week x _____weeks

__Phase I (0-1 wk): *Initial wound healing, provisional fracture consolidation.*
-No formal PT.
-Wear sling at ***all*** times.
-Maintenance motion at home (Codman shoulder swings, elbow/wrist ROM in sling 2-3 times per day)

__Phase II (1-6 wks): *Protected PROM (no active motion)*
-Start formal PT
-Sling at all times, except for hygiene/PT.
-Elbow and wrist ROM exercises out of the sling 3x/day

-Supervised PROM within the following limits (based on intra-op security of the repair):

a. forward elevation in the scapular plane ___
b. IR with arm at side ___
c. ER with arm at side ___
d. ***Avoid abduction in the coronal plane.***

-Gentle deltoid and periscapular isometric exercises ***(avoid isolated rotator cuff contraction until after 8 wks as this may compromise repair)***

__Phase III (6 wks – 3 months): *Advance motion and gentle strengthening.*

-Discontinue sling if fracture healing adequate

-Light passive stretching at end ranges; begin active-assisted ROM and gradually progress beyond above ROM limits. After 8 wks, may progress to AROM as tolerated.

-Advance deltoid and periscapular isometric strengthening. After 8 wks, may begin light cuff isometrics with arm at side.

__Phase IV (3-6 months): *Achieve terminal motion and more aggressive strengthening*.

-Terminal passive stretching at end ranges (especially posterior capsule); progress A+AAROM in all planes.

-**Advance as tolerated from isometrics → bands → light weights (1-5lbs)** w/8-12 reps x 2-3 sets for cuff, deltoid, scapular stabilizers (*Only do this **3x/wk** to avoid cuff tendonitis*)

-@ 4.5 months, begin eccentrically resisted motions, plyometrics (*weighted ball toss*), proprioception (*body blade*) and then progress as tolerated into sports-related rehab and advanced conditioning

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