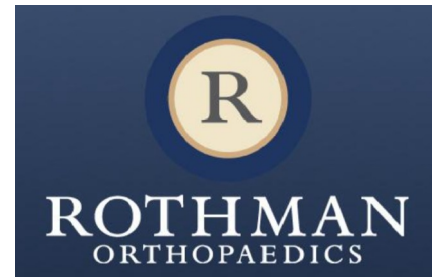


Brandon J. Erickson, MD
Mackenzie Lindeman, ATC
176 3rd Ave New York, NY
658 White Plains Rd Tarrytown, NY
450 Mamaroneck Rd Harrison, NY
Phone: 914-580-9624
Brandon.erickson@rothmanortho.com
Mackenzie.lindeman@rothmanortho.com
<https://rothmanortho.com/physicians/brandon-j-erickson-md>



POSTERIOR STABILIZATION WITH BONE GRAFT PHYSICAL THERAPY PROTOCOL

Name _____ Date _____

Diagnosis s/p RIGHT/LEFT Posterior Labral Repair With Distal Tibial Allograft

Date of Surgery _____

Frequency: _____ times/week Duration: _____ Weeks

_____ Weeks 0-4:

Sling in neutral rotation for 3 weeks (padded abduction sling)
Codman exercises, elbow and wrist ROM Wrist and grip strengthening

_____ Weeks 4-6:

Restrict to FF 90° IR to stomach PROM→AAROM→AROM
ER with arm at side as tolerated
Begin isometrics with arm at side FF/ER/IR/ABD/ADD
Start scapular motion exercises (traps/rhomboids/lev. scap/etc)
No cross-arm adduction, follow ROM restrictions
Heat before treatment, ice after treatment per therapist's discretion

_____ Weeks 6-12:

Increase ROM to within 20° of opposite side; no manipulations per therapist; encourage patients to work on ROM on a daily basis
Once 140° active FF, advance strengthening as tolerated: isometrics→bands→light weights (1-5 lbs); 8-12 reps/2-3 sets per rotator cuff, deltoid, and scapular stabilizers with low abduction angles
Only do strengthening 3x/week to avoid rotator cuff tendonitis Closed chain exercises

_____ Months 3-12:

Advance to full ROM as tolerated
Begin eccentrically resisted motions, plyo (ex. Weighted ball toss), proprioception (es. body blade)
Begin sports related rehab at 3 months, including advanced conditioning
Return to throwing at 4 months
Push-ups at 4 - 6 months
Throw from pitcher's mound at 6 months
MMI is usually at 12 months post-op

____ Functional Capacity Evaluation ____ Work Hardening/Work Conditioning ____ Teach HEP

____ Electric Stimulation ____ Ultrasound ____ Iontophoresis ____ Phonophoresis ____ Heat before
____ Ice after ____ Trigger points massage ____ TENS ____ Therapist's discretion

Signature _____ Date _____