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 GRFT 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_____