ROTATOR CUFF REPAIR (SUBSCAPULARIS REPAIR)
Physical Therapy Protocol

Patient Name: _____ Date of Surgery: _____

_____ **Evaluate and Treat** _____ **Provide patient with home exercise program**

Frequency: _____ x/week x _____ weeks

_____ Phase I (0 - 6 Weeks):

- **ROM:**
  0-3 weeks: None.
  3-6 weeks: Begin PROM.
  Limit 90° flexion, 45° ER, 20° extension.
- **Immobilizer:**
  0-2 weeks: Immobilized at all times day and night.
  Off for hygiene and gentle home exercise according to instruction sheets.
  2-6 weeks: Worn daytime only.
- **Exercises:**
  0-2 weeks: Elbow/wrist ROM, grip strengthening at home only.
  2-6 weeks: Begin PROM activities Limit 45° ER.
  Codman's, posterior capsule mobilizations; avoid stretch of anterior capsule and extension; No active IR.

_____ Phase II (6 - 12 Weeks):

- **ROM:** Begin active/active- assisted ROM, passive ROM to tolerance.
  Goals: full ER, 135° flexion, 120° abduction.
- **Immobilizer:** None.
- **Exercises:**
  Continue Phase I work; begin active- assisted exercises, deltoid/rotator cuff isometrics at 8 weeks.
  Begin resistive exercises for scapular stabilizers, biceps, triceps and rotator cuff.*
  No resisted IR.

_____ Phase III (12 - 16 Weeks):

- **ROM:** Gradual return to full AROM.
- **Immobilizer:** None.
- **Exercises:**
  Advance activities in Phase II; emphasize external rotation and latissimus eccentrics, glenohumeral stabilization.
  Begin muscle endurance activities (upper body ergometer).
  Cycling/running okay at 12 weeks.

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_____ **Phase IV (4 - 5 Months**):**

- **ROM:** Full and pain-free.
- **Immobilizer:** None.
- **Exercises:**

  Aggressive scapular stabilization and eccentric strengthening.
  Begin plyometric and throwing/racquet program, continue with endurance activities.
  Maintain ROM and flexibility.

_____ **Phase V (5 - 7 Months):**

- **ROM:** Full and pain-free.
- **Immobilizer:** None.
- **Exercises:**

  Progress Phase IV activities, return to full activity as tolerated.

*Utilize exercise arcs that protect the anterior capsule from stress during resistive exercises, and keep all strengthening exercises below the horizontal plane in phase II

**Limited return to sports activities

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.

Physician Name: _____ Date: _____

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