RADIAL HEAD REPLACEMENT
Physical Therapy Protocol

Patient Name: ____ Date of Surgery: ____________________

Procedure: Right / Left Radial Head Replacement

_____ **Evaluate and Treat**

_____ **Provide patient with home exercise program**

Frequency: ______ x/week x ______ weeks

_____ **Phase I - Immediate Post Operative Phase:** ***(Week 0-1).***

Goals:

- Allow soft tissue healing.
- Decrease pain and inflammation.
- Retard muscular atrophy.

Week 1:

- Posterior splint at 90∞ elbow flexion with wrist free for motion (sling for comfort).
- Elbow compression dressing.
- Exercises:
  - Gripping.
  - Wrist ROM (passive only).
  - Shoulder isometrics (no shoulder ER).

_____ **Phase II - Intermediate Phase: Protected PROM** ***(Week 3-7)***

Goals:

- Restore full pain free range of motion.
- Improve strength, power, endurance of upper extremity musculature.
- Gradually increase functional demand.

Weeks 3-5:

- Progress elbow ROM, emphasize full extension.
- Initiate flexibility exercises for:
  - Wrist ext/flexion.
  - Forearm supination/pronation.
  - Elbow ext/flexion.

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- Initiate strengthening exercises for:
    - Wrist ext/flexion.
    - Forearm supination/pronation.
    - Elbow ext/flexors.
    - Shoulder program (Thrower's Ten Shoulder Program).

Weeks 6-7:

- Continue all exercises listed above.
- Initiate light sport activities.

______ **Phase III - Advanced Strengthening Program:** ***(Week 8-12)***

Goals:

- Improve strength/power/endurance.
- Gradually initiate sporting activities.

Weeks 8-11:

- Initiate eccentric exercise program.
- Initiate plyometric exercise drills.
- Continue shoulder and elbow strengthening and flexibility exercises.
- Initiate interval throwing program for throwing athletes.

______ **Phase IV - Return to Activity:** ***(Week 14-32)***

Goals:

- Gradual return to activities.

Week 12:

- Return to competitive throwing.
- Continue Thrower's Ten Exercise Program.

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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