

PROXIMAL HUMERUS FRACTURE POST OPERATIVE PROTOCOL

	Time Frame (Weeks)	Guidelines	Goals
PHASE I	0 to 6	SLING: x 6 weeks ROM: No shoulder x 2 weeks; ROM as instructed by MD EXERCISE PROGRESSION • Ice and modalities to reduce pain and inflammation • Cervical ROM, basic deep neck flexor activation (chin tuck) • Instruction on proper posture (head, neck and shoulder alignment) • Active hand and wrist range of motion • PROM/AAROM biceps range of motion • Active shoulder retraction • *ROM instructions will differ among referring physicians, it is important to communicate with each Dr. prior to beginning ROM exercises to specify when each patient can begin* • PROM ◊ Flexion: 90° (wks 2-4), 120° (wks 4-6) ◊ External rotation: 0°-30° (wks 2-4), 30°-60°(wks 4-6) • Early ROM is key, although painful, range of motion is often restricted with this rehab. MANUAL INTERVENTION • STM – global shoulder, cervical spine and elbow • Scapula mobilization (patient may not tolerate being positioned in sidelying) • CT junction mobilization and STM (patient may not tolerate moving into prone position)	• Reduce inflammation • Decrease pain • Postural education • PROM as instructed • Evaluate or discuss with patient regarding any distal injuries, radial nerve injuries are not common, however need to be addressed early in rehab. Patient may exhibit “wrist drop” or numbness and require intervention.
PHASE II	6 to 8	EXERCISE PROGRESSION • Progress range of motion to include A/AAROM (Use a combination of wand, pulleys, wall walks or table slides) • Serratus activation; ceiling punch (weight of arm) and patient may need assistance • Scapula strengthening – prone scapular (Rows and I’s) • Low to moderate cardiovascular exercise MANUAL INTERVENTION • STM – global shoulder, cervical spine and elbow as needed • ST and CT mobilization	• Discontinue sling • Gradual progression with passive range of motion • Emphasis on ROM with HEP • Postural education
PHASE III	8 to 10	EXERCISE PROGRESSION • Passive and active range of motion/stretching; attempting to maximize range of motion for ADLs • Add resistance to ceiling punch • Sub-maximal rotator cuff isometrics (no pain) • Advance prone series with weight or by adding T’s • Add rows or shoulder extension pull-downs • Supine PNF patterns • Bicep and triceps • Scaption—focusing on good scapular thoracic and scapular humeral kinematics	• Emphasis on range of motion • Activation of RC/SS with isometric and isotonic progression • Posterior chain strengthening

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PHASE III (continued)	10 to 12	EXERCISE PROGRESSION • Therapist directed quadruped or counter top weight shifts MANUAL INTERVENTION • STM and joint mobilization to CT junction, GHJ and STJ as needed • PNF patterns • Manual perturbations	
PHASE IV	12 to 20	EXERCISE PROGRESSION • Stretching: TUB, sleeper, door/pec stretch, open book • Return to gym adding lat pulls, anterior shoulder/chest and above 90 degrees as tol. • Progress rotator cuff strengthening to include band work or resistive training at the gym • Initiate plyometric or rebounder drills as appropriate RETURN TO PLAY • Continue with gym/home strengthening program as outlined • RTS testing for interval programs (golf, tennis, etc) Microfet testing as appropriate • Follow up examination with physician (6 months) for release to full activity	• <i>Prioritize the patient's needs and goals. Many patients will not progress to this phase and will benefit more from increased manual treatment and focus on restoring range of motion</i> • Begin RTS progression. • Evaluation with physician for clearance to full activity.