

Reverse Total Shoulder Arthroplasty Rehabilitation Protocol

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Patient: _____

Surgery date: _____

For uncomplicated primary reverse total shoulder arthroplasty. This pathway uses early, protected motion because current comparative evidence shows similar long-term outcomes and no higher instability rate than delayed rehabilitation. Progress is both time- and criteria-based. Surgeon instructions supersede this protocol, especially after fracture, revision, tendon repair, or complex reconstruction. [1-7]

Phase 1 Protection and controlled motion		0 to 3 weeks
Goals and progression - Protect the reconstruction, control symptoms, and preserve distal motion. - Wear the sling except for hygiene and prescribed exercises; sleep in it unless otherwise directed. Therapy and home program - Full active hand, wrist, and elbow motion; grip and gentle scapular-setting exercises. - Gentle supported passive or active-assisted flexion and external rotation only within prescribed limits. Do not force end range. - Use short, frequent motion sessions rather than aggressive stretching.		Precautions - No internal rotation behind the back or shoulder extension beyond neutral. - Avoid combined extension, adduction, and internal rotation. - No lifting, pushing, pulling, resisted shoulder exercise, weight-bearing, or using the arm to rise.
Phase 2 Restore motion and light function		3 weeks to 3 months
Goals and progression - Discontinue the sling at 3 weeks unless otherwise directed; restore flexion and external rotation with good mechanics. Therapy and home program - Full passive and active flexion and external rotation are permitted as tolerated. - Progress assisted to active elevation: supine, then incline, then upright; avoid shrug compensation. - Use the arm for light ADLs. Gentle deltoid, external-rotator, and periscapular activation may begin when controlled; use high repetitions and no more than 5 pounds.		Precautions - No internal rotation behind the back until 3 months. - No lifting or strengthening greater than 5 pounds until 3 months. - Avoid sudden loading, heavy pushing or pulling, and weight-bearing through the arm. - Do not progress through increasing acromial or scapular-spine pain.
Phase 3 Progressive strength and endurance		3 months and beyond
Goals and progression - Restore strength, endurance, and functional use with controlled mechanics and no focal acromial or scapular-spine tenderness. Therapy and home program - Progressively strengthen the deltoid, internal and external rotators, and periscapular muscles. - Begin with low-to-moderate load and higher repetitions; progress one variable at a time. - Progress behind-the-back motion without forceful stretching; advance wall-based work to functional lifting.		Precautions - Avoid abrupt maximal lifting and repetitive heavy overhead loading. - Stop for sharp pain, instability, sudden loss of elevation, or symptoms that remain worse the next day. - Heavy work, higher-demand recreation, and sport require surgeon clearance.

Contact the surgical team for wound drainage, fever, increasing redness, new neurologic symptoms, deformity, a traumatic event, sudden loss of function, or pain that is worsening rather than improving.

Clinical Progression and Literature Guidance

Criteria to progress • Incision healed and no clinical concern for infection. • Pain controlled and exercise response returns near baseline by the next day. • No new instability, neurologic deficit, or sudden functional loss. • No focal acromial or scapular-spine tenderness. • Active elevation progresses without marked shrug or substitution.	Use a slower pathway when present • Reverse arthroplasty for proximal humerus fracture or tuberosity fixation. • Revision arthroplasty, bone grafting, or complex reconstruction. • Subscapularis or other tendon repair requiring protection. • Osteoporosis, poor bone stock, or prior acromial/scapular-spine pathology. • Axillary nerve dysfunction, deltoid compromise, poor balance, or high fall risk.
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Exercise Emphasis by Stage

Stage	Primary emphasis	Examples
0-3 weeks	Protection and distal mobility	Hand/wrist/elbow ROM, grip, scapular setting, supported flexion and ER within prescribed limits
3-6 weeks	Motion quality and functional use	AAROM to AROM elevation, supported ER, light ADLs, posture and scapular control
6-12 weeks	Active control and light endurance	Gravity progression for elevation; gentle deltoid, ER, and periscapular work; no load over 5 lb
12+ weeks	Progressive strength and task training	Low-load/high-repetition resistance, rows, supported ER/IR, wall press progression, functional lifting

Return to Activity Guidance

Typical timing after uncomplicated recovery • Driving: only when off the sling, off impairing medication, and able to control the vehicle safely; surgeon clearance is advised. • Sedentary work: commonly 1-2 months; light work: about 2-3 months. • Moderate work: commonly 3-6 months; heavy work: 6 months or later. • Low-impact sport: commonly 4-6 months when motion, strength, and control are adequate.	Long-term considerations • Timing varies by procedure indication, dominant arm, job or sport demands, and recovery. • High-impact and contact sports are generally discouraged or require individualized discussion. • No universal permanent lifting limit is supported by high-level evidence; use surgeon-specific guidance for heavy or repetitive overhead loads.
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Evidence Summary

A 2026 systematic review of 1,606 shoulders found that motion started within 14 days modestly improved early flexion without increasing dislocation or overall complications; by 6-12 months, outcomes were equivalent. A 2025 meta-analysis of 1,763 nonfracture cases likewise found only small early benefits and no increase in instability or revision. Evidence supports early protected motion for uncomplicated primary RTSA, but remains limited for fracture, revision, tendon-repair, and high-risk bone populations. [1-7]

References

1. Alkhouri S, et al. Early versus conventional postoperative rehabilitation after reverse total shoulder arthroplasty: a systematic review of functional outcomes and complications. *Disabil Rehabil*. 2026. doi:10.1080/09638288.2026.2683002.
2. Thamrongkulsiri N, et al. Early mobilisation versus delayed protocols after reverse total shoulder arthroplasty for nonfracture indications: a systematic review and meta-analysis. *J Exp Orthop*. 2025;12:e70449.
3. Edwards PK, et al. A randomised trial comparing two rehabilitation approaches following reverse total shoulder arthroplasty. *Shoulder Elbow*. 2021;13:557-572.
4. Hagen MS, et al. A randomized single-blinded trial of early rehabilitation versus immobilization after reverse total shoulder arthroplasty. *J Shoulder Elbow Surg*. 2020;29:442-450.
5. Kornuijt A, et al. Direct active rehabilitation after reverse total shoulder arthroplasty: an international multicentre prospective cohort safety study with 1-year follow-up. *BMJ Open*. 2023;13:e070934.
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7. Lamb CJ, et al. Rehabilitation and long-term outcomes including return to work or sport following reverse total shoulder arthroplasty. *Curr Rev Musculoskelet Med*. 2025;18:173-181.

Literature reviewed through September 2026. Modify according to operative findings and surgeon instructions.