



RADIAL HEAD REPLACEMENT

PHYSICAL THERAPY PROTOCOL

Bryan M. Saltzman, M.D.

OrthoCarolina

Assistant Professor of Orthopaedic Surgery, Atrium Health

Sports Medicine & Shoulder/Elbow

1915 Randolph Rd, Charlotte, NC 28207

704-323-3000

www.BryanSaltzmanMD.com

Patient Name: _____ **Date of Surgery:** _____

Procedure: Right / Left Radial Head Replacement

___ Evaluate and Treat ___ Provide patient with home 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 (Week 3-7)

- **Goals**
 - Restore full pain free range of motion
 - Improve strength, power, endurance of upper extremity musculature
 - Gradually increase functional demands
- **Week 3-5**
 - Progress elbow ROM, emphasize full extension
 - Initiate flexibility exercises for:
 - Wrist ext/flexion
 - Forearm supination/pronation
 - Elbow ext/flexion
 - Initiate strengthening exercises for:
 - Wrist ext/flexion
 - Forearm supination/pronation
 - Elbow ext/flexors
 - Shoulder program (Thrower's Ten Shoulder Program)
- **Week 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
- **Week 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.

Date: _____

Bryan M. Saltzman, MD