

Patient: _____ Date of Surgery: _____

Procedure: Right/Left Biceps Tenodesis

Associated procedures:

Distal Clavicle Resection: Avoid cross-body adduction x 6 weeks
Acromioplasty: Avoid shoulder abduction x 6 weeks

Week 1: No formal PT. Sling at all times except for hygiene and pendulums if instructed. Home exercises of elbow and wrist ROM, grip strengthening and pendulums.

Phase I (1-4 wks): *Begin formal PT (2-3x per week)*

Weight bearing: NWB, ok for typing if in sling

Brace: Sling at all times. Pillow is optional for sling.

Ice: Not directly on skin, recommend as much as possible. 5x/day, 20 min/session for first 2 weeks. Then after activity at minimum.

ROM: Shoulder and Elbow - PROM to AAROM to AROM as tolerated without restriction (*unless acromioplasty or distal clavicle performed as above*). No resistance for elbow.

Exercises: No resisted elbow motions for 4 weeks. Periscapular strengthening.

Phase II (4-8 wks): *Discontinue immobilization*

Weight bearing: < 5 lbs operative arm

Brace: Discontinue sling after 4 weeks.

ROM: Advance AROM shoulder and elbow with goal of 140 FF by 8 weeks.

Exercises: Start periscapular and cuff/deltoid isometrics at side, progress to bands as tolerated. Avoid resisted elbow flexion >5 lbs or supination.

Phase III (8 wks-12 wks): *Progress with strength*

Weight bearing: Advance to tolerance. Avoid heavy impact activities until after 3 months.

ROM: No restriction. Aggressive end range stretching if full ROM not achieved.

Exercises: Advance as tolerated to bands and to light weights (1-5 lbs) with 8-12 reps x 2-3 sets for cuff, deltoid, scapular stabilizers. No more than 3x / week to avoid cuff tendinitis. Begin to eccentrically resisted motions.

Phase IV (12 wks to 6 mo): *Advanced activities*

Weight bearing: Full

Sports: 4 mo ok to progress to light throwing. Golf progression may begin at 3 months.

Work: Overhead heavy lifting can begin to tolerance at ~3 months. Heavy labor may take 4-6 months.

Exercises: Start light gym weight training activities.

Frequency: _____x/week x _____weeks

By signing this referral, I certify that I have examined this patient and physical therapy is medically necessary.

Dax Varkey MD, MPH

Date: _____