Murphy Wainer Orthopedic Specialists
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Patient: _____ Date of Surgery: _____

Procedure: Right/Left Pectoralis Repair

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 small pendulums.

Phase I (1-6 wks): ***Begin formal PT (2-3x per week)***

Weight bearing: NWB, ok for typing if in sling
Brace: Sling at all times except hygiene. 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: PROM only – only should be performed with arm adducted and limited to 130° degrees. ER limited to neutral with arm at side. IR to belly. Goals at 6 weeks: 130° FE, 0° ER, IR Belly.
Exercises: None except grip strengthening.

Phase II (6-12 wks): ***Discontinue immobilization***

Weight bearing: < 2-5 lbs operative arm
Brace: Discontinue sling after 6 weeks.
ROM: Light passive stretching at end ranges. Begin AAROM (canes, pulleys, etc.) and progress supine to vertical. Gradually progress with AROM. Goal full motion by 12 weeks.
Exercises: Begin periscapular, deltoid and cuff isometrics with arm below shoulder level. Avoid any adduction, internal rotation strengthening until after 12 weeks. No resisted shoulder motions until after 12 weeks.

Phase III (12 wks-18 wks): ***Progress with strength***

Weight bearing: Advance to tolerance for daily activities.
ROM: No restriction
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.

Phase IV (18 wks to 9 mo): ***Advanced activities***

Weight bearing: Full
Sports: At 6 months if full strength achieved can return to light weight high rep pushups and bench.
Work: Overhead heavy lifting can begin to tolerance at ~5 months. Heavy labor may take ~6 months.
Exercises: Begin eccentrically resisted motions, plyometrics (weighted ball toss), proprioception and progress to sport specific, job specific conditioning.

Frequency: _____x/week x _____weeks

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

_____ Date:_____

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