Clavicle Fracture ORIF Repair

Purpose:
This guideline is designed to return the individual to their full activities as quickly and safely as possible, following a shoulder Clavicle Fracture ORIF Repair. Modifications to this guideline may be necessary dependent on physician specific instruction or other procedures performed. This evidence-based guideline is criterion-based; time frames and visits in each phase will vary depending on many factors. The therapist may modify the program appropriately depending on the individual's goals for activity following this surgery.

This guideline is intended to provide the treating clinician with a frame of reference for rehabilitation. It is not intended to substitute clinical judgment regarding the patient's post-operative care based on exam/treatment findings, individual progress, and/or the presence of concomitant procedures or post-operative complications. If the clinician should have questions regarding post-operative progression, they should contact the referring physician.

PHASE	SUGGESTED INTERVENTIONS	MILESTONES FOR PROGRESSION
Phase I Weeks 1-3	**Precautions:** • Full time in sling, no running, walking only • Avoid IR behind the back, lifting more than 1-2 lbs. and horizontal adduction • Maintain use of sling at all times for 3-4 weeks or until physician instructs to DC • Sleep in immobilizer for 3-4 weeks or until physician instructs to DC • No AROM ER, extension, or abduction • NWB x 6 weeks post-op • No lifting > 1-2lbs x 6 weeks **Therapy:** • Cervical ROM as tolerated • AROM wrist and hand • Passive and active elbow flexion and extension • Shoulder shrugs and scapular retraction (preventing shoulder extension) • PROM table slides into flexion to 90° only • Ice and modalities for pain and swelling • Shoulder pendulums at 1 week post-op • PROM at 3 weeks: — Flexion and abduction to 90°, ER up to 45° as tolerated with elbow at side, IR to 45° with elbow away from side in supine, extension to 20°	**Goals:** • Protection of the post-surgical shoulder • Diminish pain and inflammation • Postural education: don't slouch • Pain free PROM up to 90°

Phase II Weeks 3-6	**Precautions:** • Gradually DC sling around the house at 4 weeks if comfortable — Still need sling when going out in public up until 6 weeks post-op • Decrease exercise if increased pain • NWB x 6 weeks post-op • No lifting > 1-2lbs x 6 weeks **Therapy:** • ROM: — Passive flexion and abduction to 120° — ER and IR as tolerated in supine — Begin posterior capsule stretches ⇒ No inferior or anterior GH mobilization — Active elbow flexion and extension • Begin no-load serratus exercise at 5-6 weeks • Advance to passive multi-plane pulley when 120° flexion is achieved in supine • Begin limited range, no resisted active ER and IR with towel roll • Sub-max isometrics with elbow at side • If pain level is not decreasing, decreased intensity and volume of exercise • Begin AAROM and AROM below 90°, pain free • Modalities for pain, as needed	• Goals: • Prevent negative effects of immobilization • Range of motion as allowed per guideline • Scar tissue management • Begin light pain free strengthening in neutral
Phase III Weeks 6-9	**Precautions:** • All exercises and activities will remain non-provocative • Begin strengthening exercises only if overall pain level is low • Address capsule tightness appropriately **Therapy:** • ROM as tolerated in all planes • Mobilization to GH joint as needed • Begin UBE, below shoulder level • May start sleeper stretch and functional IR behind the back • Supine kinesthetic awareness exercise in ER/IR only, low load • Begin rows with theraband, but not beyond plane of body • Advance pulley to active assisted in multiple planes • AROM:	**Goals:** • DC immobilizer

	— Supine shoulder flexion — Standing flexion — Seated shoulder ER — Side-lying shoulder ER • Begin light theraband for: — IR — ER — Flexion — Abduction — Biceps and triceps below shoulder level, advance as tolerated • Begin strengthening exercises only if overall pain level is low • Modalities for pain as needed	
Phase IV Weeks 9-12	**Precautions:** • Utilize exercise arcs that protect the anterior capsule from stress during resistive exercises, and keep all strengthening • Exercises below the horizontal plane in Phase II **Therapy:** • Continue stretches towards normal ROM • Continue posterior capsule stretches as needed • May begin running at 12 weeks • Increase resistance with theraband exercises as tolerated • Prone T's and Y's • Begin supine, low intensity rhythmic stabilization at 110-120° flexion for rotator cuff and deltoid co-contraction • Advance kinesthetic awareness exercise to multi-angle and gradually work from short to long lever arm • Closed Kinetic Chain progression: — Quadruped — Ball compression — Wall pushups — Knee pushups — May add perturbations from therapist in each position • Overhead ROM progressing from light to moderate resistance • ER/IR strength at 90/90 • Plyometric training at 10-12 weeks • Sports specific training at 10-12 weeks	**Goals:** • ROM: full extension, ER, IR, 135° Flexion, 120° Abduction

	• Progress only without signs of increasing inflammation	
Phase V 3-6 Months	**Precautions:** • Gradual progression with pressing and overhead activity • Cycling/running okay at 3 months or sooner if given specific clearance • Gradual return to full activity as tolerated • Limited return to sports activities as directed by physician **Therapy:** • Continue stretches and mobilizations as needed to maintain full ROM • Advance strengthening for rotator cuff, low weight, increasing reps • Advance scapular stabilization exercises and eccentric strengthening • Advance strengthening for the rest of the U/E • Begin muscle endurance activities (UBE) • Begin plyometric and throwing program • Start light weight training and progress as tolerated • No bench press until after 16 weeks • Progress to light work simulation at 4-5 months or as requested by physician	**Goals:** • Full AROM and flexibility **Return to Sport:** • Follow RTS criteria for Upper Extremity