INTRODUCTION

Shoulder arthroplasty is now one of the rapidly growing orthopaedic reconstructive procedures giving good results for both hemi and total joint replacement. Arthritic and degenerative disorders of the glenohumeral joint constitute a major cause of joint related morbidity. Similarly, complex fractures of the proximal humerus represent a special difficulty since accurate reduction and fixation difficult to maintain **(Smith et al, 1998)**.

Such cases treated in the past with resection of the articular surfaces or excision of the head, which result in flail shoulder or with arthrodesis which relieve pain but compromises the joint function.Excellent results have been reported in over 90% of cases for both hemi and total shoulder arthroplasty. Rate of complications is lower than that of any other major joint reconstruction **(cofield, 1977).**

It is essential that patients receive proper rehabilitation following total shoulder arthroplasty and should ideally include preoperative visit.The rehabilitation program itself needs to be well defined ,logical sequence that respects the tissue healing joint morbidity and muscle strength***(Kisner and Colby, 1985).***

The assessment of a patient's general health and quality of life are important in understanding the outcome of any medical or surgical treatment. The purpose of shoulder arthroplasty is to restore comfort and function to the glenohumeral joint. Four basic mechanical characteristics are essential: Motion, stability, strength and smoothness. Each of these is commonly compromised in the arthritic shoulder and can potentially be restored by shoulder arthroplasty**(Radford et al ,1993).**