



Physical Therapy Protocol for Patients Following Shoulder Surgery

- **Rotator Cuff Surgery**
- **Shoulder Stabilization Procedures**
- **Labral Repairs**

General Guidelines:

- The program is designed to take into account whether tissue has been repaired or just arthroscopically cleaned and shaved
 - If tissue was repaired then an obligatory period of protection (immobilization) is necessary. Usually this is for no less than 4 and no more than 6 weeks.
 - If no tissue has been repaired then the program is more symptom driven rather than time dependent.
- Once therapy begins, the patient is encouraged to get rid of the sling/immobilizer
- Patients are counseled to avoid quick sudden movements, repetitive movements, reaching for any weight over a pound or two and avoiding any activity that requires force or power. Patients are discouraged from using arms (especially operated side) to get up from chair, bed, etc.
- Driving is not recommended until such time as the patient can safely get both hands on the steering wheel and operate the vehicle safely.
- Daily showers and hygiene is encouraged with the precautions already stated.

Considerations for Need for Protection Period

1. Type and size of tear
 - a. Partial v. complete
 - b. Small, medium, large or massive
2. Surgical Procedure performed
 - a. Arthroscopic repair
 - b. Mini-open (no deltoid detachment)
 - c. Standard open approach (deltoid detached)
 - d. No repair just debridement (usually for partial tears or massive irreparable tears)
 - e. Need for artificial patch graft
3. Method of fixation
 - a. Side to side repair
 - b. Tendon to bone usually with anchors
4. Mobility of tissue and ease of repair
 - a. Tissue mobile and easily repaired
 - b. Tissue somewhat mobile and difficult but repaired

- c. Tissue not mobile and only partial repair achieved
 - d. Tissue not mobile and cuff irreparable
5. Quality of tissue
- a. Good quality tissue and bone holds sutures/implants well
 - b. Decent quality (no significant concerns)
 - c. Fair to poor quality tissue

Phase I

0-2 weeks

- Most important concern is pain control, protection and personal hygiene
- Patients are instructed in proper showering, dressing and ADL
- Precautions are stated in post op instructions (given to patient after surgery) depending on what was done at surgery and the quality of the tissue/repair
- Patients should sleep with immobilizer and not take any chances
- Elbow, forearm, wrist and digits are mobilized to avoid stiffness and minimize edema at the elbow and hand
- Grip strengthening by using a "squeezy ball" keeps muscle pump going to reduce dependent edema
- Patients are seen at approximately 2 weeks for suture removal and wound check

2-4 weeks

- No significant changes are made
- Prescription is given for PT to start depending on what was done
 - No tissue repair just arthroscopic debridement- start at 2 weeks
 - Tissue repaired (any method) but good quality- start at 4 weeks
 - Tissue repaired but concerns about tissue integrity- start physician guided exercises at 4 weeks, formal PT at 6 weeks

Phase II

Begins when patient meets and begins working with therapist (usually at 4 weeks but may be as much as 6 weeks post op) and lasts up till about 10-12 weeks post op

- May discontinue sling/immobilizer unless needed out of the house or for comfort. It's use now becomes counter productive
- May sleep without sling
- May begin driving as soon as safe and confident (usually determined by patient)
- Therapy is 3 sessions a week for 4 weeks at a time
- Patients are encouraged and instructed in daily home stretches to assist therapist in achieving functional ROM

Motion

- Consists of AAROM with gentle passive assist by therapist to improve ROM and function (therapist manually guides patient through range of motion with slow steady stretching)
- Directions include forward flexion, abduction, IR, ER
- UBX, pulleys, cane stretches are all acceptable means to achieve ROM

Strengthening

- No isometrics (they generate very high tension which may disrupt tissue repair)
- Begin distally with grip strengthening, elbow flexion/extension PRE's with light hand held weights
- For proximal muscle strengthening think 3 P's (in sequence)
 1. **P**rimarily joint stabilizers - begin at core by conditioning the cuff muscles with light hand held weights and low resistance theraband to recover glenohumeral stabilizers
 2. **P**eri-scapular muscles – work on scapular retraction, protraction and elevation
 3. **P**ower movers – then lastly work on major limb positioners (pectoralis, deltoid, latissimus)
- Strengthening begins lightly and increases over time as tissue heals (no power activity for at least 3 months post op)
- Work muscle groups in proper sequence (i.e., don't do push ups for serratus before 3 months)

Function

- May begin using limb for ADL
- Light desk work is OK
- Non operative arm can be used as tolerated
- Significant restrictions remain for operated limb
- May do lower extremity cardiovascular type exercises

Phase III

10-12 weeks through 6 months

- Tissue to bone healing should be almost complete
- ROM should be approaching normal or at least making steady gains on a weekly basis
- No sports or heavy physical work yet
- Continue regular therapy schedule

ROM

- Need to be more hands on for patients who are not at near functional levels
- Encourage patients to “do what they cannot do”
 - If they can't reach behind then show them how to do this, if they can't wash their underarm show them how to reach for those areas with good stretches
 - Use unoperated side to help get operated limb to reach for those areas that are hard to get to

Strengthening

- Continues as before with progression to power movers and peri-scapular muscle strengthening
- Anterior and middle deltoids are key to success and proper shoulder function. They should be heavily emphasized during this time.

Function

- No sports that require any overhead, throwing. No recreational weight training except the exercises in PT which patient can do on non-therapy days at home
- Golf may be tried after 4 months if no pain, good ROM, normal or near normal strength (hit ball off tee for first month after return then resume normally)
- Progress in work hardening type program until back to normal function
- May do some light ground stroking for tennis players after 4 months progressing to easy overheads at 5 months, full serve at 6 months. Try doubles first then singles.

Phase IV

6 months until back to normal

- Throwers, overhead athletes (volleyball, tennis) and upper extremity weight bearing athletes (gymnasts) will take longest and may continue to progress over the next few months before full return is possible

SLAP Repair

For Patients who have undergone SLAP repair, use guidelines and timeframe for small cuff tear with good quality repair and tissue (i.e., start formal PT at 4 weeks) with following exceptions:

- Avoid abduction/ER coupled motion for the first 6 weeks post-op
- Avoid biceps resistance exercise for 8 weeks post-op

Shoulder Stabilization procedures

Capsular plications, capsular shifts, Bankharts (whether open or arthroscopic) use guidelines and timeframe for small cuff tear with good quality repair and tissue (i.e., start formal PT at 4 weeks) with following exceptions:

- Avoid abduction/ER-coupled motion for the first 6 weeks post-op; at 6-week point, slowly progress this coupled movement over next 4 weeks. Full abd/ER allowed 10 weeks post-op
- Go slow with ER at side – limit to 30 degrees at side for 6 weeks; at 6-week point, progress ER at side over next 4 weeks
 - For open repair, must violate the subscapula, therefore, as a general principle – protect subscapula

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