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ARTHROSCOPIC LABRAL REPAIR AND OPEN CAPSULAR SHIFT PROTOCOL

PHASE I (0-4 WEEKS)

Goals: To protect healing tissue, to minimize inflammation and pain, and to prevent atrophy/contractures of distal musculature while wearing sling.

PRECAUTIONS

- Sling wear required 24 hours/day (except to perform exercises described below)
- No shoulder elevation – active or passive

HOME EXERCISE PROGRAM

- Wrist and elbow AROM (remove sling and use caution not to elevate G-H joint)
- Grip strengthening
- Cryotherapy PRN
- If subacromial decompression was performed (look for lateral portal 3" inferior to subacromial arch), add the following exercise:
  PROM: 30° internal and external rotation at 0 and 45° of G-H abduction (rest elbow on supporting surface and use other hand to passively rotate arm in/out)

PHASE II (4-8 WEEKS)

Goals: To achieve full G-H PROM by 8 weeks but not sooner. To protect subscapularis repair and labral repair during the danger period. To gain proximal G-H stability with progression from isometric early to active by 6-8 weeks.

PRECAUTIONS

- G-H PROM and progression to AROM is allowed as progressed in physical therapy treatment
- With anterior labral repair – avoid excessive abduction and external rotation
- No isokinetic strengthening or theraband, hand weights or weight machines
- Sling wear discouraged (except when needed as visible sign of vulnerability in uncontrolled environment)

PHYSICAL THERAPY TREATMENT

4-6 WEEKS POST-OP:

- Grade I & II G-H mobilizations
- Scapulothoracic mobilizations and PROM
- AAROM using cane begin in supine position as tolerated by pain and strength and as limited by PROM
- G-H PROM progressed to achieve full ROM by 8 weeks but NO SOONER
- Aquatic Therapy: Begin AROM with shoulder submerged within comfortable ranges of motion (within precautionary ROM, if there are restrictions in place per MD) and progress toward full as passive range improves. All motions should be done with correct

biomechanics, include: scapular plane elevation, horizontal abduction/adduction, IR/ER at 0° pendulums.

6-8 WEEKS POST-OP:

- PROM using UBE at least resistive setting
- Light manual periscapular and cuff strengthening (rhythmic stabilization at 90, IR/ER at 0° and 45°)
- Progress AAROM to active with progression to reclined and then upright
- PNF scapular diagonals

HOME EXERCISE PROGRAM

- Pendulum exercises with emphasis on relaxed shoulder and using trunk as primary moving force
- Isometric strengthening of all G-H motions at 0° abduction
- Isometric strengthening of elbow flexion/extension
- AAROM with the cane in supine as tolerated by pain, strength and PROM
- Active shoulder elevation reclined with progression to upright once started in PT

PHASE III (8-12 WEEKS)

Goals: Progressive strengthening of RC and periscapular muscles. Full AROM

PRECAUTIONS:

- Full passive and active G-H ROM
- No weight machines or isokinetics except for controlled use of seated row and pulleys

PHYSICAL THERAPY TREATMENT

8-10 WEEKS:

- Grade I-IV G-H joint mobilizations, scapulothoracic joint mobilization if indicated stretching if full PROM has not yet been achieved
- Upper body ergometer (UBE) active exercise with little resistance and comfortable pace
- Rhythmic Stabilization with progression to PNF in a limited arc with progression to wider arcs
- G-H AROM in biomechanically correct ROM. Should include:
  - Supine serratus "punches", elevation in the scapular plane, sidelying ER, IR/ER with yellow Theraband at 0° of abduction

10-12 WEEKS - Add:

- Prone exercises – prone row, extension, abduction and scaption (row, ←, T, & Y)
- Begin light resistive isotonic strengthening of rotator cuff and periscapular muscles (manual resistance, theraband, light dumbbells) in mid-ranges and progress to end ranges as tolerated

HOME EXERCISE PROGRAM

- Continue Phase II exercises
- Active ROM and light strengthening as started in PT (for a total of 3-5/weeks including PT sessions)

PHASE IV (Weeks 12-24)

Goals: Maximize strength of rotator cuff muscles, periscapular muscles, and humeral movers (deltoid, latissimus, and pectoralis) as limited by pain/inflammation and incorrect biomechanics. Functional progression back to work and/or sports

PRECAUTIONS:

- Refer to physician for advice regarding activity restrictions

PHYSICAL THERAPY TREATMENT

- G-H joint mobilizations and PROM when indicated (aggressive stretching is indicated if full PROM has not yet been achieved)
- Progress isotonic strengthening of rotator cuff, periscapular muscles and humeral movers as tolerated (hand weights, theraband, weight machines. Work at 20% of maximal effort with increased repetitions and decreased amount of weight. Large muscle exercises including shoulder press, lat pull-downs, bench press – do not allow elbow to extend past plane of thorax
- Isokinetic rotator cuff strengthening in modified position (begin at 120-240°/sec.) Progress to 90° abduction (sitting or supine) and progress speed
- Begin and progress functional training (e.g. plyoball, work/sports-related skills) Progress to one-handed plyos including ball toss, ball on wall. Refer to physician regarding higher levels of function such as throwing, overhead sports, contact sports
- Eccentric RC strengthening using plyoball, deceleration tosses, T-band

- For high school athletes: at 12 weeks, passive ER should be 100-105°; allow the athlete to gain the rest on his own.
- For college/pro athletes: at 12 weeks, active ER should be 100-105° and passive ER should be 110-115° - allow the rest to come on its own
- Initiate interval throwing/toss program at wk 16 – consult with physician first
- Initiate sports specific/functional training

- At week 12, do a biodex test at 180°/sec and 300°/sec. – goal is for strength to be at 80% of unaffected side

- Expected Biodex results:
    - ER/IR ratio at 180°/sec: male–66; female- 71
    - Peak T/BW range for ER at 180°/sec: male11-15; female 8-12
    - Peak T/BW range for IR at 180°/sec: male 17-23; female 13-17

HOME EXERCISE PROGRAM

- Maintain ROM
- Continue Phase II-III exercises
- Progress to independence with strengthening program prior to discharge