

Post-Operative Shoulder Rehabilitation

These multidisciplinary guidelines form the basis of a progressive rehabilitation programme. These are general guidelines for the most common shoulder surgical procedures and are not designed to replace sound clinical reasoning. Any specific instructions from the consultant orthopaedic team either verbally or in post-operative notes must take precedence.

Rehabilitation Goals

- Preserve the integrity of surgical repair
- Restoration of functional range of movement
- Restoration of Rotator Cuff (RC) and scapula control through range
- Restore proprioceptive acuity
- Prevent compensatory movement patterns that may compromise recovery

Principles of Post-operative shoulder rehabilitation

The following should be considered at all times throughout the rehabilitation process:

- Good communication with the consultant team is paramount to a successful outcome for the patient.
- Comprehensive pain control should be in place and supported prior to discharge from hospital. Patients should be educated regarding appropriate levels of pain, particularly in response to exercise to reduce fear and anxiety.
- Cervical spine, elbow, wrist and hand activity should be maintained throughout.
- Quality of movement should not be sacrificed in the pursuit of range.
- Progression should follow the basic principles of rehabilitation from passive (PROM), active assisted (AAROM), active (AROM), isometric and resistance training.
- Rehabilitation programmes should only include 2-4 exercises. Too many exercises will affect adherence.
- Consider using short lever movements or closed kinetic chain (CKC) positions in appropriate situations.
- Consider incorporating functional movements whenever possible – for example use of the hand for specific occupational or sports activities.
- Functional milestones are for guidance only. Patients should not be accelerated through time markers without discussion with a member of the consultant team. Similarly, range, control and strength goals must be met before patients are deemed ready for progression, regardless of whether or not they have reached the time marker.
- The law states that patients **MUST** be in full control of a car before returning to driving. It is the patient's responsibility to ensure this and to inform their insurance company of their surgery.

Criteria for progression

Criteria for progression of exercise should always be based on:

- Ability to perform a movement with the correct movement pattern
- The patient being able to maintain good rotator cuff and scapula control – there should be no evidence of significant scapula winging or humeral head translation.
- Evidence that movement can be performed without compensatory muscle patterning (particularly Pectoralis Major and Latissimus Dorsi)

Bony Stabilisation Procedure – Latarjet

	Day 0	0-2 weeks	2-4 weeks	4-6 weeks	6-12 weeks	12weeks +
Advise	<p>Sling/collar & cuff for 4/52 only to be removed for axillary hygiene and exercises</p> <p>Neck /elbow/wrist/hand movements</p> <p>Pendular exercises</p>	Continued sling use and initial exercises	<p>At 4/52 gradually wean out of sling during day. Continue to wear at night for comfort as required</p> <p>Passive/supported flexion <120° e.g.</p> <ul style="list-style-type: none"> • Table slides • Walk backs <p>ER to neutral only (handshake position)</p>	<p>Light activities only should be performed – as a guideline no more than the weight of a cup of tea within field of vision, using short lever positions</p> <p>Progress supported movement to AROM.</p> <p>Gradual increase range of ER</p>	<p>Gradual introduction of ABD/ER positions</p> <p>Gradual introduction of OKC Long lever activities</p> <p>Isometric rotator cuff activity through available range. Patient should be able to achieve adequate ER (60-70%) before introducing resisted cuff activity above 90°</p> <p>Consider:-</p> <ul style="list-style-type: none"> • Kinetic chain integration • CKC work • Cuff and scapula recruitment through range • Functional movements with correct movement pattern 	<p>Functional active range of movement and strength</p> <p>Cuff and scapula recruitment through range with load in line with rehab principles</p> <p>Kinetic chain integration</p> <p>Incorporate sports/occupational specific rehab as required ensuring sufficient through range dynamic control (including eccentric control)</p>
Avoid	<p>AVOID:-</p> <ul style="list-style-type: none"> • Abduction/ER • Forced ER including EOR mobilisation • ER Stretching 				<p>AVOID:-</p> <ul style="list-style-type: none"> • Forced ER or ABD/ER • Resisted elbow flexion including heavy carrying 	

Key clinical points

- This procedure is mainly performed when there is some bone loss from the front of the glenoid (as a result of a bony bankart lesion or repeated dislocations wearing away the front of the glenoid). The procedure involves transfer of the coracoid with it's attached muscles to the deficient area over the front of the glenoid. This replaces the missing bone and the transferred muscle also acts as an additional muscular strut preventing further dislocations.
- Healing priorities are the same as other stabilisation procedures.