YORKSHIRE SHOULDER CLINIC

LEEDS | YORK | HARROGATE | ELLAND

ARTHROSCOPIC SUB-ACROMIAL DECOMPRESSION +/- ACJ RESECTION REHAB PROTOCOL

Aim of surgery: To relieve symptoms of sub-acromial and acromioclavicular pain syndrome.

Expected log-term outcome: Patient reports a relatively pain free shoulder which facilitates return to normal functional activities. Some patients may continue to experience mild discomfort with repetitive or heavy tasks overhead. These may need to be modified. Some patients may not regain full range into combined rotation (hand behind back) position.

It may take 6-12 months for patients to realise their full potential following the above procedure.

Rehab Guidelines

Up to Week 2

- Discard polysling as soon as pain allows
- Use arm as soon as comfortable
- Active-assisted to active elevation, limit OKC elevation above shoulder height
- Isometrics for rotator cuff
- Pain restricting range of motion to no less than 75% of pre-op.

Weeks 2 – 4

- Scapular exercises
- Theraband rotator cuff strengthening
- Minimize OKC elevation above shoulder height

Weeks 4 – 6

- Progress strengthening and ROM to full OKC
- Sport specific exercise when ROM allows and strength 90% of unaffected side
- Capsular stretches if appropriate
- No ROM restriction

Week 6

- Range of motion equal to the pre-operative range of motion
- Commence sport/repetitive overhead activities providing above goals achieved
- Majority have discomfort for at least 3 months
- Expected long term outcome may take 6-12 months to achieve

Milestones

- Sling for comfort 1-2 days
- Dressings removed 7-10 days post op
- Driving when comfortable
- Light work 3-4/52
- Return to pre op range of movement by 6/52
- Heavy/manual work 6-8/52

Options if failure to achieve Milestones

- Outpatient physiotherapy.
- Hydrotherapy.
- Referral to the Upper Limb team clinic

Failure to progress

If a patient is failing to progress, then consider the following:

Possible problem	Action
Pain inhibition	• Adequate analgesia • Keep exercises pain-free • Return to passive ROM if necessary until pain controlled • Progressing too quickly – hold back • If severe night pain/resting pain – refer to Shoulder Unit
Patient exercising too vigorously, patient not doing home exercise programme (HEP) regularly enough	• Increase or reduce physiotherapy/ (HEP) (max 2-4x/day) for few days/weeks and assess difference • Ensure HEP focuses on key exercises and link to function
Returned to activities too soon	Decrease activity intensity
Cervical/thoracic pain referral	Assess and treat accordingly
Unable to gain strength	Passive ROM may need improving – need 90° passive flexion to start eccentric deltoid work
Altered neuropathodynamics	Assess and treat accordingly
Poor rotator cuff control	• Ensure passive range gained first • Consider isometrics through range • Rotation dissociation through range with decreasing support and increasing resistance • Ensure not progressing through Therabands too quickly
Poor scapula control	Work on scapula stability through range without fixing with pec major/lat dorsi
Poor core stability	Work on improving core stability
Secondary frozen shoulder (more likely with RCR).	Maintain passive ROM as able