

ARTHROSCOPIC SHOULDER STABILISATION PROTOCOL

Aim of surgery: to repair the detached antero-inferior labrum (Bankart lesion) to the glenoid.

Possible complication: tight inferior capsule.

With more traumatic injuries, there may also be an avulsion of the anterior/inferior glenoid as well as the labrum and therefore surgery must re-establish the bony congruence. During a 'Latarjet procedure' part of the coracoid process is dissected and attached to the antero-inferior glenoid as a 'bone graft'.

Post-op rehabilitation is the same following a Bankart repair and a Latarjet procedure – although as the Latarjet procedure is more extensive this may be more uncomfortable initially, and may end up with some restriction of motion into elevation and external rotation, as a final outcome.

Expected long-term outcome Stabilisation: Pain-free, stable shoulder, which allows return to moderate – heavy activities. May need to modify duties if requires heavy overhead work (anterior stabilization) or heavy pushing, upper limb weight bearing (posterior stabilization). It may take 6-12 months for patients to realise their full potential following stabilisation surgery.

Day 1

- Instructions given regarding removal of the sling for washing / dressing, Axillary hygiene
- Polysling applied in theatre and retained for 3 weeks
- Teach scapula stabilising programme if indicated
- Table slides within safe range (provided in operation note)
- Kinetic chain exercises in sling
- CKC rhythmic stabilisation
- Commence **passive** forward flexion to tolerance, abduction to 90°, external rotation to 20° (unless directed otherwise by surgical team)
- Teach elbow, wrist and hand exercises
- Isometric rotator cuff exercises if arthroscopic procedure only, 30% maximal voluntary contraction
- Contralateral shoulder exercise advice



3 Weeks

- Initiation of **active** mobilisation programme; flexion as tolerated starting CKC and progressing to OKC once appropriate strength/range/control, external rotation 20°, abduction 90 degrees (unless directed otherwise by surgical team).
- Avoid passive stretch of external rotation beyond 20° or abduction beyond 90° until 4 weeks post-op.
- Scapula stabiliser programme if indicated
- **No terminal stretches into external rotation in abduction until 12 weeks.**
- Weight bearing rhythmic stabilisation (**NOT IF POSTERIOR REPAIR**)
- Proprioceptive exercises
- Kinetic chain exercises

6 Weeks

- Correct abnormal movement pattern
- Progress scapula stabilisation programme
- Rotator cuff rehabilitation
- Progress proprioceptive exercises

12 weeks

- Full exercise programme and strengthen the rotator cuff, through range of active movement.
- No limits on external rotation in neutral or abduction
- Check scapula control through full range of movement
- Commence terminal external rotation in abduction stretches
- Plyometric exercises
- Impact exercises

16 Weeks

- Graduated return to full activity
- Contact sport after 4 months (if milestones met)



Milestones

- Dressings removed 7-10 days post op
- Sling for 3 weeks
- Driving approx. 6/52
- Passive range of flexion at least 50% of pre-operative level @4/52
- Passive range of motion equal to pre-operative level and active range of motion at least 50% of pre-operative level @8/52
- Active range of motion equal to pre-operative level @12/52

Failure to progress

Possible problem	Action
Pain inhibition	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

