

Arthroscopic Shoulder Labral Repair Rehabilitation Protocol

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SHOULDER SURGERY

The recovery process after Shoulder surgery is straight-forward and this document is designed to help you and your physical therapist to get the best outcome!

Please visit Dr. Huang's website for post-operative care and early motion exercises. This page has many resources for you including training videos on dressing removal, crutch instruction, brace instruction, and even range of motion exercises!

The website is: <https://www.huangortho.com/shoulder-surgery-patients>

General recommendations:

- Do not hesitate to contact Dr. Huang's team with any questions or concerns
- Less is more! Do not push too hard, rest is an important aspect to recovery
- Manual therapy is an important part of your recovery, make sure your therapist includes range of motion, soft tissue manipulation, and joint mobilizations throughout your recovery.
- Setbacks are normal, recovery is never a smooth and straight line. Try not to get frustrated if you hit a setback and aim to work through it with your therapist

AFTER SURGERY

1. Medications: we give you a variety of medications to try to make the recovery go smoothly. Remember that most of these medications are AS NEEDED. So, if you do not need them, do not use them.
 - a. Pain medication (usually oxycodone or hydrocodone). This is the narcotic. It is to take the edge off of surgical pain. It will not eliminate the pain. These are addictive so please use sparingly.
 - b. Stool softener (Colace). While taking the narcotic, please take a stool softener to counteract the constipation caused by the pain medication.
 - c. Anti-nausea (ondansetron or phenergan). This is provided if you have nausea after surgery.
 - d. Muscle relaxant (cyclobenzaprine or other). This is provided to help with muscle spasms that can occur after surgery. This can be taken with the pain medication or all by itself. Please be aware that it makes most patients sleepy.
 - e. Blood thinner (aspirin or other). All surgical patients are at risk for blood clots. Based on your personal risk, we will prescribe one. Duration is based on the complexity of the surgery and the duration of risk.
2. Shoulder Sling: Prior to leaving the operating room a shoulder sling will be applied.
 - a. The sling helps to keep the shoulder in relative position. It WILL NOT be rigid.
 - b. For the first 24 hours, we recommend keeping it on at all times. After removing the dressing on the first day, you may remove the remove. The sling should be on

when you are up and walking/standing. The sling should be on when you laying down and sleeping. See video on Dr. Huang's website (www.huangortho.com)

- c. When sitting or reclining, the sling is NOT necessary and may be removed. This includes removing it during bathroom activities and also when showering.
3. If you chose to have a N'Ice or GameReady machine, we will help you set this up ahead of time. Please give us advanced notice.
 - a. For either machine, you can leave the cold compression on for 30-45 minutes before giving it a break. **Please note that the N'Ice or GameReady may not be reimbursed by your insurance company and that the patient may incur the cost of these devices.**
 - b. Ice packs or frozen bag of peas can be a great way to provide cold therapy to the knee. We recommend keeping these on for 20 minutes at a time and then allowing the knee to warm back up for another 20 minutes. Always keep a wash cloth or other layer between the skin and the ice pack.

RETURN TO WORK

1. As far as returning to work, if you have a desk type job you can return to work when your pain medication requirements decrease. Typically, this is between 5 - 10 days after surgery.
2. Patients who have jobs where light duty is not permitted will be out of work for a minimum of 6 - 12 weeks. Please discuss this with us as soon as possible so we can help you get all the details right!

WHEN CAN I DRIVE A CAR?

**REMEMBER, IT IS ILLEGAL TO TAKE PRESCRIPTION PAIN MEDICATIONS
AND OPERATE A MOTOR VEHICLE!**

1. First, you must not be taking any prescription pain medications.
2. Patients who have had surgery on the shoulder should not drive until they have good muscular control of the arm and feel that they can control the vehicle safely. This usually takes 1-6 weeks.

SHOULDER LABRUM REPAIR PROTOCOL

The intent of this protocol is to provide the therapist and patient with guidelines for the post-operative rehabilitation course after arthroscopic shoulder debridement, subacromial decompression, and labral repair. This protocol is based on a review of the best available scientific studies regarding shoulder rehabilitation. It is by no means intended to serve as a substitute for one's clinical decision making regarding the progression of a patient's post-operative course. It should serve as a guideline based on the individual's physical exam/findings, progress to date, and the absence of post-operative complications. If the therapist requires assistance in the progression of a post-operative patient they should consult with Dr. Huang. *Progression to the next phase based on Clinical Criteria and/or Time Frames as Appropriate.*

The physical therapy rehabilitation for shoulder labrum repairs will vary in length depending on factors such as:

- Degree of shoulder instability/laxity.
- Size and location of the tear.
- Length of time immobilized.
- Strength/range of motion status.
- Expected performance/activity demands.

PHASE I: (0 - 2 WEEKS) POST-SURGERY:

During Phase I, caution must be used to not overstress the repair. The primary focus during this phase is restoring range of motion. Depending on the size and type of repair, the physician may limit certain planes of motion.

- Patient is immobilized in a sling.
- Sling may be removed for gentle passive range of motion (ROM) exercises (flexion, abduction, external rotation) following physician restrictions.
- Active ROM for shoulder internal/external rotation (arms are positioned at the side with elbows flexed).
- Use modalities as needed.
- Joint mobilization of the glenohumeral and scapular thoracic joints.
- Shoulder shrug exercise.
- Scapular adduction.
- Ball squeezes.
- Pendulum exercise (Codmans).
- Active elbow flexion/extension (not resistance).

PHASE I: (2 - 4 WEEKS):

- Patient may or may not be in an arm support/sling.
- Use of modalities as needed (heat, ice, electrotherapy, etc.).
- Continue passive ROM exercises. Active-assistive (wall climbs, wand, pulleys, etc.) and active ROM exercises may be added.
- Add soft tissue massage / stretching to pectoralis minor.
- Continue with joint mobilization to improve ROM.

- Isometric exercises - internal/external rotation, abduction, flexion, extension. These may be done at multiple angles throughout the pain-free range of motion.
- Add forearm strengthening exercises (elbow and wrist).
- Active internal/external rotation exercises: the arm is position at the side. Tubing is used for resistance within the pain-free range of motion (as tolerated).
- Rows with tubing: low rows- stop at plane of body; rows at 90 degrees flexion- stop at scapular plane.
- Shoulder extension lying prone or standing (bending at the waist). Avoid the shoulder extended position by preventing arm movement above the plane of the body.
- Active horizontal adduction (supine) as tolerated (begin in scapular plane and continue in a pain-free range).
- Progress shoulder shrug exercise.
- As strength improves, progress to the following free weight exercises:
 - **Shoulder internal rotation:** perform sidelying with the involved side resting on the plinth. Elevate or support the lateral chest wall (pillow, bolster, wedge, etc.) to decrease the joint compression on the involved shoulder.
 - **Shoulder external rotation:** lie on the uninvolved side. Avoid excessive anterior translation of the humeral head by limiting the degrees of external rotation and shoulder extension, as needed.
 - **Supraspinatus exercise:** in the scapular plane if adequate range of motion is available (0° - 90°). The scapular plane is approximately 20° - 30° forward of the coronal plane.
 - **Active shoulder flexion:** exercise through available pain-free range of motion.
 - **Active shoulder abduction exercise:** to 90° performed in the scapular plane.
 - **Arm ergometer/Cycle:** for endurance exercise.

PHASE II (4 - 12 WEEKS):

- Continue capsular stretching, mobilization, and range of motion exercises as needed.
- Continue shoulder strengthening with free weights. Emphasize eccentric phase of contraction for the rotator cuff and posterior shoulder girdle musculature.
- Active horizontal adduction exercise - begin exercise with the starting position in the scapular plane.
- Add military press (performed in flexion angle of 140-160 degrees).
- Add push-ups. Maintain proper alignment of the shoulders and elbows at the starting position. Do not lower the body beyond the elbows. Instructing the patient to concentrate upon protraction of the scapula can emphasize the serratus anterior. Begin with wall-push ups. As strength improves, progress to floor push-ups (modified - hands and knees) or military (hands and feet) as tolerated.
- Initiate other closed chain stability exercises.
- Skill development. Begin practicing skills at a low intensity level for the specific sport/activity (e.g. tennis, baseball, etc.).
- For throwing athletes, initiate throwing program with emphasis on technique and endurance. (See Throwing Program).
- Add total body conditioning with emphasis on strength, endurance, and core stabilization. Include flexibility exercises as needed.
- Isokinetic test. Perform isokinetic strength and endurance test for the following suggested patterns: shoulder internal/external rotation (arm at side) if requested by MD.

PHASE III (12+WEEKS):

- Continue progressive sport specific skills.
- Continue capsular stretching as needed.
- Continue to emphasize the eccentric phase in strengthening the rotator cuff.
- Continue to progress isotonic exercises.
- Continue arm ergometer/cycle for endurance.
- Continue total body conditioning with emphasis on the shoulder (rotator cuff).