Dr. Travis Frantz
Texas Health Orthopedic Specialists
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Shoulder Posterior Labrum Repair Physical Therapy Protocol

Key Considerations

Surgical Technique and Procedures

- The labrum and capsule are sewn back to the bone using anchors placed in the bone and non-dissolvable sutures. This is done with a small camera called an arthroscope and through tiny incisions so that the rotator cuff and other muscles around the shoulder joint are minimally disrupted. The goal is often to "tighten" the shoulder joint so that there is no future instability, and the intent of the rehab protocol is to allow the shoulder to heal in this "tighter" state initially, and then gradually be stretched out in the later stages of the protocol to a functional level.

Patient Education

- It is important to take the time initially and throughout the course of rehabilitation with patients to discuss and review important considerations related to their injury. Remember that each patient will present with different post-surgical considerations, pain levels, goals etc. Reviewing this information with the patient and what to expect throughout the rehabilitation is of paramount importance.

Range of Motion/Sling

- Consistent usage of an immobilizing sling immediately following surgery will help to protect the surgical repair. It is safe to be out of sling only during showers, PT and HEP for the first 4-6 weeks with consideration of protecting all repaired structures from excessive stress. After 4-6 weeks per the surgeon's exam and protocol, it is safe to disregard usage of the sling.
- For the first 6 weeks, we want to avoid any passive stretching of the shoulder, particularly in the direction of prior instability (i.e. avoid internal rotation stretching for posterior shoulder labral repairs)

Strengthening

- Utilization of gradual muscle activation, proprioception and strengthening will be used in accordance with the protocol outlined below as well as physician guidance per each phase.

If at any time there are signs of infection (increased swelling, redness, drainage from the incisions, warmth, fever, chills or severe pain that is uncontrolled with the pain medication), please contact us at the office: (817) 283-0967

Rehab Milestones and Required Postop Clinical Visits in Office

- Sling wear (0-6 weeks)
- First post op visit (2 weeks)
  - Gentle range of motion (2-6 weeks)
- Second post op visit (6 weeks)
  - More aggressive range of motion (6-12 weeks)
- Third post op visit (12 weeks)
  - Transition to strengthening (12-20+ weeks)
- Fourth post op visit (20-24 weeks)
  - Return to sport anticipated around 24 weeks (6 months)

Physical therapy protocols, post-operative instructions, and other information can all be accessed at any time at *www.frantzorthopedics.com*

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Phase 1: Max Protection Phase (0-6 weeks)

Goals	• Pain and swelling control • Protection of repair • Maintain cervical spine, elbow-wrist-hand ROM
Precautions	• Wear sling at all times, including sleeping, for first 6 weeks. Only times it is ok to remove are during PT, during showers, and when performing home exercises. • **Avoid passive stretching of the shoulder in position of prior instability - for posterior shoulder instability this is adduction and internal rotation** • All exercises performed to tolerance only • No cardiovascular conditioning other than stationary bike with sling on

Suggested Exercises	• AROM elbow, wrist (gripping exercises, elbow motion/strength with arm in neutral)
	• AROM Cervical spine
	• Week 2-4
	  ◦ Begin PROM of shoulder at week 2, limiting supine flexion to 90 degrees, abduction to 60°
	• Week 4-6
	  ◦ Begin AAROM at week 4 (Pulley/rope/T-bar)
	  ◦ Do not push past 140 degrees flexion, 110° abduction, 20° IR, 20° extension
	• Pendulums (non-weighted) if patient tolerates (sometimes anterior labral repairs have pain with pendulums, do not perform if pain)
	• Anterior capsular mobilizations (avoid any stretch of posterior or inferior capsule/ extension)
	• Scapular strengthening and mobilizations in neutral (shrugs, depression, protraction, retraction)
	• Submaximal isometrics in all planes (ER only to neutral - straight ahead position)
	• Initiate proprioceptive training at week 3 (rhythmic stabilization drills)
	• Lower Extremity
	  ◦ Body weight squats
	  ◦ Calf raises
	  ◦ Glute activation (clams, bridges, lateral band walks)
	  ◦ Single plane lower extremity weight machines

Frequency & Duration	• 1x/week formal PT ◦ If patient rapidly progresses in ROM and joint kinematics in first 6 weeks, save PT visits for later phases of recovery, we will not skip ahead out of phase 1 before 6 weeks regardless of their clinical progress • Cryotherapy at least 3x/daily for 20 minutes for first 7-10 days, then at least for 10-15 minutes after every PT session
Progression Criteria	• Proper tissue healing and function • Minimal pain/swelling • Easy 120 degrees forward flexion, 90 deg abduction

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Phase 2: Early strengthening and regain ROM (6-12 weeks)

Goals	• Gradually restore full ROM • Protection of repair • Early scapular and rotator cuff strengthening with appropriate mechanics • Enhance neuromuscular control
Precautions	• Ok to discontinue sling at 6 weeks • No passive internal rotation stretching until 8 weeks postop at earliest • No maximal muscle contractions • No pushing/pressing motions • All exercises remain low to medium velocity • Avoid activities where there is a higher risk for falling or outside forces to be applied

Suggested Exercises	• PROM, AAROM (in scapular plane), AROM all ok, avoid any aggressive IR stretching
	  • Goal is for symmetric ROM in all planes but IR by week 10 (ER should still be a little tight) - avoid strengthening activities with posterior loading of shoulder
	• Elbow
	  ○ Continue banded wrist and hand exercises
	• Shoulder
	  ○ Range of Motion
	  ○ L-Bar active-assisted exercises
	  ○ Rope and Pulley exercises, Finger ladder exercises
	  ○ Strengthening Exercises
	  ○ Tubing exercises IR/ER at 45 degrees abduction
	  ○ Rhythmic stabilization exercises
	  ○ Begin PNF activation/patterns
	  ○ Initiate isotonic dumbbell program
	  ○ Bicep, tricep push downs
	  ○ Latissimus dorsi, rhomboids
	  ○ Scapular strengthening with arm at 0 or 30 degrees abduction
	  ○ Prone rows, extensions
	  ○ Prone horizontal abduction without ER
	• Thoracic
	  ○ Scapular activation, shrugs
	  ○ Can initiate upper-extremity weight-bearing exercises (hands on bench, table, wall)
	• Lower Extremity
	  ○ Ok to begin multiplane lower extremity machines (e.g. leg press), avoid any lower body exercises where bilateral upper extremity involvement or lower extremity balance is required
	• Manual resistance and perturbation training
	• Side lying ER, standing series, prone abduction/extension (progress ER strengthening to 90/90 position at week 10)
	• Ok for cardio work (walking, jogging, stationary bike - no swimming)
	• Ok for chip/putt golf at 8 weeks

Frequency & Duration	• Frequency of PT visits: formal PT 3x weekly (ok for 2x week if 3x is not possible)
Progression Criteria	• Pain free full active shoulder flexion and abduction with no scapular dyskinesis • 4/5 MMT for scapular/rotator cuff muscles

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Phase 3: Advanced/dynamic strengthening (12-20 weeks)

Goals	• Maintain full ROM • Restore muscular strength, power, endurance, and balance • Protection of repair • Gradually initiate functional activities
Precautions	• No contact, no throwing or overhead sports • All exercises should be gradually progressed - don't lift 20 lbs if you haven't lifted 10 lbs, try not to progress more than 10-20% per week

Suggested Exercises	• Continue to progress resistive exercises (can increase intensity and decrease reps)
	• Initiate light plyometric activities (starting with 2 hands, progressing to 1 after 2 weeks)
	• Increase eccentric exercises, speed of exercises, diagonal patterns
	• Neuromuscular/proprioceptive exercises
	• Shoulder
	  ○ Advance ROM to functional demands of sport
	  ○ Dumbbell and medicine ball exercises incorporating rotator cuff usage
	  ● ER bands/tubing exercises at 90 deg abduction
	  ○ Advance dumbbell strengthening program
	  ○ Prone exercises (bands, small dumbbells)
	  ○ Push up progressions
	  ○ Advanced PNF patterns
	  ○ Thrower's Ten
	• Thoracic
	  ○ Medicine ball thoracic rotational forces
	• Lower extremities
	  *Lower body training to be performed on off days of rehab.
	  ○ Continue to advance barbell training per PT and physician discretion
	  ○ Advanced balance and proprioceptive training
	• Cardio
	  *Advance cardio conditioning to sport specific training per PT and physician discretion
	  ● Sprinting, sleds, ropes

Frequency & Duration	• Frequency of PT visits AND frequency/duration limitations: 2x week
Progression Criteria	• Full, nonpainful ROM (ER within 10-15 degrees compared to nonsurgical side) • Fully symmetric posterior shoulder mobility • 5/5 isometric shoulder MMT, 5/5 scapulothoracic and rotator cuff MMT • Strength 70% or better than nonsurgical side

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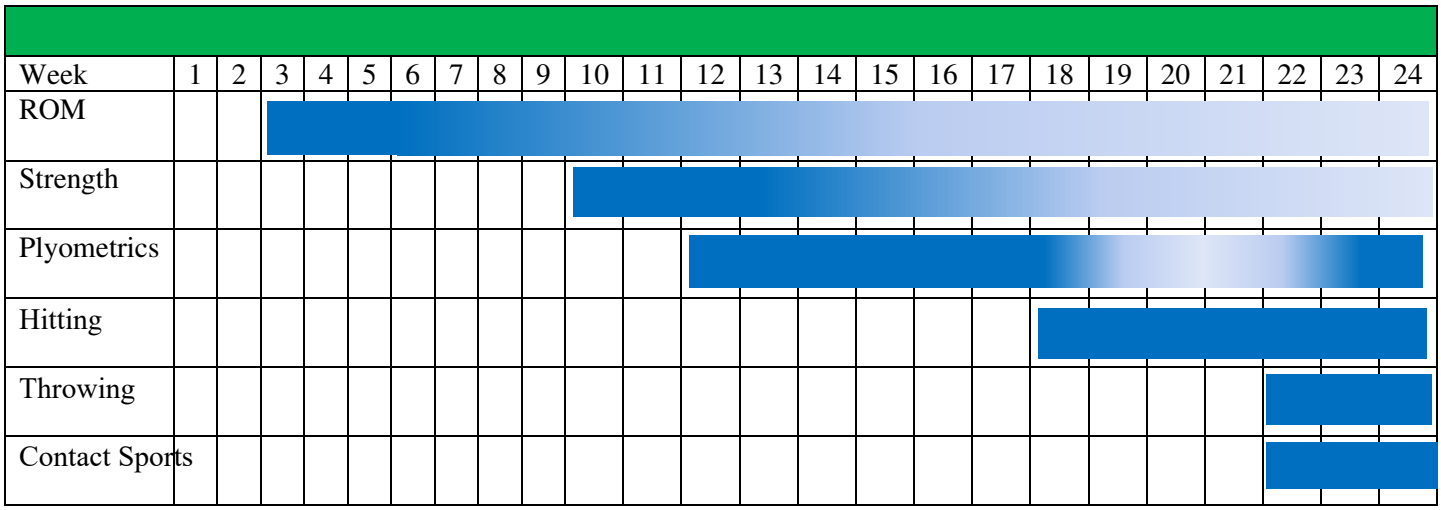
Phase 4: Return to Sport (□□□weeks)

Goals	• Enhance strength, power, endurance • Progress functional/sports activities • Maintain shoulder mobility
Precautions	• Advancing return to sport exercises based on patient comfort and tolerance • Communicate with MD regarding setbacks
Suggested Exercises	○ Thrower's ten ○ Plyometric strengthening ○ Neuromuscular control drills ○ Continue flexibility exercises ○ Continue isotonic strengthening program ○ Interval return to sports programs (links to throwing/hitting programs online at frantzorthopedics.com)
Frequency & Duration	• Frequency of PT visits AND frequency/duration limitations: 1-2x week
Progression Criteria	• Full painless ROM • Strength equal to nonsurgical shoulder • MD clearance for final return to sport



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