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Arthroscopic shoulder stabilisation is a common procedure to restore shoulder stability in patients with capsulolabral avulsions without substantial bone loss.

These guidelines are designed to aid the therapist treating the patient who had an arthroscopic stabilisation procedure.

Rehabilitation considerations

Reassurance and support regarding the injury and the rehabilitation process has an impact in successful return to play following shoulder stabilisation. It is important to ascertain any fears associated with the shoulder instability and educate the patient accordingly to optimize outcome.

Phase I (Weeks 0-4)

Goals:

- Protect the integrity of the surgical repair and optimize tissue healing
- Minimise shoulder pain and inflammatory response
- Gradual restoration of passive range of motion
- Enhance scapular stability
- Prevent compensatory movement patterns that may compromise recovery

Rehabilitation

- The sling is worn for 3-4 weeks to relieve pain and to protect the repair and avoid the arm being accidentally knocked into risk positions. The sling can be removed to allow axillary hygiene and rehab.
- In patients who present with high pain levels and, or lack neutral rotation at 2 weeks post-surgery, it is important to remove the sling at this stage
- Can wean out of sling after 3 weeks if comfortable

- It is important to be aware to the 'safe zone' from the post-operative notes. The 'safe zone' positions are areas in space where it is safe to move the surgical arm, preventing significant stress on the surgical repair or injury

(Funk, 2016). Generally, this is movement anterior to the scapula plane below 120 of elevation. Do not push into pain.

- Avoid combined abduction and external rotation
- Avoid forced end range mobilization especially external rotation with arm in neutral.
- Elbow/wrist/Hand range of motion and grip strengthening
- Begin shoulder active assisted / active supported range of motion (do not force any painful motion) within the safe zone.
- Rotator cuff / Scapula muscle facilitation exercises. Note that the patient requires adequate rotational range of motion before introducing active, through range cuff facilitation work above 90.
- Incorporate kinetic chain
- Heat/Ice before and after PT sessions.

Phase II. (Weeks 4-10)

Goals

- Protect integrity of the surgical repair
- Restoration functional range of motion
- Cuff recruitment and scapula control through range
- Re-educate and enhance proprioceptive acuity

Rehabilitation

Avoid passive stretching into combined abduction / external rotation. Can encourage active movement into this position provided the patient demonstrates good control and does not report apprehension.

- Progress cuff and scapula recruitment through range
- Incorporate kinetic chain
- Dynamic rhythmical stabilisation for cuff and scapula
- Closed kinetic chain work

Phase III – Strengthening (Weeks 10-16)

Goals

- Restore full active range of motion

- Optimise reactive neuromuscular stability
- Restore optimal cuff and scapula control through range and under load
- Optimise shoulder power, strength and endurance
- Return to full work, sport and recreational activities

Rehabilitation

- Regain range of motion into combined positions
- Enhance neuromuscular control through range and incorporated with kinetic chain
- Functional plyometrics
- Dynamic rhythmical stabilisation drills in risk positions
- Functional specific strengthening, power and endurance exercises for rotator cuff and scapulothoracic muscles
- Functional specific kinetic chain strength and endurance

Phase IV Overhead activity / return to work and sport (Months 4-6)

Goals

- Regain full range of motion
- Return to full strenuous work and recreational activities

Rehabilitation

- Progress strengthening as tolerated through full range of motion
- Continue shoulder stretching and strengthening at least 4 times per week
- Weight training can gradually resume with caution especially with exercises such as wide grip bench press, triceps dips, pull-downs behind the neck where the arms are repeatedly placed behind patient. Be sure to always see your elbows.
- Return to sport at 4-6 months. May initiate plyometrics / interval programme if cleared by surgeon. Incorporate return to play / contact drills.
- Average return to play currently reported as 5-14 months