TWIN CITIES ORTHOPEDICS

Brian Bjerke, MD

Arthroscopic Anterior Shoulder Stabilization

Post-Operative Protocol

Maximum Protection (Weeks 0 to 2):

Weeks 0-2:

- Sling: 4-6 weeks
  - May remove sling for hygiene and physical therapy purposes only
  - Dr. Bjerke will instruct when okay to transition from the sling
    - Generally around 4-6 weeks post-operatively
- Non-weight bearing operative extremity x2 weeks
- No glenohumeral joint ROM x2 weeks

- Goals:
  - Reduce inflammation
  - Decrease pain
  - Postural education
- Exercise Progression:
  - Sling x4-6 weeks
  - No GHJ ROM x2 weeks
  - Ice and modalities to reduce pain and inflammation
  - Cervical ROM and basic deep neck flexor activation (chin tucks)
  - Active hand and wrist ROM
  - Passive elbow flexion
  - Active shoulder retraction
  - Encourage walks and low intensity cardiovascular exercise to promote healing
- Manual Intervention:
  - Upper trapezius, para-scapular soft tissue massage as needed
  - Effleurage massage to forearm and upper arm as needed

Phase I – Passive Range of Motion (Weeks 2 to 4):

- Goals:
  - Postural education with cervical spine and neutral scapular positioning
  - Shoulder flexion to 120° by week 4
  - Shoulder external rotation 30-45° at 45° abduction by week 4

- Exercise Progression:
    - Supine flexion using contralateral arm for ROM at least 3x/day
    - Supine ER using T-bar
    - Shoulder pendulums
    - DNF (deep neck flexors) and proper postural positioning with shoulder retraction exercises
    - Cervical ROM
    - Low to moderate cardiovascular work
        - May add elliptical but no running
- Manual Intervention:
    - Soft tissue massage: global shoulder and cervicothoracic junction
    - Scar tissue mobilization when incisions are healed
    - Graded glenohumeral mobilizations
    - ST mobilizations
    - Gentle sub-maximal therapist directed isometrics to achieve ROM goals

Phase II – Active Range of Motion (Weeks 4 to 6):

- Goals:
    - Discontinue sling as instructed
    - Shoulder flexion to 150°+ by week 6
    - Shoulder external rotation 45°-60° at 75° abduction
        - Patient should approach full ROM by week 10
    - Internal rotation to belt line
- Exercise Progression:
    - Serratus activation; ceiling punch (weight of arm) many initially need assistance
    - Manual perturbations supine with arm in 90° flexion and ER/IR at 0°
    - Scapular strengthening – prone scapular series (rows and I's)
        - Emphasize scapular strengthening under 90°.
    - External rotation on side (no resistance)
    - Cervical ROM as needed to maintain full mobility
    - DNF and proper postural positioning with all RC/SS exercises
    - Low to moderate cardiovascular work. May add elliptical but no running
    - Continue with combined passive and active program to push full flexion and external rotation achieving ROM goals outlined above
    - Stick off the back progressing to internal rotation with thumb up back and sleeper stretch
    - Sub-maximal 6 direction rotator cuff isometrics (no pain)
- Manual Intervention:
    - Soft tissue massage: global shoulder and CT junction
    - Scar tissue mobilization
    - Graded GH mobilizations
    - ST mobilizations

- Gentle CR/RS to gain ROM while respecting repaired tissue

Phase III – Progressive ROM and Strengthening (Weeks 6 to 12):

- Goals:
  - Gradual progression to full P/AROM by week 10-12
  - Normalize GH/ST arthrokinematics
  - Activate RC/SS with isometric and isotonic progression
- Exercise Progression:
  - Continue with combined passive and active program to push full flexion and external rotation
  - Internal rotation with thumb up back and sleeper stretch
  - Continue with ceiling punch adding weight as tolerated
  - Advance intensity of sub-maximal rotator cuff isometrics
    - May discontinue once isotonic RC/SS program is fully implemented.
  - Advance prone series to include T's and Y's adding resistance as tolerated
  - Resisted ER in side-lying or with bands
  - Gym: rows, front lat pulls, biceps and triceps
  - Scaption; normalize ST arthrokinematics
  - Supine progressing to standing PNF patterns, adding resistance as tolerated
    - Protect end range 90/90
  - CKC progression – Quadruped, ball compression, counter weight shift, knee scapular push-ups, knee push-ups; all as tolerated
    - 1/2 to 3/4 ROM protecting the anterior shoulder capsule
  - Therapist directed RS and perturbations in quadruped – bilateral progressing to unilateral-tri pod position
- Manual Intervention:
  - STM and Joint mobilization to CT junction, GHJ and STJ as needed
  - CR/RS to gain ROM while respecting repaired tissue
  - Manual perturbations
  - PNF patterns

Phase IV– Advanced Strengthening and Plyometric Drills (Weeks 12 to 24):

- Goals:
  - Gradual progression to full ROM with protection at end range 90/90
  - Normalize GH/ST arthrokinematics
  - Advance gym strengthening program
  - Begin RTS progression
  - Evaluation with physician for clearance to full activity

- PRE/PSE:
    - Full range of motion all planes – protecting end range 90/90
    - Begin strengthening at or above 90° with prone or standing Y's, D2 flexion pattern and 90/90 as scapular control and ROM permit
        - Patient goals/objectives will determine if strengthening above 90° is appropriate
    - Continue to progress RC and scapular strengthening program
    - Continue with closed chain quadruped perturbations; add open chain as strength permits
    - Advance gym strengthening program maintaining anterior shoulder precautions with pressing and chest fly exercises
    - Initiate plyometric and rebounder drills as appropriate
    - RTS testing for interval programs (golf, tennis etc.)
    - Follow-up examination with the physician (6 months) for release to full activity
- Manual Intervention:
    - STM and Joint mobilization to CT junction, GHJ and STJ as needed
    - CR/RS to gain ROM while respecting repaired tissue
    - Manual perturbations
    - PNF patterns

Criteria for return to play/discharge:

- Full, pain-free ROM
- Normal GH/ST arthrokinimatics
- >90% MMT using handheld dynamometer
- Full progression through interval program
- Anticipated return to play for contact athlete is 4 months
- Anticipated return to play for throwing athlete, swimmer and volleyball is 6-9 months

*Please feel free to contact Dr. Brian Bjerke's office with any questions or concerns. Dr. Bjerke's care coordinator Andria Larson is available by phone at 952-456-7095.