OUTPATIENT POST-OPERATIVE PHYSIOTHERAPY GUIDELINES

Posterior stabilisation of the shoulder (for post instability).

This operation is **done infrequently** in comparison to Anterior stabilisation procedures. The shoulder will be dislocating predominantly postero-inferiorly. Conservative care (physiotherapy) is the first line of treatment. The shoulder problems can be complicated in this group of patients, often involving *pain & elements of abnormal muscle patterning*.

The operation normally involves tightening the capsule to try and prevent posterior dislocation. This involves a) a capsular tightening repair and b) posterior putti-platt procedure. A glenoid osteotomy may also be done if necessary to provide a posterior bony buttress. Infraspinatus will be shortened (the equivalent of subscapularis in the anterior stabilisation procedure). **Medial rotation, flexion & adduction will 'stretch' the repair**.

Therefore the shoulder ***may need*** to be *immobilised in abduction and external or 0° rotation immediately after the operation*. The exact amount of this will be dependent on the instability of the individual shoulder. A general guide is 15° flex, 0° rotation, 40° abduction, but it may be more or less. 'Routine' time for immobilisation is 4 weeks but it may be longer (rarely more than 6 weeks). Splint only removed for axilla hygiene and elbow movement.

Outpatient

Once doctors have given instructions for mobilisation to start – normally 4 weeks – wean out of splint.
Can use polysling or collar and cuff until comfortable & to stop inferior distraction, if occurring.

For 4 weeks following mobilisation date – **main emphasis is on regaining movement through abduction & lateral rotation, facilitating appropriate muscle activity around scapula & cuff.**

Passive to active assisted to active (eg. Slings, hydrotherapy, sliding boards) not above 90°. Short levers to long levers
Encourage movement **through abduction** or plane of the scapula
Neutral to lateral rotation with movement
Extension
Lateral rotation – passive and active assisted
Do not start with pendular swings etc.
Start **isometric** abduction and lateral rotation
Get scapula movement & stability
Do not emphasise latissimus dorsi work
Correct any trunk side-flexion and hyper-lordosis.
If regains movement quickly – do not push mobility.
Work on *movement patterning* and muscle re-education – scapula & cuff. Open and closed chain.

At 8 weeks post mobilisation – main emphasis is on regaining flexion & medial rotation range of movement without force/stretch

Start flexion – active assisted to active
Start hand behind back
Progress to isotonic cuff and general strengthening (look for and avoid any over-activity in muscle groups – e.g.latissimus, pectoralis)
Progress scapula muscle activity

At 12 weeks post mobilisation – main emphasis is on regaining cross body adduction and maximising muscle control and strength around shoulder complex.

Start horizontal flexion/cross body adduction range
If regaining range quickly do not emphasize end of range stretches
Generalised strengthening but with care (see above – emphasis on abductors and lateral rotators)
Movement patterning without effort may still be more important at this stage

Guidelines for returning to activities

Dependent on start of mobilisation programme
Protective phase can be long, depending on degree of instability & pre- operative muscle activity.
e.g. Driving may not be possible for 8 weeks
No heavy work and/or contact sports for at least 6 months
Surgeon should advise/liase as necessary.

If you would like further information/advice regarding rehabilitation please contact Jane Moser, Clinical Physiotherapy Specialist; 01865 227245.