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SHOULDER REHABILITATION GUIDELINES FOR ROTATOR CUFF REPAIR

Shoulder rotator cuff repair may be performed either arthroscopically or in an open fashion. Frequently, it is performed in a "mini-open" fashion. Other surgery may have been involved such as subacromial decompression, or A/C joint resection or labral reattachment. Smoking is discouraged for 6 weeks post-operatively to promote healing. Weight loss is encouraged when appropriate to decrease tissue stretching.

Please keep in mind the driving surgical intervention. Sometimes multiple simultaneous procedures are performed on the shoulder. In this event, the driving surgery should take precedence over the other procedures in terms of rehabilitation in the following order: posterior capsular stabilization (arthroscopic)>rotator cuff repair>anterior capsulorhaphy(arthroscopic)>SLAP repair>anterior capsulorhaphy or Bankart repair(open)>total shoulder replacement or hemiarthroplasty>biceps tenodesis>adhesive capsulitis MUA or resection>subacromial decompression.

Stage 1(day 1-4 weeks): Either the "mini-abduction" or the large abduction pillow stays on at all time when not exercising, ranging from 4 to 6 weeks. Gravity pendulum exercises (20 seconds--4x/day). Place back in abduction pillow when not exercising except to shower. Release wrist strap 4x/day x 20 seconds to bend and extend elbow, then reattach. Can passively externally rotate to 30 degrees with arm abducted on the pillow. Begin gripping exercises with ball or putty. Cervical spine AROM. Cryocuff use encouraged.

___If checked, complex repair (multi-directional instability, complex revision or obesity), then patient must remain in immobilizer 6 weeks, then proceed to stage 2 of protocol. This group may also have the large abduction pillow rather than the "mini-abduction pillow."

Stage 2(4-8 weeks): Can wall climb forward and lateral to 110 degrees 4x/day.(or 6 weeks if modification if checked above). Can passively or actively externally rotate up to 30 degrees at side and 90 abduction, progressing up to no more than *minus* 10 degrees of ER compared to the other side). Passive horizontal flexion 20 degrees passed straight in front of body. Submaximal isometrics may be started.

If these motions are achieved: PRE and 1-2 pounds strengthening can be initiated. Shoulder shrugs and ROM retraining, no passive stretching beyond above limits; postural retraining. Can initiate deltoid strengthening, elastic tubing or Theraband or free weights, wall pulleys.

Stage 3(6-8 weeks): Can initiate peri-scapular, deltoid, biceps, triceps strengthening with elastic tubing,

free weights, wall pulleys. Do not stretch the last 10 degrees of external rotation or abduction or forward elevation as compared to opposite side; let this come back on its own, but should stretch up to this point. Emphasize posture, scapular stabilization (protraction, retraction, and elevation), and external/internal muscular endurance.

Stage 3(8 weeks-12 weeks): Advance to home program or self directed gym program, teaching PNF patterns, upright rows, shoulder strengthening and endurance. You may monitor this 1-2 x/month and make adjustments. Patient should avoid overhead activities and vibration. Patient may gradually progress up to lifting, pushing, pulling up to 50% of "normal" load.

Stage 4(12 weeks and beyond): Patient gradually progress to lifting, pushing, pulling up to 100% over the course of the next 4 weeks. Patient may progress to overhead activities by 4 months post-operative. Start functional rehabilitation for throwing or other functional rehabilitation programs, as necessary.