Edmonton Region Shoulder Rehabilitation Guidelines - Arthroscopic Bankart Repair

Surgery Date:_____ **Surgeon:**_____ **Procedure / Tissue Repaired:**_____

Specific Patient Information: _____

☐ **Standard Protocol** ☐ **Non - Standard Protocol** **Explain:** _____

_____

PHASE I - Immobilization (0 – 4 weeks)

GOALS OF PHASE	SPECIFIC TREATMENT INTERVENTION	CRITERIA FOR PROGRESSION TO PHASE II

Primary:
• Optimize / Protect healing (capsulolabral) tissue
• Decrease Pain and Inflammation
 	
Secondary:
• *Protected* GH joint ROM and Strength
• Scapulothoracic Stabilization
• Address Kinetic Chain (adjacent joints, posture, etc.)
• General Health / Wellness
Cautions:
• **No active or passive movement beyond the specified ROM, *especially External Rotation (ER)***
• **No heavy lifting, pushing, pulling or use of arm beyond ROM listed**
	Primary:
	• Immobilization in sling/swath
	• Out of sling 3 – 4 times/day for washing / PT exercises only *(shld maintained in add/IR)*
	
	• Ice/EPAas needed for pain relief
	• Advice on sleep/rest/ positions
	
	Secondary:
	
	Dosage for all exercises are dictated by pain and patient being able to perform <u>without compensation</u>
	
	• Standing pendular ROM exercise (unweighted; ROM to dinner plate circumference only)
	• AAROM flexion 0 - 30° / scaption 0 - 30° / ER to neutral
	
	• Submaximal isometric exercises as pain allows (shoulder in adduction and IR)
	
	• Scapular setting exercises in sitting (retraction/retraction & depression)
	  • Shoulder in sling or supported at side in adduction/IR
	  • May progress to sitting on physio ball or standing
	
	• Wrist / hand / elbow ROM / ball gripping ex. with shoulder in sling or supported at side in adduction/IR
	• C-spine/T-spine ROM exercises (as directed by PT)
	• Posture exercises (as directed by PT)
	
	• CV exercises with shoulder in sling (recumbent stationary bike, walking)
		• Tissue healing ie. no sign of abnormal / disruption to repair / adherence to immobilization
		
		• Pain significantly reduced at rest
		
		• Patient able to properly set scapula with arms at side

For more information regarding these guidelines please go to:

https://www.ualberta.ca/rehabilitation/research/research-groups/shoulder-and-upper-extremity-research-group-of-edmonton/shoulder-rehabilitation-guidelines

PHASE II - Initial Mobilization & Strengthening (4 weeks – 12 weeks)

GOALS OF PHASE	SPECIFIC TREATMENT INTERVENTION	CRITERIA FOR PROGRESSION TO PHASE III

Primary:
• Increase GH joint ROM (Active-Assist, Active)
• Improve shoulder girdle neuromuscular strength and control
• Protect healing capsulolabral tissue
• Minimize shoulder pain
Secondary:
• Increase functional activities (ADL)
• Increased integration of kinetic chain (adjacent joints, posture, etc.)
• General Health / Wellness
Cautions:
• **No passive stretching of the shoulder beyond the boundary achieved with active ROM <u>unless directed</u> <u>by surgeon</u>,** ***especially into ER***
• **No heavy lifting, pushing, pulling or use of arm beyond ROM listed**
• **No strengthening or loading of the shoulder in abduction and ER**
	Primary:
	• Immobilization in sling/swath discontinued
	• AAROM → AROM exercises
	No stretching beyond AROM limit <u>(NO ABD+ER UNTIL 12 WEEKS)</u>
	Patient can progress to active ROM when able to move through range <u>without pain and without compensation</u>
	• Pendular ROM exercises (unweighted; ROM to dinner plate circumference only)
	  • May progress by adding scapular retraction / protraction
	• Isometric → Isotonic strength exercises:
	  • Focus on rotator cuff in neutral first, then in painfree ROM
	  • Avoid long lever exercises and position of abd+ER
	  • Progress to above shoulder height only if patient can control scapula and perform without compensation
	• Scapular stabilization exercises (retraction / retraction & depression AND protraction)
	  • Progress to arms at side, short arc/short lever dynamic movements with resistance (rowing, ball on bed ex.)
	All shoulder girdle strength exercises should be performed with <u>Proximal Stability</u> (proper spine posture and stable scapula) and progressed only if patient can maintain this position while performing the exercise
	• Closed Kinetic Chain exercises (Eg. gentle weight-bearing onto large physio ball/table, quadruped position – all with proper scapular positioning)
	• Ice and EPAs as needed for pain relief
	Secondary:
	• Continue wrist / hand / elbow / spine ROM and posture exercises as required (especially C-spine side flexion & T-spine extension and rotation ROM)
	• Progress CV exercises (directed by PT)
	• Educate/advise on appropriate and safe return to ADL activities
		• Patient able to actively elevate shoulder to a minimum of 120° of scaption **AROM achieved with minimal to no pain and with proper scapulohumeral rhythm**
		• Patient able to easily set scapula with arms at side AND maintain with dynamic arm activity (below 90° shoulder elevation)
		• Patient able to perform prescribed dosage of strength exercises with good technique/control and without reproducing pain and/or symptoms
		• Improved strength of shoulder girdle musculature from initial assessment (outcome measure: resisted isometric testing)
		• Patient reports overall increase in use of affected arm in ADL activities

PHASE III – Strengthening & Return to Activity (12 – 24+ weeks)

GOALS OF PHASE	SPECIFIC TREATMENT INTERVENTION	CRITERIA FOR PROGRESSION TO RTA/ HOME PROGRAM

Primary:
• Improve and normalize shoulder girdle neuromuscular strength, endurance & proprioception
• Full, functional ROM of GH joint and entire U/E kinetic chain
Secondary:
• Full return to all ADLs, work and recreational activities
• Protect healing capsulolabral tissue; especially in positions of abd/ER
 	
Cautions:
• **Stretching of the shoulder into abd/ER**
• **Heavy lifting, pushing, pulling or use of arm in ER positions ; <u>especially abd and ER</u>**
• **Overhead dynamic activities (ie. throwing)**
	Primary:
	• Shoulder Girdle Strengthening (emphasis on scapular stabilizers and rotator cuff)
	  • Begin with shoulder in neutral at side then gradually progress to performing exercises at waist level, shoulder level, etc.
	  • Progress to combined, functional movement patterns vs. isolated movements)
	  • Dosage should reflect strength & endurance goals
	
	All exercise progressions based on patient being able to perform prescribed dosage with good technique (i.e. scapular control) AND without reproducing pain and/or other symptoms
	
	• Functional / U/E Kinetic Chain Exercises (wall washing, ball on the bed or wall, functional movement patterns, PNF patterns)
	  • Progress dosage, ROM, functional positions, speed, reaction time, L/E challenge
	• Closed Kinetic Chain exercises (as in Phase II)
	  • Progress by increasing weight bearing through U/E, adding perturbations, endurance, functional positions, etc.
	
	All kinetic chain exercises should be performed with <u>Proximal Stability</u> (proper spine posture and stable scapula) and progressed only if patient can maintain this position while performing the exercise
	
	• Range of Motion / Stretching
	  • Continue AROM – focus on combined, functional ROM
	  • May begin active only ROM into ABD+ER
	  • May begin careful stretching / <u>careful stretching into ER</u> (shoulder in adduction) only as required
	  • Posterior capsule and/or pectoralis minor stretching as required
	
	No stretching in apprehension position (90° abduction / 90° ER)
	
	Secondary:
	• Activity-specific exercises to address functional goals for returning to ADL/work/recreational activities
	  o including advise on weight training exercises – avoid exercises such as dips, chin ups, or any exercise that places the arm/elbow behind the plane of the body)
	
	• Advise on maintaining or increasing CV fitness
		• Improved strength and endurance of shoulder girdle musculature (compared to beginning of Phase III)
		
		• Patient able to demonstrate proper scapular control with dynamic testing (ie. GH joint ROM and/or functional movement pattern)
		
		• Full, functional GH joint AROM **AROM should be painfree and performed with proper scapulohumeral rhythm**
		
		• Patient able to use affected arm in ADL activities and has been able to return to work
		
		• Patient has been able to return to recreational/sport activity (unless restricted by surgeon)