

OUTPATIENT POST-OPERATIVE PHYSIOTHERAPY GUIDELINES

Posterior stabilisation of the shoulder (for posterior instability).

This operation is **done much less frequently** than 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 and 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 neutral or slight external 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, 30° 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.

Pre-admission clinic (PAC)

Baseline assessment

Splint – (Donjoy 30° abduction) check stock (is size and side dependent)

Can show patient

Patient must be told some form of splint will be worn for a minimum of 4 weeks.

Inpatient/immobilisation phase

Patient will return from theatre with a temporary immobiliser (pillow and strapping) in optimal position for their shoulder.

Splint will then be fitted (now use Donjoy 30° abduction splint – to maintain some abduction and neutral (or lateral) rotation).

Splint will remain for 4 weeks, possibly longer.

Sling off only for:

axilla hygiene – rest elbow on surface and move body away

elbow movements

Maintenance exercise for neck, scapula, wrist and hand

Discuss post op management plan with doctors re earliest mobilisation dates, likely to be after shoulder clinic appointment.

Arrange outpatient physiotherapy appointment if date of mobilisation known – 4 weeks (or longer). Send guidelines.

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 and to stop inferior distraction, if occurring.

4–8 weeks weeks post op (or at mobilisation point) – main emphasis is on

Weaning out of sling

Regaining movement through abduction and lateral rotation

Facilitating appropriate muscle activity around scapula and cuff

Hydro can be very helpful

'Passive' and active assisted lateral rotation, abduction

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 (as pain allows)

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 and cuff. Open and closed chain.

8–12 weeks post-op (or mobilisation point) – **main emphasis is on**

Regaining range in scaption

Medial rotation range of movement without force/stretch

As scaption range improves, progress into more flexion without force/stretch

Regaining normal movement for ADL

Start regaining scaption

Start hand to belly

Progress to flexion – active assisted to active

Progress to 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 12–16 weeks post op – **main emphasis is on**

Regaining cross body adduction

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)

Optimal movement patterning may still be important at this stage

Guidelines for returning to activities

Dependent on start of mobilisation programme

e.g. Driving may not be possible for 8 weeks

Variable and dependent on progress – can get very stiff in glenohumeral joint which influences rehab and progress

No contact sports for at least 6 months

Heavy work will not be possible for at least 3 months

Liaise with Surgeon as necessary.