THE ROBERT JONES AND AGNES HUNT ORTHPAEDIC HOSPITAL NHS FOUNDATION TRUST

REHABILITATION GUIDE FOLLOWING ATHROSCOPIC ROTATOR CUFF REPAIR
SLOW for Large/Massive/Fragile/ or Repairs Under Tension
(This is not an exhaustive list of all rehabilitative techniques or therapies and this should not over rule any clinical judgement)

Indications

To reduce pain and improve function in patients with rotator cuff tears. The patients usually present with signs and symptoms of rotator cuff related pain associated with cuff weakness on clinical testing.

Procedure

The glenohumeral joint and acromioclavicular joint is examined arthroscopically and an assessment of any lesions or pathology of rotator cuff, labrum, bursa and articular surfaces made.
If amenable the rotator cuff will then be repaired (this may proceed to open repair if technically too difficult). The under surface of the acromion is shaved to decompress subacromial space.
Procedure may be performed awake under local block, or under general anaesthetic.
Some patients will receive an interscalene block whilst under anaesthetic for pain relief which will last 12 - 36hrs on average, but can last longer. This will also result in temporary muscle paralysis.

Post operative protocol summary

Sling 6/52 (Body belt only if instructed) only remove for exercising or washing
May remove sling when sitting provided arm is supported on pillows
AAROM 6/52 don't stress repair
6/52-8/52 can start gentle active movement
NO resistance 8/52
External rotation by side not beyond 30° for 6/52
No abduction beyond 60 for 6/52
Avoid HBB for 6/52

Subscapularis Repair -
External rotation to neutral, may consider external rotation to 30º after 3/52, pain allowing and adhering to post op instructions
No extension until 6/52
No resistance into internal rotation for 6/52

Please check Consultant Instructions in Post op notes (there may be specific instructions depending on muscle repaired and cuff tear shape)

TIMESCALE	REHABILITATION EXERCISES	GOALS
Day 1 – 3	• Wrist, hand and elbow exercises • Shoulder girdle / cervical spine exercises • Scapula setting / postural correction	• **Check if specific post-operative instructions have been given and amend the guide accordingly** • Good understanding of post- operative rehabilitation • No complications following surgery • Control of pain with adequate pain relief • Sling to be worn (except when washing or exercising) • Teach sling application and axillary hygiene • D/C with advice and ensure follow up appt made • Ice therapy/ cryocuff 3 – 4 times a day • Normal sensation returned to limb • **AAROM ONLY- Flex 90º, Ext Rot 0º, NO extension, NO abduction** (once block worn off until 3/52)
Day 3 - 3 weeks	• Continue with exercises as Day 1 – 3 • Gradually increase active assisted flex to 90° and Ext Rot to neutral, **NO** extension, **NO** abduction • Scapula setting and control	• Continue to protect in sling (except when washing or exercising) • Commence scar tissue management after 10 days • Continue with ice • Encourage daily walk or light CV work within sling • **AAROM ONLY- Flex 90º, Ext Rot 0º, NO extension, NO abduction** (once block worn off until 3/52)
3 - 6 weeks	• Aim to increase AAROM forward flexion to full by 6/52 (no stress) • Increase AAROM external rotation to 30°, abduction to 60° • Progress proprioceptive loading in sitting	• Continue to protect in sling

	or standing	
6 – 8 weeks	• Avoid repetitive abduction and don't push into pain, increase range beyond 60˚ • Don't push HBB avoid pain • Select appropriate level 1 exercises ensuring good glenohumeral movement NOT scapulo thoracic within protocol confines • DO NOT FORCE or STRETCH • Appropriate level 1 proprioceptive exs • Encourage and maintain lower limb fitness	• Wean off sling commence • Should have 50% PROM by 6/52.
8 – 12 weeks	• Commence sub-maximal isometric cuff exercises avoid muscle repaired • Continue through appropriate level 1 exercises. When able to perform with good control and rhythm progress to level 2 exercises as appropriate • Gradually progress to 4 point kneeling proprioceptive exercises	• Out of sling by 8/52 • Return to driving 8 weeks onwards is safe from a surgical perspective but competency to drive is the responsibility of the individual patient • Breast stroke swimming 10/52 onwards • Light lifting from 8 weeks • Return to sedentary work after 8/52 • PROM = Pre-op level 8/52 • AROM at least 50% of PROM • JAMAR grip strength measure correlates with global upper limb strength
12 weeks onwards	• Gradually progress level 2 exercises with increased repetitions • Progress to appropriate level 3 as control allows • Strengthen through range	• Ensure scapula dynamic control through active ROM • Freestyle swimming 4/12 depending on control and size of tear • Cycling 12/52 onwards • Golf 12/52 onwards

	• Dynamic strengthening • Use kinetic chain	• Avoid racquet sports for 4/12 • Heavy lifting from 4/12 avoiding repetitive lifting overhead- may need to look at activity modification long term • Manual work not before 4/12 (guided by surgeon) • 16/52 AROM ≥ Pre-op level • Oxford shoulder score

Catrin Maddocks/ Julie Lloyd Evans
Advanced Physiotherapy Practitioners Upper Limb : February 2024

Review Date : February 2026
Tel: 01691 404464
E Mail: catrin.maddocks@nhs.net/ julie.lloyd-evans@nhs.net