THE ROBERT JONES AND AGNES HUNT ORTHPAEDIC HOSPITAL NHS FOUNDATION TRUST

REHABILITATION GUIDE FOLLOWING ARTHOSCOPIC ROTATOR CUFF REPAIR ROUTINE MEDIUM TEAR
(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 GA.
Some patients will receive an interscalene block whilst under anaesthetic for pain relief which will last 12-36 hrs, but may last longer. This will also result in temporary muscle paralysis.

Post operative summary

Sling (No body belt, only if instructed) 3/52 - 6/52. Only remove sling for exercise and washing
** May also remove sling when sitting provided arm is supported on pillow
Active assisted ROM for 6/52, aim for full flexion but don't stress repair
No active elevation 6/52
Gentle ext rot but no force or stress on tendon
Avoid HBB, as a repetitive stretch and not into pain but can use occasionally for functional activities within comfort ie pulling trousers up – consider strength of repair
Avoid abduction above 60º for 6/52 (don't push into pain)

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

TIMESCALE	REHABILITATION EXERCISES	GOALS
Day 1 – 3	• Wrist, hand and elbow ex's • Shoulder girdle / cervical spine ex's • 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 • 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	• Active assisted ROM as per surgeons post op instructions and within pain free range, do not stress tendon. Gradually progress forward flexion • 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	• Gradually progress active assisted forward flexion • Gentle extension, gentle active assisted abduction to 60° – avoid stress on repair • Commence external rotation to 30° – avoid stress • Level 1 proprioceptive exercises as appropriate	• Wean off sling around house, may continue to wear when out and about • **NO** combined External Rotation Abduction • Active elevation to 90º by 6/52 • Light functional tasks such as washing and dressing • Return to sedentary work after 3/52 • 4/52 50% of pre-op PROM

	• Gravity minimised active assisted range of movement exercises (Level 1 exercises but no active) • Commence sub-maximal isometric cuff exercises **avoiding** muscle repaired • DO NOT FORCE or STRETCH • If subscap been repaired gradually progress ER aiming full range by 6 /52 • Encourage and maintain lower limb fitness	
<u>6 – 8 weeks</u>	• Commence gentle active exercises- **ensure good scapula dynamic control throughout range** • Begin stretching the capsule • Emphasize correction movement pattern in activities of daily living • Use the kinetic chain • Work through level 1 exercises. When able to perform with good control and rhythm progress to level 2 exercises • Commence 4 point kneeling proprioceptive exercises	• Discard sling • Should have full passive flexion by 8/52. Gradually increase hand behind back/ functional internal rotation over 6 – 12 /52 • Return to driving 6 weeks onwards is safe from a surgical perspective but competency to drive is the responsibility of the individual patient. Average 8 weeks • Light lifting from 6 weeks • 6/52 PROM= Pre-op level
<u>8 – 12 weeks</u>	• Continue with level 2 exercises gradually increasing repetitions • Continue with exercises as 6-8 weeks	• Breast stroke swimming from 8 weeks • Cycling from 8 weeks • JAMAR grip strength measure correlates with global upper limb strength

12 weeks onwards	• Level 3 exercises • Strengthen through range • Dynamic strengthening • Use kinetic chain	• Ensure scapula dynamic control through active ROM • Freestyle swimming depending on control and size of tear • Golf 12/52 onwards • Heavy lifting from 3/12 avoiding repetitive lifting overhead- may need to look at activity modification long term • Manual work not before 3/12 (guided by surgeon) • 12/52 AROM ≥ Pre-op level • Oxford shoulder score

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