OSWESTRY POST OPERATIVE REHABILITATION GUIDELINE
ARTHROSCOPIC ROTATOR CUFF REPAIR
ROUTINE MEDIUM TEARS

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 this will also result in temporary muscle paralysis.

Associated Procedures

Tenotomy / Tenodesis of long-head of biceps
Subscapularis repair
Labral repair
Excision of lateral end of the clavicle
MUA / Capsular release

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 functionally occasionally for activities within comfort ie pulling trousers up – consider strength of repair
Avoid abduction above 60 for 6/52 (don't push into pain)
S**ubscapularis 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)

Day 1 -3 - ONLY – AAROM - Flex 90º, Ext Rot 0º, NO extension, NO abduction (once block worn off until 3/52)

- Sling to be worn (except when washing or exercising)
- Teach sling application and axillary hygiene
- Wrist, hand and elbow ex's
- Shoulder girdle / cervical spine ex's
- Scapula setting / postural correction
- Ice therapy
- D/C with advice and ensure follow up appt made

Day 3 – 3 Weeks

- Continue to protect in sling (except when washing or exercising)
- Active assisted ROM as per surgeons post op instructions and within pain free range, do not stress tendon. Gradually progress forward flex
- Scapula setting and control
- Continue with ice

3 – 6 weeks

- Wean off sling around house at 3 – 4 weeks, continue to wear sling when out
- 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
- 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

6 - 8 Weeks

- Discard sling
- 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

- Should have full passive flexion by 8/52. Gradually increase hand behind back/ functional internal rotation over 6 – 12 /52

8 – 12 Weeks

- Continue with level 2 exercises gradually increasing repetitions
- Continue with exercises as 6-8 weeks

12 Weeks +

- Level 3 exercises
- Strengthen through range
- Dynamic strengthening
- Ensure scapula dynamic control through active ROM
- Use kinetic chain

RETURN TO FUNCTIONAL ACTIVITES

- Driving - 6 weeks onwards when safe and functional ability allows. Aveage 8 weeks
- Swimming - Breast stroke 6 weeks onwards (gentle)
  - Freestyle 3 months onwards (depending on control and size of tear)
- Golf - 3 months onwards
- Lifting - Light – 6 weeks
  - Heavy 3 months earliest

avoid overhead repetitive lifts for 3 months (good idea to change working practice)

- Return to work - sedentary 3 weeks / manual not before 12/52 guided by surgeon

MILESTONES

4 / 52	50 % of pre-op passive ROM
6 / 52	Passive ROM = pre-op level
12 / 52	Active ROM = pre-op level

Treatment Note

Rehabilitation is essentially adapted on an individual basis depending on many factors including surgeon's assessment of the risk factor of re-tear; this in turn depends upon the size of the tear, quality of tissue, the tension of the repair etc.
This is essentially a subjective assessment made by the surgeon and so communication is as ever, essential.
Rehabilitation will therefore incorporate a spectrum from early active mobilisation to complete immobilisation.
The importance of communication between therapist and surgeon cannot be stressed enough – these individual variations have significant implications for ensuring the most appropriate rehabilitation regime.

Level exercises are there as guidance with varying degrees of difficulty within each level. Progress through level depending on patients co-ordination, control and pain.
NO exercises should give lasting pain, some minor discomfort that settles quickly is acceptable.

IF IN DOUBT ALWAYS ASK

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