OSWESTRY POST OPERATIVE REHABILITATION GUIDELINE ATHROSCOPIC ROTATOR CUFF REPAIR SLOW for Large/Massive/Fragile/ or Repairs Under Tension

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 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 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)

Post Operative Treatment

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

- Poly sling to be worn (except when washing or exercising)
- Teach sling application and axillary hygiene
- Wrist, hand and elbow exercises
- Shoulder girdle / cervical spine exercises
- Scapula setting / postural correction
- Ice therapy/ cryocuff 3 – 4 times a day
- Discharge with advice and ensure follow up appt made

Day 3 - 3 Weeks

- Continue to protect in sling (only remove for exercising and washing)
- Continue with exercises as Day 1 – 3
- Gradually increase active assisted flex to 90° and Ext Rot to neutral, **NO** extension, **NO** abduction
- Scapular setting and control

3 - 6 Weeks

- Continue to protect in sling
- 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 or standing

6 - 8 Weeks

- Wean off sling commence
- 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

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

12 weeks +

- Gradually progress level 2 exercises with increased repetitions
- Progress to appropriate level 3 as control allows
- Strengthen through range
- Dynamic strengthening
- Ensure scapula dynamic control through active ROM
- Use kinetic chain

RETURN TO FUNCTIONAL ACTIVITES

- Driving - 8 weeks onwards

- Swimming - breast stroke 10/52 onwards
  - freestyle 4 months onwards (depending on control and size of tear)

- Golf - 3 months onwards

- Lifting - Light at 8 weeks

  - Any heavy or repetitive lifting 4 /12 and guided by surgeon. Gradual increase on short lever, advisable to avoid repetitive lifting or loading long term - particularly overhead

- Return to work - sedentary 8 weeks / manual not before 16/52 guided by surgeon

MILESTONES

6 / 52	50 % of pre-op passive ROM
8 / 52	Passive ROM = pre-op level
16 / 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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Review Date : June 2021

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