Massive Rotator Cuff Repair
Outpatient Rehabilitation Protocol
Dr. Michael Thomas Edgerton

Patient to be seen 2-3x/week beginning after 1st office visit
MD will note on script if biceps tenodesis or subscapularis repair is completed.

Post-op Weeks 1-6

Pendulums
Scapular retraction and depression (no shrugs)
Cervical, elbow, and wrist AROM and grip strengthening
PROM shoulder exercises

- Flexion, scaption, and abduction to 140
- ER to 40 degrees
- IR in scapular plane as tolerated
- NO IR behind back, NO IR in abduction, NO extension, and NO cross-body adduction x 6 weeks

Self-assisted ROM

- Forward elevation (with elbow bent) to 90 degrees using contralateral arm to assist and support UE. (discontinue if patient is unable to complete passively)
- ER in adduction to 40 degrees with wand/stick

Modalities for pain control as needed
Incision mobilization and desensitization following suture removal
Exercises are to be completed 2-3 times per day followed by cryotherapy x 15-20 minutes
Sling should be worn at all times except during bathing, dressing, and exercise sessions. Patient is to sleep in sling.

***NOTES**:

*If biceps tenodesis is performed, NO resistive elbow flexion or supination x 6 weeks
*If subscapularis repair is performed, ROM limitations are as follows:
-ER: 30 degree limit x 6 weeks, then add 10 degrees per week beginning week 7
-Flexion, Scaption, and Abduction limit of 90 degrees x 6 weeks

Post-op Weeks 7-8

Progressive return to full passive flexion, abduction, and ER
Initiate PROM IR in abduction
Initiate table glides, pulley, and ER doorway stretch
Initiate cross body stretch in supine for posterior capsule
Grade I-II glenohumeral and scapulothoracic mobilizations
Sling may be discontinued at week 7
Continue precautions with no active use of arm
Continue modalities as needed

Post-op Weeks 9-12

Continue PROM for flexion, abduction, IR and ER.
Initiate IR stretching behind back
Initiate side-lying IR stretch in abduction
Initiate ER stretching at 45 degrees abduction
Initiate dowel extension stretches
Grade III-IV glenohumeral and scapulothoracic mobilizations
Initiate supine dowel two-hand press
Initiate AROM for flexion, scaption, abduction, and IR/ER with no resistance (assess for substitution patterns)
Initiate gentle submaximal isometrics for flexion, extension, abduction, IR, and ER
Initiate biceps and triceps strengthening with elbow supported
Initiate theraband for scapular strengthening with rows, shrugs, and punches
Continue modalities as needed

Post op Weeks 13-16

Continue flexibility training
Emphasize posterior capsular stretching and scapular mobility
Initiate anterior chest wall stretching
Begin light resistive rotator cuff and periscapular strengthening

- Submaximal isometrics, isotonic exercises with theraband or light dumbells
- Emphasize anterior deltoid strength
- Avoid exercises in impingement position

- Notes: Resistance must be added gradually
  Strengthen in multiple angles – start low level and progress as strength improves
  Submaximal resistance to painful motions should be used until motions are pain-free
  Emphasis early should be on lower weight and higher repetition

Progress scapular stabilization program

- Forward and reverse UBE
- Serratus, latissimus, trapezius, rhomboid, and pectoralis strengthening

May start upper extremity proprioception and functional progression activities as indicated

Weeks 17+ (Functional Phase)

Continue strengthening program with progressive increase in resistance
Return to functional activities
Work/Sport specific conditioning to enhance endurance and coordination

- May include one-handed plyometrics, eccentric cuff strengthening, and large muscle strengthening: Lat pull downs, bench press, military press

UBE at high resistance

_____ _____

Dr. Michael Thomas Edgerton Date