OIO Orthopaedic Institute of Ohio
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SHOULDER ARTHROSCOPIC LABRAL REPAIR—POSTERIOR

Physical Therapy, Strength and Conditioning

PHASE I: MAXIMUM PROTECTION (WEEKS 0 TO 4)

Goals

- Reduce inflammation
- Decrease pain
- Postural education

Restrictions/Exercise Progression

- Gunslinger or Abduction pillow x 4 weeks with arm positioned with midline of the body and the humerus externally rotated to neutral.
- No GHJ ROM x 4 weeks as determined by physician following ROM check at 4 weeks.
- Ice and modalities to reduce pain and inflammation.
- Cervical ROM and basic deep neck flexor activation (chin tucks).
- Active hand and wrist range of motion.
- Passive elbow flexion.
- Active shoulder retraction.
- Encourage walks and low intensity cardiovascular exercise to promote healing.

Manual Intervention

- UT, parascapular STM as needed. Effleurage massage to forearm and upper arm as needed.

PHASE II: PASSIVE RANGE OF MOTION (WEEKS 4 TO 6)

Goals

- Move from gunslinger/abduction pillow into regular sling at 4 weeks post-op.
- Postural education with cervical spine and neutral scapular positioning.
- Shoulder flexion to 90° with gradual progression to full in the scapular plane.
- Full Shoulder external rotation.

Exercise Progression

- Supine flexion using contralateral arm for ROM at least 3x/day.
- Supine ER using T-bar.
- DNF and proper postural positioning with shoulder retraction exercises.
- Cervical ROM.
- Low intensity cardiovascular work, no running.

Manual Intervention
- STM—global shoulder and CT junction.
- Scar tissue mobilization when incisions are healed.
- Grade 1-2 GH mobilizations as needed.
- ST mobilizations.
- Gentle sub-maximal therapist directed isometrics to achieve ROM goals.

PHASE III: AROM (WEEKS 6 TO 8)

Goals
- Discontinue sling as instructed.
- Full shoulder flexion and external rotation.
- Begin internal rotation with stick off back.

Exercise progression
- Serratus activation; Ceiling punch (weight of arm) many initially need assistance.
- Manual perturbations supine with arm in 90° flexion.
- Scapular strengthening—prone scapular series (rows and I's). Emphasize scapular strengthening under 90°.
- External rotation on side (no resistance).
- Cervical ROM as needed to maintain full mobility.
- DNF and proper postural positioning with all RC/SS exercises.
- Continue with combined passive and active program to push full flexion and external rotation achieving ROM goals outlined above.
- Stick off the back progressing to internal rotation gradually introducing thumb up the back.
- Sub-maximal 6 direction rotator cuff isometrics.
- Low to moderate cardiovascular work. May add elliptical but no running.

Manual Intervention
- STM – global shoulder and CT junction.
- Scar tissue mobilization.
- Graded GH mobilizations. Limit aggressive posterior capsule mobilization.
- ST mobilizations.
- Gentle CR/RS to gain ROM.

PHASE IV: PROGRESSIVE ROM AND STRENGTHENING (8-12 WEEKS)

Goals
- Gradual progression to full P/AROM by week 10-12.
- Normalize GH/ST arthrokinematics.
- Activate RC/SS with isometric and isotonic progression.

Exercise Progression
- Continue with combined passive and active program to push full flexion and external rotation.
- Internal rotation with thumb up back; gradually introducing sleeper stretch as ROM deficits direct.
- Continue with ceiling punch adding weight as tolerated.
- Advance intensity of sub-maximal rotator cuff isometrics. May discontinue once isotonic RC/SS program is fully implemented.
- Advance prone series to include T's and Y's adding resistance as tolerated.
- Resisted ER in side-lying or with bands.
- Gym: rows, front lat pulls, biceps and triceps.
- Scaption; normalize ST arthrokinematics.
- Supine progressing to standing PNF patterns, adding resistance as tolerated.

- CKC progression (10 weeks)–Quadruped weight shift with slight elbow flexion. Avoid lock-out position to limit posterior directed force. Therapist directed RS and perturbations in quadruped – bilateral progressing to unilateral-tri pod position (again, avoiding lock-out position).

Manual Intervention
- STM and Joint mobilization to CT junction, GHJ and STJ as needed.
- CR/RS to gain ROM while respecting repaired tissue.
- Manual perturbations.
- PNF patterns.

PHASE V: ADVANCED STRENGTHENING AND PLYOMETRIC DRILLS (12-24 WEEKS)

Goals
- Gradual progression to full ROM.
- Normalize GH/ST arthrokinematics.
- Advance gym strengthening program.
- Begin RTS progression.
- Evaluation with physician for clearance to full activity.

PRE/PSE
- Full range of motion all planes—protecting end range 90/90.
- Begin strengthening at or above 90° with prone or standing Y's, D2 flexion pattern and 90/90 as scapular control and ROM permit. Patient goals/objectives will determine if strengthening above 90° is appropriate.
- Advance CKC exercises—ball compression, counter weight shift, knee scapular push-ups, knee push-ups; all as tolerated. May introduce DB pressing and straight bar pressing with light resistance and very gradual increase in loading.
- Continue to progress RC and scapular strengthening program.
- Continue with closed chain quadruped perturbations; add open chain as strength permits.
- Initiate plyometric and rebounder drills as appropriate.
- RTS testing using microfet dynamometer for interval programs.
- Follow-up examination with the physician (6 months) for release to full activity.

Manual Intervention
- STM and Joint mobilization to CT junction, GHJ and STJ as needed.
- CR/RS to gain ROM while respecting repaired tissue.
- Manual perturbations.
- PNF patterns.

Criteria for Return to Play/Discharge
- Full, pain-free ROM.
- Normal GH/ST arthrokinimatics.
- >90% MMT using handheld dynamometer.
- Full progression through interval program.
- Anticipated return to play for contact athlete is 6 months.
- Anticipated return to play for throwing athlete, swimmer and volleyball is 6-9 months.