

Anterior Shoulder Stabilization Guidelines[©] *

Follow physician's modifications as prescribed

POST – OPERATIVE PHASE I (WEEKS 0-3) MAXIMUM PROTECTION PHASE

GOALS:

- Promote healing : reduce pain, inflammation and swelling
- Elevation in plane of scapula: to 90°
- External Rotation: Arthroscopic to Neutral; Open to 30°
- Independent home exercise program

Emphasize:

- PROTECTING SURGICAL REPAIR
- Patient compliance with sling immobilization

TREATMENT RECOMMENDATIONS:

- AAROM elevation in plane of scapula, ER to neutral, scapular mobility and stability (sidelying, progressing to manual resistance) sub-max deltoid isometrics in neutral, modalities for pain and edema
- Emphasize patient compliance to HEP and protection during ADLs
- Other: _____

PRECAUTIONS:

- Immobilizer at all times when not exercising
- External Rotation and Extension limited to neutral (30° for Open)

MINIMUM CRITERIA FOR ADVANCEMENT:

- External Rotation to neutral (30° for Open)
- Elevation in plane of scapula: to 90°

Minimal pain or inflammation

MODIFICATIONS TO PHASE I:

Patient Name: _____

Physician's Signature: _____ M.D. Date: ___ / ___ / ___

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POST – OPERATIVE PHASE II (WEEKS 3-6)

GOALS:

- Continue to promote healing
- Arthroscopic: External rotation to 45°;
Elevation in plane of scapula to 120°
- Open: External Rotation to 60°;
Elevation in plane of scapula to 145°
- Begin to restore scapula and rotator cuff strength

Emphasize:

- PROTECTING SURGICAL REPAIR
- Avoiding excessive stretch to anterior capsule
- Avoiding inflammation of rotator cuff

TREATMENT RECOMMENDATIONS:

- D/C immobilizer (MD directed), AAROM FF and ER, scapular stabilization, sub-maximal isometrics ER/IR, modalities for pain and edema, progress HEP

PRECAUTIONS:

- Limit External rotation to 45° (arthroscopic)
- Avoid excessive stretch to anterior capsule
- Avoid rotator cuff inflammation

MINIMUM CRITERIA FOR ADVANCEMENT:

- Minimal pain and inflammation
- Arthroscopic: External rotation to 45°; Elevation in plane of scapula to 120°
- Open: External rotation to 60°; Elevation in plane of scapula to 145°
- Internal rotation/ external rotation strength 4/5

MODIFICATIONS TO PHASE II:

Patient Name: _____

Physician's Signature: _____ M.D. Date: ___ / ___ / ____

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POST – OPERATIVE PHASE III (WEEKS 6-12)

GOALS:

- Restore full shoulder range of motion
- Restore normal scapulohumeral rhythm
- Upper extremity strength 5/5
- Restore normal flexibility
- Begin to restore upper extremity endurance
- Isokinetic IR/ER strength 85% of unaffected side

Emphasize:

- PROTECTING SURGICAL REPAIR
- Avoiding excessive passive stretching
- Avoiding inflammation of rotator cuff
- Establishing normal strength base

TREATMENT RECOMMENDATIONS:

- Initiate AAROM IR, progress isotonic and stabilization exercises for periscapular and RC muscles, humeral head rhythmic stabilization, PNF patterns as tolerated, UE endurance (UBE), initiate flexibility exercises as needed, modalities prn, modify HEP

PRECAUTIONS:

- Avoid rotator cuff inflammation
- Continue to protect anterior capsule
- Avoid excessive passive stretching

MINIMUM CRITERIA FOR ADVANCEMENT:

- Normal scapulohumeral rhythm
- Minimal pain and inflammation
- IR/ER strength 5/5
- Full upper extremity range of motion
- Isokinetic IR strength 85% of unaffected side

MODIFICATIONS TO PHASE III:

Patient Name: _____

Physician's Signature: _____ M.D. Date: ___ / ___ / ___

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POST – OPERATIVE PHASE IV (WEEKS 14-18)

GOALS:

- Restore normal neuromuscular function
- Maintain strength and flexibility
- Isokinetic IR/ER strength at least equal to the unaffected side
- > 66% Isokinetic ER/IR strength ratio
- Prevent Re-injury

PRECAUTIONS:

- Pain free plyometrics
- Significant pain with a specific activity
- Feeling of instability

TREATMENT RECOMMENDATIONS:

- Full UE strengthening, ER/IR in 90/90 position (overhead athlete), initiate plyometrics, sport and activity related program, modify HEP

CRITERIA FOR DISCHARGE:

- Pain free Sport or Activity specific program
- Isokinetic IR/ER strength at least equal to unaffected side
- > 66% Isokinetic ER/IR strength ratio
- Independent Home Exercise Program
- Independent Sport or Activity specific program

MODIFICATIONS TO PHASE IV:

Patient Name: _____

Physician's Signature: _____ M.D. Date: ___ / ___ / ___