Anterior Labrum Repair Protocol

**Stage I (0-4 weeks):**

Key Goals:

- Protect the newly repaired shoulder.
- Allow for decreased inflammation and healing.
- Maintain elbow, wrist and hand function.
- Maintain scapular control.
- Begin passive abduction and forward flexion

1. Immobilizer use:
   - The immobilizer will be placed on patient’s shoulder in surgery.
   - The patient may remove the immobilizer for dressing and hygiene.
   - The patient should wear the immobilizer full-time for four weeks.

2. Restrictions:
   - No shoulder external rotation.
     - The capsular repair is stressed with movement into external rotation. Since the repair is performed with the shoulder in a neutral position external rotation must be limited for six weeks following the repair.
   - When arm is out of the immobilizer, forearm must be touching abdomen.
   - Acceleration of rehabilitation for “fast healers” may reduce results and lead to long-term problems.

3. Exercises:
   - Pendulum exercises.
   - May begin passive shoulder range of motion beginning the week after surgery
     - Passive external rotation to neutral position only for weeks 1 - 4
   - Active assistive range of motion of the involved elbow, wrist and hand in the plane of the body. The patient may progress to active range of motion as comfort improves.
   - Scapular control exercises (Immobilizer on)
   - Core training(Immobilizer on)
Stage II (5-15 weeks):

Key Goals:
• Full active elevation at 12 weeks from surgery.
• Surgical shoulder external rotation of 80% of uninvolved shoulder.
• Normal scapular mechanics 12 weeks from surgery.
  o Scapular mechanics should be evaluated on a regular basis.
• Normal scapular stabilizer, rotator cuff and core strength at 16 weeks from surgery.

1. Weeks 5-6:
   a. Brace use:
      i. Immobilizer will be used at this time while sleeping until six weeks post-op.
      ii. Sling is worn during the day for comfort. Wean as comfort improves.
   b. Range of motion:
      i. External rotation:
         1. Passive to active assistive to active range of motion as able.
         2. Limited to 20 degrees maximum until 6 weeks from surgery.
         3. No subscapularis or anterior shoulder stretching until 6 weeks from surgery.
      ii. Internal rotation:
         1. Passive to active assistive to active range of motion as able.
            a. Begin in supine with scapula stabilized, and progress to other postures as tolerated.
      iii. Flexion/Scaption/Abduction:
         1. Passive to active assistive to active range of motion as able.
            a. Supine with scapula stabilized.
         iv. Gleno-humeral mobilizations:
            1. No anterior glides until 10 weeks from surgical date.
   c. Balance training:
   d. Strengthening (4 weeks):
      i. Isometric strengthening:
         a. Internal/external rotation:
1. If open surgical procedure, NO internal rotation strengthening until six weeks post-op.

   ii. Core training:

2. **Week 7:**
   a. Immobilizer use at night can be discontinued.
   b. Range of motion:
      1. As tolerated no limits.
   c. Strengthening:
      i. Scapular stabilizer strengthening:
      ii. Core training:

3. **Week 8:**
   - **Warning:** No soreness with the above rotator cuff strengthening.
   - The program must be modified to avoid cuff aggravation.
     a. Balance training:
     b. Range of motion:
        i. No anterior apprehension or impingement.
        ii. Scapular mechanics need to be functioning properly and if not need to be addressed.
        iii. Hip mobility:
     c. Strengthening:
        i. Scapular mechanics:
        ii. Forearm strengthening:
        iii. Rotator cuff strengthening:
        iv. Core training

4. **Week 12:**
   a. **Testing:**
      i. Full pain free active range of motion for elevation and internal rotation.
ii. A 20 degree difference in shoulder external rotation is acceptable.

iii. Normal scapular mechanics.

iv. ROM is within 10 degrees of other side.
   1. ROM should be within 5 degrees or less by 16 weeks.

v. Int Rotation difference is less than 20 degrees or 2 spinal levels.

vi. Squat screen (FMS):

vii. Hurdle step screen (FMS):

viii. Shoulder mobility screen (FMS):

ix. Hand held dynamometer:
   1. 0 degrees with arm at side IR and ER.
   2. Seated IR and ER at 90 degrees of abduction and 45 degrees of external rotation.
   3. ER/IR=65%

**Warning:**
- Any deficits in mobility, stability, or scapular mechanics need to be addressed now prior to beginning return to throw program at 20 weeks.

b. Range of motion:
   i. Any flexibility deficits need to be addressed before return to program begins at 16 weeks.
      1. See above testing.
      2. **Begin external rotation/pectoral stretching.**

c. Strengthening:
   i. Scapular stabilizer:
   ii. Rotator cuff:
   iii. Plyometric training
      1. Upper extremity.
      2. Lower extremity.
   iv. Core training:
   v. Endurance training:

**Stage III (Weeks 20-26)**

Initiation of Interval Sport Program for Baseball, Tennis, and Golf:
• Return-to-sport activities after injury that include attention to the entire body.
• A gradual progression of applied forces to lessen the chance of re-injury.
• Proper warm-up and maintenance exercises.
• Proper biomechanics to minimize the chance of re-injury.
• Variability is based on each athlete’s skill, level, goals and injury.
• Program needs to be followed rigidly. Some athletes will try and rush through the plan.
  o No skipping of steps is allowed.
  o Patient must demonstrate successful completion of each step.
• Program should be supplemented with a high-repetition, low intensity weight training program focusing on the posterior rotator cuff and scapular musculature.
• Outcome measures:
  o PSFS: Patient specific functional scale.
  o Quick Dash: Quick disabilities of the arm, shoulder and hand score.

1. Basic menu of program:
   a. Warm-up.
   b. Stretch.
   c. 1 set of each exercise prior to ISP.
   d. ISP.
   e. 2 sets of each exercise.
   f. Cryotherapy.