

ROTATOR CUFF REPAIR

General Considerations:

- Read operative report: large or massive tears have a much slower rehab
- Type of Procedure: Arthroscopic Vs. Open
- Type of Tear: Side to side – can be treated same as SAD (more aggressive than tendon to bone)
Tendon to bone – should be more cautious with end range stretching and wait longer to perform AROM to maintain integrity of tissues
- Immobilization/Resting position: position varies, the classic position is adducted and internally rotated for as little as 1-3 weeks or as long as 6 weeks
- Regardless of procedure, early passive ROM of the GH joint is essential to prevent capsular adhesions and fibrosis; PROM should be done in a position which shortens involved muscles and ligaments (“scapular plain” – flexion with abduction and ER) – ER is most important to regain early in order to halt tightening of coracohumeral ligament
- Proper scapulothoracic mechanics/stabilization/posture should be closely monitored with all AROM to minimize compensation or substitution, avoid impingement and promote healing
- Physical therapy should begin immediately post-op and continue for 12 weeks – 6 months depending upon clinical presentation, response to treatment and patient independence with home exercise program
- These guidelines should also be followed for Hemiarthroplasty for fracture, as entire RTC and attachments usually damaged and repaired, therefore wait 6 weeks before performing AROM. Functional outcome for hemiarthroplasty is same as for total shoulder replacement but also dependent upon RTC strength

Phase I (0-6 Weeks)

- Protection of surgically repaired tissues is a priority in this phase; no full, active overhead shoulder flexion until 6 weeks
- Passive or active-assisted ROM in pain tolerable ranges, usually 90-120
- Begin PROM day 1 (pendulum and pulleys), goal is 180 flexion and abduction, 60 IR/ER, by 3 weeks
- Soft tissue work should emphasize ER to prevent scarring of the coracohumeral ligament
- Avoid excessive adduction and IR behind the back with supraspinatus repair for 6 weeks
- Begin gear shift, pendulum, wand exercises and pulleys – keep elbow in a bent position to decrease active muscle use
- Immediate isometrics to shoulder girdle complex; resume pre-op isometric activities
- Scapular mobilizations, active ROM to cervical and thoracic spine, elbow, wrist, and hand to tolerance
- Postural education and positioning in sitting, sleeping, walking
- Hand gripping exercises should be initiated
- Ice

Phase II (4-12 weeks)

- Note: call MD if not achieving ROM goals by 4 weeks, consider medicating prior to session for pain control
- Regain functional ROM via soft tissue release, joint mobilizations – keep in mind that scar tissue forms by 6 weeks
- Regain active flexion then progress to abduction: progress to internal and external rotation in abduction
- Strengthen scapular stabilizers, rotator cuff muscles, anterior and posterior muscles of the shoulder
- Avoid passive end-range loading causing anterior shear and heavy active resistance with overhead activity
- Neuromuscular control techniques including rhythmic stabilization, joint compression, weight-bearing, feedback

Phase III (12-16+ weeks)

- Advanced neuromuscular control techniques
- Dynamic strengthening; eccentrics as well as concentric activities; closed chain as well as open chain
- No empty can or other supraspinatus isolation exercises above 90 shoulder elevation
- Discharge with maintenance program

Functional Outcomes:

- Full ROM by 6-8 weeks
- Full strength/function by 6-12 months depending upon tear size, age and prior functional level
- Return to high level activity/sports by 4-6 months with caution