Northwest Ohio Orthopedics and Sports Medicine
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Phone: 419.427.3109 Fax: 419.427.3020

NWO Therapy Department

Rehabilitation Guidelines for Rotator Cuff Repair: 1 centimeter or less

The intent of this protocol is to provide the clinician with a guideline to establish and progress a patient through post operative rehabilitation. It is not intended to be a substitute for one's clinical decision making. The plan of care should be based upon the patients clinical exam and individual goals. Prior to initiation of interventions the therapist needs to check with the surgeon/operative report regarding progression. The therapist needs to take into consideration multiple variables including: mechanism of injury, tear location, repair type, tissue quality, and patient characteristics including co-morbidities, age, goals, and expectations. **If the patient has a concomitant injury/repair (especially SLAP repair) then treatment may vary. Consult with surgeon.** Based upon these variables, wide variations of progressions and patient outcomes may exist, however the following is a basic guideline that can be used to reference.

- Notify the surgeon ***immediately*** of any concerns for infection, edema, or significant variation in expected progression/outcomes.

- **Pre-op (if available)**
  - Fit with post-op sling/swathe with abductor pillow
  - Measure and provide patient with Thigh High TED hose (to be worn 2-4 weeks post-operatively).
  - Provide Polar Care Unit – to be utilized 2 weeks post-op on a prn basis
  - Initial PT Evaluation should be schedule 2-3 days post-operative
  - Provide patient with education/instructions from surgery date to initial PT eval.

- **Phase I: 0-6 weeks**
  - Goals:
    - Maintain integrity of repair
    - Decrease pain and inflammation
    - Promote tissue healing
    - Progressively increase passive range of motion
    - Prevent muscle inhibition
    - Patient education of precautions and progressions
  - Precautions:
    - No quick movements
    - No lifting of objects
    - No excessive stretching
    - No supporting body weight by hands
    - PROM that is too aggressive or provokes muscle guarding
    - Keep incisions dry and clean

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- Continue with sling with abductor pillow

➢ 0-2 weeks
- PROM flexion as tolerated
- PROM IR/ER in scapular plane at 45 degrees abduction as tolerated

➢ 2-6 weeks
- Initiate AAROM/AROM
  - Avoid compensations
- Isometrics into flexion, IR, ER, ABd

➢ 4-6 weeks
- Initiate isotonic strengthening activities
- Initiate functional activities
- Continue to monitor for improper compensations.

❖ **Phase II: 6-12 weeks**

➢ Criteria to progress to phase II
- Minimal pain with AROM and strengthening activities
- Full AROM without substitution
- Good strength without substitution

➢ Goals
- Full P/AROM
- Enhance dynamic stability
- Gradual restoration of strength, power, and endurance
- Advance neuromuscular control
- Return to full ADLs/work

➢ 6-12 weeks
- Advance all activities based upon patient goals and expectations

❖ **Phase III: 12+ weeks**

➢ Advance all activities based upon patient goals and expectations

❖ **Additional Criteria**
- Sling per MD
- If concomitant procedures, modify as appropriate
- **Close communication with surgeon is always necessary**

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References:

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Leggin B, Kelley M, Williams G. Postoperative Management of the Shoulder. Postoperative Mangement of Orthopaedic Surgeries: Independent Study Course 15.2.6; 2005.

Leggin B, Wilcox R, Williams G, Thigpen C. Controversies in Rehabilitation Progression Following Rotator Cuff Repair: An Evidence-Based, Consensus Guideline by the American Society of Shoulder and Elbow Therapists. APTA's CSM, San Diego. Februrary 19, 2010.

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Rehabilitation Guidelines for Rotator Cuff Repair: 2-4 centimeters

The intent of this protocol is to provide the clinician with a guideline to establish and progress a patient through post operative rehabilitation. It is not intended to be a substitute for one's clinical decision making. The plan of care should be based upon the patients clinical exam and individual goals. Prior to initiation of interventions the therapist needs to check with the surgeon/operative report regarding progression. The therapist needs to take into consideration multiple variables including: mechanism of injury, tear location, repair type, tissue quality, and patient characteristics including co-morbidities, age, goals, and expectations. **If the patient has a concomitant injury/repair (especially SLAP repair) then treatment may vary. Consult with surgeon.** Based upon these variables, wide variations of progressions and patient outcomes may exist, however the following is a basic guideline that can be used to reference.

- Notify the surgeon ***immediately*** of any concerns for infection, edema, or significant variation in expected progression/outcomes.
- **Pre-op (if available)**
  - Fit with post-op sling/swathe with abductor pillow
  - Measure and provide patient with Thigh High TED hose (to be worn 2-4 weeks post-operatively).
  - Provide Polar Care Unit – to be utilized 2 weeks post-op on a prn basis
  -
  - Initial PT Evaluation should be schedule 2-3 days post-operative
  - Provide patient with education/instructions from surgery date to initial PT eval.

- **Phase I: 0-6 weeks**
  - Goals:
    - Maintain integrity of repair
    - Decrease pain and inflammation
    - Promote tissue healing
    - Progressively increase passive range of motion
    - Prevent muscle inhibition
    - Patient education of precautions and progressions
  - Precautions:
    - No active range of motion
    - No quick movements
    - No lifting of objects
    - No excessive stretching

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- No supporting body weight by hands
- PROM that is too aggressive or provokes muscle guarding
- Keep incisions dry and clean
- Continue with sling with abductor pillow

➢ 0-2 weeks
- PROM flexion 120 degrees
- PROM IR/ER in scapular plane at 45 degrees abduction to 30-45 degrees

➢ 2-4 weeks
- Rhythmic stabilization exercises
- Scapular Isometrics

➢ 2-6 weeks
- Sub-maximal Isometrics into flexion, IR, ER, ABd
- Progress PROM flexion to tolerance,
- Progress PROM IR/ER to tolerance and can begin ER/IR at 90 degrees abduction

❖ **Phase II: 6-12 weeks**

➢ Criteria to progress to phase II.
- Appropriate healing by adhering to precautions in phase I
- Staged ROM goals achieved
- Minimal pain

➢ Goals for Phase II
- Allow healing of soft tissue
- Do not overstress healing tissue
- Restore full PROM by week 12
- Normalize AROM
- Begin to increase strength and endurance
- Initiate gradual return to functional activities and light work activities

➢ 6-8 weeks
- Initiate AAROM/AROM activities
  - Avoid compensations

➢ 8-10 weeks
- Initiate isotonic strengthening
- Initiate functional activities
- Continue to monitor for improper compensations.

❖ **Phase III: 12+ weeks**

➢ Criteria to progress to phase III
- Minimal pain with AROM and strengthening activities
- Full AROM without substitution
- Good strength without substitution

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- Goals
  - Full P/AROM
  - Enhance dynamic stability
  - Gradual restoration of strength, power, and endurance
  - Advance neuromuscular control
  - Return to full ADLs/work

- 12+ weeks
  - Advance all activities based upon patient goals and expectations.

- Additional Criteria
  - With biceps tenodesis, limit biceps loading until 8 weeks
  - With subscapularis repair, limit PROM ER/AROM IR 6 weeks
  - Sling per MD
  - If concomitant procedures, modify as necessary.
  - **Close communication with surgeon is always necessary**

References:

Ghodadra N, Provencher M, Verma N, Wilk K, Romeo A. Open, Mini-open, and All-Arthroscopic Rotator Cuff Repair Surgery: Indications and Implications for Rehabilitation. J Orthop Sports Phys Ther. 2009; 39 (2): 81-89.

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Rehabilitation Guidelines for Rotator Cuff Repair: 5 centimeters or greater (Large to Massive)

The intent of this protocol is to provide the clinician with a guideline to establish and progress a patient through post operative rehabilitation. It is not intended to be a substitute for one's clinical decision making. The plan of care should be based upon the patients clinical exam and individual goals. Prior to initiation of interventions the therapist needs to check with the surgeon/operative report regarding progression. The therapist needs to take into consideration multiple variables including: tear size, tissue quality including atrophy and retraction, tear location including tendons involved, mechanism of failure (acute versus chronic), patient characteristics including age, goals, expectations, and general health including smoking, diabetic, thyroid disorders etc. , and surgeon specific philosophy/preferences. Based upon these variables, wide variations of progressions and patient outcomes may exist, however the following is a basic guideline that can be used to reference.

- Notify the surgeon ***immediately*** of any concerns for infection, edema, or significant variation in expected progression/outcomes.
- **Pre-op (if available)**
  - Fit with post-op sling/swathe with abductor pillow
  - Measure and provide patient with Thigh High TED hose (to be worn 2-4 weeks post-operatively).
  - Provide Polar Care Unit – to be utilized 2 weeks post-op on a prn basis
  -
  - Initial PT Evaluation should be schedule 2-3 days post-operative
  - Provide patient with education/instructions from surgery date to initial PT eval.

- **Phase I: 0-8 weeks**
  - Goals:
    - Maintain integrity of repair
    - Decrease pain and inflammation
    - Promote tissue healing
    - Patient education of precautions and progressions
  - Precautions:
    - No active range of motion
    - No quick movements
    - No lifting of objects
    - No excessive stretching
    - No supporting body weight by hands
    - PROM that is too aggressive or provokes muscle guarding
    - Keep incisions dry and clean (first 2 weeks)
    - Continue with sling with abductor pillow

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- 0-8 weeks
  - Initiation of PROM may begin initially or be delayed up to 6 weeks. Please refer to surgeon/operative report for progression

❖ **Phase II: 8-16 weeks**

- Criteria to progress to phase II.
  - Appropriate healing by adhering to precautions in phase I
  - Staged ROM goals achieved
  - Minimal pain
- Goals for Phase II
  - Allow healing of soft tissue
  - Do not overstress healing tissue
  - Restore full PROM
  - Normalize AROM
  - Begin to increase strength and endurance
  - Initiate gradual functional activities and light return to work activities
- 8-10 weeks
  - Sub-maximal Isometrics into flexion, IR, ER, ABd
  - Rhythmic stabilization exercises
  - Scapular Isometrics
- 10-12 weeks
  - Initiate AAROM/AROM activities
    - Avoid compensations
- 12 weeks
  - Initiate isotonic strengthening
  - Initiate functional activities
  - Continue to monitor for improper compensations.
- Additional Criteria
  - With subscap repair, limit PROM ER/AROM IR
  - Sling per MD
  - If concomitant procedures, modify as necessary.
  - **Close communication with surgeon is always necessary**

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