Charlotte Shoulder Institute

Patient Centered. Research Driven. Outcome Maximized.

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DISCHARGE INSTRUCTIONS & PHYSICAL THERAPY INSTRUCTIONS FOR OPEN ANTERIOR STABILIZATION (LATARJET)

Initial recovery after shoulder surgery entails healing, controlling swelling and discomfort and regaining some shoulder motion. The following instructions are intended as a guide to help you achieve these goals until your 1st postoperative visit.

A. Comfort:

Although surgery uses small incisions around the shoulder joint, swelling and discomfort can be present. To minimize discomfort, please do the following:

1. **Ice**- Ice controls swelling and discomfort by slowing down the circulation in your shoulder. Place crushed ice in cloth covered plastic bag over your shoulder for no more than 20 minutes, 3 times a day.
2. **Pain Medication-** Take medications as prescribed, but only as often as necessary. Avoid alcohol and driving if you are taking pain medication.
3. **Sling-** A sling has been provided for your comfort and should be worn as described below.
4. **Driving –** Driving is NOT permitted as long as the sling is necessary.

B. Activities:

1. You are immobilized with a sling and abductor pillow, full time, for approximately one month. Your doctor can tell you when you can discontinue use of the sling at your 1st postoperative visit. The sling may be removed for exercises and for hygiene.
2. Your sling may be removed for gentle PASSIVE range-of-motion (PROM) exercises. (SOMEONE ELSE MOVES YOUR SHOULDER). This should be done 3x a day /15 repetitions (ABDUCTION ONLY – away from your body).

3. Active range-of motion (AROM – you move your shoulder) should be performed for shoulder internal/external rotation. Keep elbow positioned at the side and flexed at 90° so forearm is parallel to the floor. This should be done within a comfortable range until you feel slight pain (3x a day for 15 repetitions). You can shrug your shoulders.
4. While your sling is off you should flex and extend your elbow and wrist – (3x a day for 15 repetitions) to avoid elbow stiffness.
5. Handball squeezes should be done in the sling (3x a day for 15 squeezes).
6. You may NOT move your shoulder by yourself in certain directions. NO active flexion (lifting arm up) or abduction (lifting arm away from body) until Dr. Romanowski or your therapist gives permission. These exercises must be done by someone else (Passive Range of Motion).
7. Physical therapy will begin approximately 3-4 weeks after surgery. Make an appointment with a therapist of your choice for this period of time. You will be given a prescription and instructions for therapy at your 1st post op or 1 month visit. Please take these with you to your first therapy visit.
8. Athletic activities such as throwing, lifting, swimming, bicycling, jogging, running, and stop-and-go sports should be avoided until cleared by Dr. Romanowski.

C. Wound Care:

1. Keep the dressing on, clean and dry until your 1 week post op follow up appointment.
2. Should your dressing come off, you may apply band-aids to the small incisions around your shoulder.
3. You may shower the first day after surgery with the dressings in place.
4. Bathing, swimming, and soaking should be avoided for two weeks after your surgery.

D. Eating:

Your first few meals after surgery should include light, easily digestible foods and plenty of liquids, as some people experience slight nausea as a temporary reaction to anesthesia.

C. Call your physician if:

1. Pain persists or worsens in the first few days after surgery.
2. Excessive redness or drainage of cloudy or bloody material from the wounds. (Clear red tinted fluid and some mild drainage should be expected). Drainage of any kind 5 days after surgery should be reported to the doctor.
3. Temperature elevation greater than 101°.
4. Pain, swelling, or redness in your arm or hand.
5. Numbness or weakness in your arm or hand.
6. Chest pain or difficulty breathing.

D. Return to the office

Your first return to the office should be within the first 1-2 weeks after your surgery. Call Dr. Romanowski's office to make your first postoperative appointment.

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Anterior Stabilization of the Shoulder: Latarjet Protocol

The intent of this protocol is to provide the clinician with a guideline of the postoperative rehabilitation course of a patient that has undergone a Latarjet procedure for anterior stabilization. It is no means intended to be a substitute for one's clinical decision making regarding the progression of a patient's post-operative course based on their physical exam/findings, individual progress, and/or the presence of postoperative complications. If a clinician requires assistance in the progression of a postoperative patient they should consult with the referring Surgeon.

Progression to the next phase based on Clinical Criteria and/or Time Frames as Appropriate.

Phase I – Immediate Post Surgical Phase (approximately Weeks 1- 3)

Goals:

- Minimize shoulder pain and inflammatory response
- Protect the integrity of the surgical repair
- Achieve gradual restoration of passive range of motion (PROM)
- Enhance/ensure adequate scapular function

Precautions/Patient Education:

- No active range of motion (AROM) of the operative shoulder
- No excessive external rotation range of motion (ROM) / stretching. Stop at first end feel felt
- Remain in sling, only removing for showering. Shower with arm held at side
- No lifting of objects with operative shoulder
- Keep incisions clean and dry
- Patient education regarding limited use of upper extremity despite the potential lack of or minimal pain or other symptoms

Activity:

- Arm in sling except when performing distal upper extremity exercises
- (PROM)/Active-Assisted Range of Motion (AAROM)/ (AROM) elbow and wrist/hand
- Begin shoulder PROM (do not force any painful motion)
- Forward flexion and elevation to tolerance
- Abduction in the plane of the scapula to tolerance
- Internal rotation (IR) to 45 degrees at 30 degrees of abduction
- External rotation (ER) in the plane of the scapula from 0-25 degrees; begin at 30-40 degrees of abduction; respect anterior capsule tissue

integrity with ER range of motion; (seek guidance from intraoperative measurements of external
- Scapular clock exercises progressed to scapular isometric exercises
- Ball squeezes
- Sleep with sling supporting operative shoulder, place a towel under the elbow to prevent shoulder hyperextension
- Frequent cryotherapy for pain and inflammation
- Patient education regarding posture, joint protection, positioning, hygiene, etc.

Milestones to progress to phase II:
- Appropriate healing of the surgical repair
- Adherence to the precautions and immobilization guidelines
- Achieved at least 100 degrees of passive forward elevation and 30 degrees of passive external rotation at 20 degrees abduction
- Completion of phase I activities without pain or difficulty

Phase II – Intermediate Phase/ROM (approximately Week 4-9)

Goals:
- Minimize shoulder pain and inflammatory response
- Protect the integrity of the surgical repair
- Achieve gradual restoration of (AROM)
- To be weaned from the sling by the end of week 4-5
- Begin light waist level activites

Precautions:
- No active movement of shoulder till adequate PROM with good mechanics
- No lifting with affected upper extremity
- No excessive external rotation ROM / stretching
- Do not perform activities or strengthening exercises that place an excessive load on the anterior capsule of the shoulder joint (i.e. no pushups, pec flys, etc..)
- Do not perform scaption with internal rotation (empty can) during any stage of rehabilitation due to the possibility of impingement

Early Phase II (approximately week 4):
- Progress shoulder PROM (do not force any painful motion)
- Forward flexion and elevation to tolerance
- Abduction in the plane of the scapula to tolerance
- IR to 45 degrees at 30 degrees of abduction
- ER to 0-45 degrees; begin at 30-40 degrees of abduction; respect anterior capsule tissue integrity with ER range of motion; seek guidance from intraoperative measurements of external rotation ROM)
- Glenohumeral joint mobilizations as indicated (Grade I, II) when ROM

is significantly less than expected. Mobilizations should be done in directions of limited motion and only until adequate ROM is gained.
- Address scapulothoracic and trunk mobility limitations. Scapulothoracic and thoracic spine joint mobilizations as indicated (Grade I, II, III) when ROM is significantly less than expected. Mobilizations should be done in directions of limited and only until adequate ROM is gained.
- Begin incorporating posterior capsular stretching as indicated
- Cross body adduction stretch
- Side lying internal rotation stretch (sleeper stretch)
- Continued Cryotherapy for pain and inflammation
- Continued patient education: posture, joint protection, positioning, hygiene, etc.

Late Phase II (approximately Week 6):

- Progress shoulder PROM (do not force any painful motion)
- Forward flexion, elevation, and abduction in the plane of the scapula to tolerance
- IR as tolerated at multiple angles of abduction
- ER to tolerance; progress to multiple angles of abduction once >/= 35 degrees at 0-40 degrees of abduction
- Glenohumeral and scapulothoracic joint mobilizations as indicated (Grade I-IV as appropriate)
- Progress to AA/AROM activities of the shoulder as tolerated with good shoulder mechanics (i.e. minimal to no scapulathoracic substitution with up to 90-110 degrees of elevation.)
- Begin rhythmic stabilization drills
- ER/IR in the scapular plane
- Flexion/extension and abduction/adduction at various angles of elevation
- Continue AROM elbow, wrist, and hand
- Strengthen scapular retractors and upward rotators
- Initiate balanced AROM / strengthening program
    - o Initially in low dynamic positions
    - o Gain muscular endurance with high repetition of 30-50, low resistance 1-3 lbs)
    - o Exercises should be progressive in terms of muscle demand / intensity, shoulder elevation, and stress on the anterior joint capsule
    - o Nearly full elevation in the scapula plane should be achieved before beginning elevation in other planes
    - o All activities should be pain free and without substitution patterns
    - o Exercises should consist of both open and closed chain activities
    - o No heavy lifting or plyometrics should be performed at this time
    - o Initiate full can scapular plane raises to 90 degrees with good mechanics
    - o Initiate ER/IR strengthening using exercise tubing at 0° of

abduction (use towel roll)
    - o Initiate sidelying ER with towel roll
    - o Initiate manual resistance ER supine in scapular plane (light resistance)
    - o Initiate prone rowing at 30/45/90 degrees of abduction to neutral arm position
- Continued cryotherapy for pain and inflammation
- Continued patient education: posture, joint protection, positioning, hygiene, etc.

Milestones to progress to phase III:

- Passive forward elevation at least 155 degrees
- Passive external rotation within 8-10 degrees of contralateral side at 20 degrees abduction
- Passive external rotation at least 75 degrees at 90 degrees abduction
- Active forward elevation at least 145 degrees with good mechanics
- Appropriate scapular posture at rest and dynamic scapular control with ROM and functional activities
- Completion of phase II activities without pain or difficulty