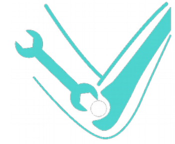


Arthroscopic Shoulder Stabilisation Procedure Protocol

- includes all labral repairs, bone block transfers +/- remplissage

(Excludes open latarjet procedure)

Procedure Summary

These are done arthroscopically so there is minimal soft tissue disruption. The exact combination of repairs depends on what is found at surgery.

Labral repair: the labrum becomes detached from its attachment to the bony glenoid, or heals in an abnormal position. The labrum is mobilized and its insertion site to the bone is abraded to provide a bleeding surface for it to heal onto. Suture anchors are used: these are small implants with sutures attached that are inserted into bone. The anchor gives a secure fixation into the glenoid bone while the attached sutures are used to fix the tissue being repaired, in this case the labrum.

Capsular plication: if the joint capsule is lax / redundant, it sometimes needs to be tightened by suturing it onto itself, ie plicating it.

Hill-Sachs remplissage: this is for significant defects in the posterior humeral head caused at the time of dislocation that if not addressed would increase the risk of redislocation if a labral repair is performed by itself. The posterior capsule and infraspinatus tendon are sutured into the defect using suture anchors to fill it ("remplissage").

Bone Block Transfer: this is for bone loss in the glenoid primarily or other 'off-track' unstable shoulders. The bone is either taken from the patients own iliac crest as autograft or allograft from an external bone graft supplier. The bone is attached and compressed to the glenoid with tensioned sutures and the labrum is repaired over the top of the reconstructed bone graft

Notes:

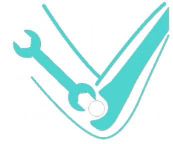
- Rehab is geared towards protecting the repair until the tissue has time to heal in its new position.
- For all capsular plication procedures do not force ROM or push on shoulder, the operation is done to increase shoulder stiffness, and movement will return gradually.

AIM: at 3 months should be achieving full active ROM and starting sport specific rehab

Protocol

Sling

6 weeks+



Day 1- 8 Weeks:

- Importance of pain control.
- Ice pack use + +
- Sling use.
- Sleeping position (e.g remove sling and use body strap for support).
- Washing and dressing.
- AROM of unaffected joints eg fingers, wrist and elbow.
- Postural advice and scapular setting.
- Encourage waist level ADL's (e.g. brushing teeth, eating).

Exercises taught on ward:
Pendulum
AA shoulder flexion as comfortable
AA shoulder ER to neutral for 2/52.
Hand, wrist and elbow ROM

Phase 1 Aim: to increase joint ROM passive to active

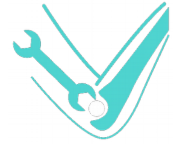
Range of movement progressing gradually through the following with restrictions:

ER to neutral for 2/52
ER to 20° for 2-4/52 **(for capsular plication limit ER to 20° for 6 weeks)**
ER to 40° at 4-6/52
Avoid active elevation past 90 degrees for 6/52
Unloaded elbow flexion for 6/52

1a Passive ROM (controlled by the patient)
1b Active assisted ROM
1c Active ROM

NOTE - encourage SCAPTION rather then pure abduction.
- progress using short to long lever principles.

Follow-up Physiotherapy
2/52 post op.



8 weeks to 3 months:

Start phase 2 avoiding ER in abduction for 3/12.

Phase 2 Aim: Stretching at end of range and strengthening

2a Stretches at end of range
- encourage stretches to be done by the patient using a broom handle etc rather than by physiotherapist
- attention to posterior capsule stretch (within relevant restrictions).

2b Strengthening against resistance only once patient is achieving functional AROM and no pain to resisted muscle testing.
- include strengthening of rotator cuff, UFT, LFT, serratus anterior, biceps, triceps, deltoid as per assessment.

3 months+ :

Phase 3 Aim: full active rehab/ higher level function

Start sport specific rehab.
Earliest contact sport or overhead throwing at 4/12.

General guidelines

Consultant post op follow up
All patients are normally followed up in clinic with consultant at 6-8/52 post op
(Stitches to be removed at 2/52 post op at GP practice).

Driving

Usually possible post op at 6/52.

This is dependant on patient function and safety and specific post op instructions. Patients should always check with the DVLA and insurance company.