Shoulder SAD and ACJ Excision Protocol

Procedure summary

The vast majority of these are now done arthroscopically, which avoids disruption to the deltoid attachment.

Subacromial decompression: the subacromial bursa and adhesions are cleared. The coracoacromial ligament is detached from its insertion to the undersurface of the acromion. Several millimetres of bone are shaved off the undersurface of the acromion, mainly anteriorly and laterally, until a smooth level surface is obtained. The simplistic view is that this increases the subacromial space and prevents mechanical impingement of bone against rotator cuff tendon. However, the exact reason why this works is not so clear and may also have something to do with denervating the area.

ACJ excision: as above, except that the lateral part of the clavicle is excised

Notes:

- Continued pain is not unusual even 4 months post op. ACJ excision is recognised to take at least 6 months to settle, so frequent patient reassurance is often necessary.

- The main concern is to avoid stiffness: do not start strengthening too soon, this will always come back in the long term if ROM is restored, and avoid pure abduction until very late as this just predisposes to recurrent impingement!

AIM: recovery likely to take between 3-6 months

Protocol

Check if a rotator cuff repair has been done in addition- if RC repair has been done then follow the RC repair protocol.

Sling

Discard as soon as comfortable

Day One

- 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 e.g. 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
AA shoulder ER
Hand, wrist and elbow ROM

Follow-up Physiotherapy

2/52 post op.

Phase 1 Aim: to increase joint ROM passive to active

Range of movement progressing gradually through the following

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.

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.

Phase 3 Aim: full active rehab/ higher level function

Start sport specific rehab.

Patients can return back to competitive sports when achieving full AROM and normal strength.

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 2/52 post op for SAD procedures.

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