PHYSIOTHERAPY GUIDELINES

Rotator Cuff Repair

Access is gained to the joint by detaching a small portion of Deltoid from the acromion and then splitting the muscle vertically. This operation normally always involves the supraspinatus tendon which will be repaired if technically possible. If the tear is medium to large it may involve infraspinatus and teres minor. A massive tear may also involve subscapularis. An arthroscopic sub-acromial decompression (SAD) is normally done as part of the procedure to give the repaired tendon more room in which to move. If the tear is irreparable, a SAD will be done for pain relief. If the tendon has been repaired it will be immobilised in a sling or an abduction brace, depending upon the tension across the repair at the time of surgery.

PRE-OP:

Assess for baseline data (esp. passsive & active range), teach passive and auto passive elevation and external rotationto 0º, pendulum exercises & scapula stability.

POST-OP (Inpatient):

Find out operative details from the operation note (attached) i.e. tendons involved, size of defect, security of repair and post-operative sling/abduction brace immobilisation.
All patients will retain sling for minimum of 3 weeks – off for exercises only.
Check for non-routine e.g. if large or massive defect repaired, or very fragile, instructions may be different i.e. longer period in sling, restrictions on movement
1) Review exercises in booklet with patient
2) Sling information – keep on except for exercises & axilla hygiene (+ body strap)
3) Axilla hygiene (passive abduction for access)
4) Cryocuff – can be helpful for pain relief
5) Arrange Outpatient Physiotherapy appointment
   - ASAP if there are problems with passive movements – to check these (or)
   - When active-assisted movement commences - normally THREE weeks post-op
6) Exercises:

PHASE ONE (0 – THREE weeks) – Main emphasis is on regaining passive range of movement with minimal muscle activity.

a) elbow, wrist, neck & scapula movements
b) scapula settting
c) Pendular exercise – 'passive' flexion (neutral rotation)
d) 'Passive' flexion – supine (assisted with other side)
e) 'Passive' external rotation – supine – to 0º. Use stick between hands & towel under humerus for support. Can take beyond 0º, if range before tension on repair is greater than 0 & recorded in operation notes. Do NOT do external rotation work for 3 weeks if subscapularis has been repaired – rare & should be recorded.

Emphasise 'passive' nature of the movement – reinforce this with patients.
Teach carer if patient not able to do alone OR is tending to do active movement.
Once a day if good mobility, twice a day otherwise, three times a day if stiff.

POST-OP (Outpatient):

PHASE TWO (THREE to SIX weeks) - main emphasis is on regaining active (assisted) movement within maximum passive range available. Facilitate movement DO NOT RESIST.

a) Wean off sling gradually as control increases
b) Continue with 'passive' range of movement – gh joint – end of range 'tight' but no forcing or sudden stretching
c) Start active assisted elevation, in scaption – progressive programme with short lever arm (elbow flexed).
   Start supine, pulleys, auto-assisted, up wall
d) Correct movement pattern
e) Progress scapula muscle programme
f) Start isometrics for internal and external rotation in neutral if pain free – do not target supraspinatus i.e.abduction
g) Hydro – exercises in water (not swimming)
h) Functional tasks (not lifting) at waist height

PHYSIOTHERAPY GUIDELINES (continued)

PHASE THREE (SIX to TWELVE weeks) – main emphasis is on improving endurance and quality of movement with reference to functional activities

a) Progress active assisted movements – extension, hand behind back, abduction
b) Progress cuff rehabilitation – through range – progressive loading – do not target supraspinatus with abduction +/- resistance exercises
c) Progress scapular activity
d) Integrate scapula/cuff with dynamic control and endurance through range
e) Build endurance
f) Increase functional tasks into elevation
g) Can stretch if required
h) No lifting

PHASE FOUR (TWELVE weeks) – main emphasis on muscular endurance and strength in relation to functional demands

a) Increase endurance for arm elevation activities
b) Progress resistance to cuff & scapula as indicated
c) Start general strengthening activities
d) No contraindications
e) Functional demands will direct rehabilitation