OUTPATIENT POST-OPERATIVE 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, and will be repaired if it is a full thickness tear.

If the tear is medium to large it may involve infraspinatus and teres minor. A massive tear may also involve subscapularis. A sub-acromial decompression (SAD) is normally done as part of the procedure, to give the repaired tendon more room in which to move. If tear is irreparable, a SAD will be done for pain relief.

If the tear has been repaired and is secure, most repairs at the NOC are immobilised in a sling for 3 weeks. Check instructions for NON- routine care.
Out-patient physiotherapy is normally started at 3 weeks post-op.

Outpatient

1) **0–three weeeks – Main emphasis is on regaining passive range of movement with minimal muscle activity.**

a) immobilised in sling – out for exercises & axilla hygiene
b) elbow, wrist, neck & scapula movements
c) scapula settting
d) Pendular exercise – 'passive' flexion (neutral rotation)
e) 'Passive' flexion – supine (assisted with other side)
f) '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 this is if subscapularis has been repaired – relatively rare & should be recorded in op notes.

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 tendency to be stiff.

2) **Three weeks – main emphasis is on regaining active movement, with maximal passive movement 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) Correst 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

3) **Six 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

4) **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