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Orthopedic Sports Medicine

MULTIDIRECTIONAL INSTABILITY

POST OPERATIVE PROTOCOL

	Time Frame (weeks)	Guidelines	
PHASE I	0 to 3-4 (per MD)	**SLING:** Gunslinger x 3-4 weeks **ROM:** No GHJ ROM x 3 weeks as determined by physician following check @ 3 weeks **EXERCISE PROGRESSION** • Ice and modalities to reduce pain and inflammation. • Cervical ROM and basic deep neck flexor activation (chin tucks) • Active hand and wrist range of motion. • Passive elbow flexion. • Active shoulder retraction. • Encourage walks and low intensity cardiovascular exercise to promote healing. **MANUAL INTERVENTION** • UT, parascapular STM as needed. Effleurage massage to forearm and upper arm as needed.	• Reduce inflammation • Decrease pain • Postural education
	3-4 to 6	**EXERCISE PROGRESSION** • Supine flexion using contralateral arm for ROM at least 3x/day. • Supine ER using T-bar. • DNF, proper postural position with shoulder retraction exercises. • Passive/active assisted elbow flexion. • Cervical ROM. • Low intensity cardiovascular work, no running. **MANUAL INTERVENTION** • STM – global shoulder and CT junction. Scar tissue mobilization when incisions are healed. Grade 1-2 GH mobilizations as needed. ST mobilizations. Gentle sub-maximal therapist directed isometrics to achieve ROM goals.	• Move from gunslinger into abduction pillow sling. • Postural education with cervical spine and neutral scapular positioning. • <u>Shoulder flexion:</u> 90° x 1 week, 120° x 1 week, gradual progression to full in the scapular plane beginning at 6 weeks. • <u>External rotation:</u> to 0° at 30° abduction x 1 week, 30° ER at 30° and 45° abduction at week 5.
PHASE II	6 to 8	**EXERCISE PROGRESSION** • Serratus activation; Ceiling punch (weight of arm) many initially need assistance. • Manual perturbations supine with arm in 90° flexion and ER/IR at 30°-45° abduction with neutral rotation. • Scapular strengthening – prone scapular series (rows and I's). Emphasize scapular strengthening under 90°. • External rotation on side (no resistance). • Cervical ROM as needed to maintain full mobility. • DNF and proper postural positioning with all RC/SS exercises. • Continue with combined passive and active program to gradually push full flexion and external rotation achieving ROM goals outlined above. • Stick off the back progressing to internal rotation gradually introducing thumb up the back. • Sub-maximal 6 direction rotator cuff isometrics. • Low/moderate cardio work. Elliptical okay, but no running. **MANUAL INTERVENTION** • STM – global shoulder and CT junction. Scar tissue mobilization. Graded GH mobilizations as needed. ST mobilizations. Gentle CR/RS to gain ROM.	• Discontinue abduction pillow, into regular sling for another 1-2 weeks as instructed. • Gradual progression to full shoulder flexion. • <u>External rotation:</u> to 45°, 70° abduction with gradual progression to full ROM by weeks 10-12. • Begin internal rotation with stick off back.

	Time Frame (weeks)	Guidelines	
PHASE III	8 to 12	**SLING:** Gunslinger x 3-4 weeks **ROM:** No GHJ ROM x 3 weeks as determined by physician following check @ 3 weeks **EXERCISE PROGRESSION** • Continue with combined passive and active program to gradually push full flexion and external rotation. • Internal rotation with thumb up back; gradually introducing sleeper stretch as ROM deficits direct. • Continue with ceiling punch adding weight as tolerated. • Advance intensity of sub-maximal rotator cuff isometrics. May stop once isotonic RC/SS program is fully implemented. • Advance prone series to include T's and Y's adding resistance as tolerated. • Resisted ER in side-lying or with bands. • Gym: rows, front lat pulls, biceps and triceps. • Scaption; normalize ST arthrokinematics. • Supine progressing to standing PNF patterns, adding resistance as tolerated. • CKC progression (10 weeks)– Quadruped weight shift with slight elbow flexion. Avoid lock-out position to limit posterior directed force. Therapist directed RS and perturbations in quadruped – bilateral progressing to unilateral-tri pod position (again, avoiding lock-out position). **MANUAL INTERVENTION** • STM and Joint mobilization to CT junction, GHJ and STJ as needed. CR/RS to gain ROM while respecting repaired tissue. Manual perturbations. PNF patterns.	• Gradual progression to full PROM and AROM by week 10-12. • Normalize GH/ST arthrokinematics. • Activate RC/SS with isometric and isotonic progression.
PHASE IV	12 to 24	**EXERCISE PROGRESSION** • Full range of motion all planes – protecting end range 90/90. • Begin strengthening at or above 90° with prone or standing Y's, D2 flexion pattern and 90/90 as scapular control and ROM permit. Patient goals/objectives will determine if strengthening above 90° is appropriate. • Advance CKC exercises - ball compression, counter weight shift, knee scapular push-ups, knee push-ups; all as tolerated. May introduce DB pressing, chest flys and overhead pressing and strength, goals and objectives indicated. • Continue to progress RC and scapular strengthening program. • Continue with closed chain quadruped perturbations; add open chain as strength permits. • Initiate plyometric and rebounder drills as appropriate. • RTS testing using microfet dynamometer for interval programs. • Follow-up examination with the physician (6 months) for release to full activity. **MANUAL INTERVENTION** • STM and Joint mobilization to CT junction, GHJ and STJ as needed. CR/RS to gain ROM while respecting repaired tissue. Manual perturbations. PNF patterns. **RETURN TO ACTIVITY** • Full, pain-free ROM. • Normal GH/ST arthrokinimatics. • >90% MMT using handheld dynamometer. • Full progression through interval program. • Anticipated return to play for contact athlete is **6 MONTHS** • Anticipated return to play for throwing athlete, swimmer and volleyball is **6-9 MONTHS**	• Gradual progression to full ROM. • Normalize GH/ST arthrokinematics. • Advance gym strength program. • Begin RTS progression. • Evaluation with physician for clearance to full activity.