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# POSTERIOR STABILIZATION
## POST OPERATIVE PROTOCOL

| | Time Frame (Weeks) | Guidelines | Goals |
|---|---|---|---|
| **PHASE I** | 0 to 3-4 | **SLING:** Gunslinger or Abduction pillow x 4 weeks<br>**ROM:** No GHJ ROM x 2-3 weeks per MD<br>**EXERCISE PROGRESSION**<br>• Cervical ROM, basic deep neck flexor activation (chin tucks)<br>• Active hand and wrist ROM<br>• Passive elbow flexion/extension<br>• Active shoulder retraction<br>• Walks, low intensity cardio exercise to promote healing<br>**MANUAL INTERVENTION**<br>• UT, parascapular STM as needed. Effleurage massage to forearm and upper arm as needed. | • Gunslinger or abduction pillow x 4 weeks with arm positioned with midline of the body and humerus externally rotated to neutral<br>• Reduce inflammation<br>• Decrease pain<br>• Postural education |
| | 3-4 to 6 | **SLING:** Move into regular sling at 3-4 weeks post-op<br>**EXERCISE PROGRESSION**<br>• Supine flexion using contralateral arm for ROM 3x/day.<br>• Supine ER using T-bar.<br>• DNF and proper postural positioning with shoulder retraction exercises.<br>• Cervical ROM.<br>• Low/moderate cardio work; Elliptical okay, no running.<br>**MANUAL INTERVENTION**<br>• STM – global shoulder and CT junction.<br>• Scar tissue mobilization when incisions are healed.<br>• Grade 1-2 GH mobilizations as needed.<br>• ST mobilizations.<br>• Gentle sub-maximal isometrics to achieve ROM goals. | • Postural education with cervical spine; neutral scapular positioning<br>• Shoulder flexion to 90° with gradually progression to full in scapular plane<br>• Full shoulder external rotation |
| **PHASE II** | 6 to 8 | **EXERCISE PROGRESSION**<br>• Serratus activation; Ceiling punch (weight of arm) many initially need assistance.<br>• Manual perturbations supine, arm in 90° flexion<br>• Scapular strengthening – prone scapular series (rows and I's). Emphasize scapular strengthening under 90°.<br>• External rotation on side (no resistance).<br>• Cervical ROM as needed to maintain full mobility.<br>• DNF proper postural positioning with all RC/SS exercises.<br>• Low/moderate cardio work; Elliptical okay, but no running.<br>• Continue with combined passive and active program to push full flexion and external rotation achieving ROM goals outlined above.<br>• Stick off the back progressing to internal rotation<br>• Sub-maximal 6 direction rotator cuff isometrics (no pain).<br>**MANUAL INTERVENTION**<br>• STM – global shoulder and CT junction.<br>• Scar tissue mobilization.<br>• Graded GH mobilizations.<br>• ST mobilizations.<br>• Gentle CR/RS to gain ROM while respecting repaired tissue. | • Discontinue sling as instructed.<br>• Full shoulder flexion and external rotation<br>• Begin internal rotation with stick off back |

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| **PHASE III** | 8 to 12 | **EXERCISE PROGRESSION**<br>• Continue with combined passive and active program to push full flexion and external rotation.<br>• Internal rotation with thumb up back; gradually introduce sleeper stretch as ROM deficits direct.<br>• Continue with ceiling punch adding weight as tolerated.<br>• Advance intensity of sub-maximal rotator cuff isometrics. May discontinue once isotonic RC/SS program is fully implemented.<br>• Advance prone series to include T's and Y's adding resistance as tolerated.<br>• Resisted ER in side-lying or with bands.<br>• Gym: rows, front lat pulls, biceps and triceps.<br>• Scaption; normalize ST arthrokinematics.<br>• Supine progressing to standing PNF patterns, adding resistance as tolerated. Protect end range 90/90.<br>• CKC progression (week 10) – Quadruped weight shift with slight elbow flexion. Avoid lock-out position to limit direct posterior force.<br>• Therapist directed RS and perturbations in quadruped – bilateral progressing to unilateral-tri pod position (Avoiding lockout position)<br>**MANUAL INTERVENTION**<br>• STM and Joint mobilization to CT junction, GHJ and STJ as needed.<br>• CR/RS to gain ROM while respecting repaired tissue.<br>• Manual perturbations.<br>• PNF patterns. | • Gradual progression to full P/AROM by week 10-12<br>• Normalize GH/ST arthrokinematics.<br>• Activate RC/SS with isometric and isotonic progression. |
| **PHASE IV** | 12 to 24 | **EXERCISE PROGRESSION**<br>• Full range of motion all planes protecting end range 90/90.<br>• 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.<br>• Progress RC and scapular strengthening program.<br>• Continue with closed chain quadruped perturbations; add open chain as strength permits.<br>• Advance CKC exercises—ball compression, counter weight shift, knee scapular push pressing with light resistance; very gradual increase in loading.<br>• Initiate plyometric and rebounder drills as appropriate.<br>• RTS testing for interval programs<br>• Follow-up examination with the physician (6 months) for release to full activity.<br>**MANUAL INTERVENTION**<br>• STM and Joint mobilization to CT junction, GHJ and STJ as needed.<br>• CR/RS to gain ROM while respecting repaired tissue.<br>• Manual perturbations.<br>• PNF patterns.<br>**CRITERIA FOR RETURN TO PLAY**<br>• Full, pain-free ROM<br>• Normal GH/ST arthrokinimatics<br>• >90% MMT using handheld dynamometer<br>• Full progression through interval program<br>• Anticipated return to play for contact athlete is 4 months<br>• Anticipated return to play for throwing athlete, swimmer and volleyball is 6-9 months. | • Gradual progression to full ROM<br>• Normalize GH/ST arthrokinematics.<br>• Advance gym strengthening program.<br>• Begin RTS progression.<br>• Evaluation with physician for clearance to full activity. |