Recommended physio protocol post Latarjet procedure

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Thank you for looking after this patient's rehabilitation post Latarjet procedure. The following is for guidance only and should not replace your clinical assessment. All patients are different and post op, pain or complications of surgery may slow progress in some. We routinely review patients at week 6, 12 and 18 with x-ray. If concerned please contact our office and we will arrange earlier review. We hope the following will help guide you when structuring your patients rehab program. Further details can be found in the following paper: https://www.ncbi.nlm.nih.gov/pubmed/31916920

The Latarjet is an advanced technique to manage instability in the setting of bone loss in the glenohumeral joint. The coracoid and associated conjoined tendon are exposed through the deltopectoral interval and transferred to the anterior glenoid via a split in the subscapularis. This fills the bone defect in the anterior glenoid and also creates a muscle sling between the conjoined and the subscap. The graft is fixed in position using screws to maintain position until bone union occurs.

It is important to remember that the procedure does alter how the shoulder works so proprioceptive changes are inevitable. In addition, like all stabilisation procedures, the goal is risk reduction rather than risk elimination and there is still a small recurrence rate. Ensuring bone union is key to success and therefore stressing the fixation through biceps and coracobrachialis resistance and forced ER should be avoided in the early phases.

Phase 1 (Week 1-4):

- Maintain arm in sling, remove only for controlled exercise
- No active range of motion (AROM) of Shoulder
- Active Hand Wrist and supported Elbow (HWE) ROM and Scapular control (STC)
- Cryotherpay and Hygiene keeping wound clean and dry and protecting from frostbite.
- No loading, especially of elbow flexion or shoulder forward elevation
- No sudden motion or body weight support
- Progress passive ROM in scapular plane. Start at 45 degrees and progress to 90 by week 4. Allow External rotation to 30 degrees through elevation if tolerated. We do not recommend pendular exercises.
- Gentle isometric cuff activation.
- Proceed to AAROM at week 4.

Phase 2 (Week 5-8):

- Discontinue sling at end of week 6
- Continue to progress AAROM and introduce AROM when full elevation achieved.
- Continued no lifting with affected upper extremity until x-ray confirmes graft position
- Gradual increases in external rotation ROM after week 6. Includes stretching but respect anterior capsule integrity.
- Commence safe cardiovascular fitness without upper limb challenge week 6
- Continue HWE, cuff isometrics and STC

Phase 3 (week 9-12):

- Surgeon to check satisfactory graft union on x-ray circa week 6 before progression to resistance
- Continue AROM to achieve controlled overhead positioning.
- Commence gentle loading of the upper limb including elbow flexion with low resistance.
- Gently advance ER range through elevation in the scapular plane.
- Ensure good scapular control and commence sleeper stretches etc for glenohumeral range at week 12 if Glenohumeral stiffness still an issue.

Phase 4 – (Week 12 – Week 18)

- Normalize strength, endurance, neuromuscular control
- Retrieve proprioceptive control to achieve controlled full active ROM before unrestricted functional use or strengthening.
- Strengthen elbow range and shoulder progressively. Start with resistance bands. Light weights etc.
- Use low percentage of max lift and high reps initially and build up for high risk positions e.g. bench or military press, overhead squat etc.
- Initiate plyometrics/interval sports program.

Allow return to contact circa week 16-18 as appropriate when:

- Comfortable with continued HEP
- No complaints of pain or instability
- Good scapular and cuff control.
- Adequate ROM for task completion
- Comparable strength and endurance to contralateral shoulder