Recommendation for Physio: Cuff repair

DIARMUID MOLONY
ORTHOPAEDICS

Thank you for looking after this patient's rehabilitation post cuff repair. The following is for guidance only and should not replace your own clinical assessment and experience. All patients are different and post op capsulitis, pain or complications of surgery may slow progress in some. Likewise because of variations in tear size, tendon involvement and degree of retraction, safe range may vary greatly. While the majority of cuff repairs will be performed arthroscopically, because of tear configuration an open approach will sometimes be needed. This means that the anterior deltoid will also need to be protected post operatively in these cases.

Your patient will be given a post op physio form with information on these issues. What follows below should be considered a general guideline. We routinely review patients at week 6 and 18. We usually copy your patient on correspondence and include advice for physiotherapy. If concerned please contact our office and we will arrange earlier review.

In general, to protect the integrity of the repair, we recommend passive range only in the first 6 weeks with active assisted- progressing to active range from week 6-12. Significant tension on the involved tendon through passive stretch should be avoided until after week 12 (e.g. limited IR in supra/infraspinatus repair and limited ER in subscapularis repair.) We recommend resistance only after week 12, the focus being on range of motion up to that point. We do not recommend pendular range of motion in the early phases. We feel passive and active assisted elevation is best done in the scapular plane to balance the tension in the repaired cuff.

It is important your patient understands the recovery from a cuff repair will take at least as long as the above and may take longer in larger tears or where post-operative inflammation and stiffness are an issue. Ongoing improvements can be made up to and beyond the 1 year post op mark. In addition, larger and more complex tears take longer to rehab as the permitted range of motion may be limited initially leading to glenohumeral stiffness. The progression may not be linear but will improve over time. If you are concerned your patient has a prolonged plateau in progression, please let us know.

Phase 1 (Weeks 1-6):

- Maintain arm in sling except for exercise (Includes in bed)
- Cryotherapy keeping wounds clean and dry
- Active hand wrist and elbow ROM (HWE) and scapular control isometrics (STC) with neck ROM
- Passive shoulder range only (PROM). Usually start with abduction to 60 and ER to 30, see post op sheet or op note for details. Progress passive elevation as tolerated but do not force the repaired tendon (e.g. minimal gentle IR in posterosuperior cuff repair and minimal gentle ER in subscap repairs)
- Loading and forced IR should be avoided (i.e. hand behind back motion)
- No supporting of body weight by hands. Avoid sudden movements
- To progress to Phase 2 aim for PROM in flexion to at least 100, ER of 30 degrees, IR of 30 degrees, ABD of 90 degrees in the scapular plane.

Phase 2 (Week 6-12):

- Wean sling
- Continue active HWE and STC
- Continue Cryotherapy as necessary, particularly post exercise
- Gradually restore full passive ROM (week 6-9)
- Commence Active Assisted ROM week 6 and progress with passive range. Supine exercise, cane assisted and sling/pulley systems may be used. Push passive range in uninjured tendons (ER in posterosuperior cuff, IR in subscap)
- Begin rotator cuff isometrics/activation week 9
- Aim for full passive and active assisted ROM by week 12.

Phase 3: (Week 12-18):

- Move to active ROM as tolerated in scapular plane and commence inner range resistance week 12 and outer range after week 16.
- Continued HWE and STC. Make sure scapular hitching is not compensating for glenohumeral stiffness.
- Continue isometric cuff strengthening, allow light free weights at this point. (no more than 2kg)
- Maintain and progress passive ROM in all directions (Sleeper stretches etc). Periscapular and glenohumeral release.
- Progress strength, power, and endurance therabands/sport cord/ tubing -and light free weight when controlled full AROM is achieved.

Phase 4 (week 18+):

- Maintain full non-painful active ROM •
- Improve muscular strength, power, and endurance.
- Develop eccentric control in all planes
- Progress proprioception and neuromuscular feedback and control.
- Gradual return to full functional activities
- Gradual return to strenuous work activities
- Consider allowing impact circa week 24 and return to sport if tolerated.