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PHYSICAL THERAPY PROTOCOL
LATARJET/OPEN BONE BLOCK PROCEDURE

Procedure	**Date of Surgery:** _____ **R L B/L** Open Anterior Stabilization with [ ] Coracoid Transfer [ ] Distal Tibial Allograft [ ] w/ Subscapular Split approach [ ] w/ Subscapularis tenotomy **Additional Procedures:**_____	**PLAN** **Physical Therapy for R L B/L** Shoulder 2-3x Per Week x 12 Weeks
General Guidelines	The intent of this protocol is to provide the clinician with a guideline of the postoperative rehabilitation course of a patient that has undergone a Latarjet procedure for anterior stabilization. It is no means intended to be a substitute for one's clinical decision making regarding the progression of a patient's post-operative course based on their physical exam/findings, individual progress, and/or the presence of postoperative complications. If a clinician requires assistance in the progression of a postoperative patient they should consult with the referring Surgeon. Progression to the next phase based on Clinical Criteria and/or Time Frames as Appropriate.	
PHASE I **(Weeks 1-3)** Immediate Post-Surgical Phase	**GOALS** • Minimize shoulder pain and inflammatory response • Protect the integrity of the surgical repair • Achieve gradual restoration of passive range of motion (PROM) • Enhance/ensure adequate scapular function **TREATMENT RECOMMENDATIONS** • Arm in sling except when performing distal upper extremity exercises • (PROM)/Active-Assisted Range of Motion (AAROM)/ (AROM) elbow and wrist/hand	**PRECAUTIONS/ PATIENT EDUCATION** • No active ROM (AROM) of the operative shoulder • No excessive external rotation range of motion (ROM) / stretching. Stop at first end feel felt. • Remain in sling, only removing for showering, resting in chair and home exercise. Shower with arm held at side • No lifting of objects with operative shoulder • Keep incisions clean and dry • Patient education regarding limited use of upper extremity despite the potential lack of or minimal pain or other symptoms

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	• Begin shoulder PROM (do not force any painful motion) • Forward flexion and elevation to tolerance • Abduction in the plane of the scapula to tolerance • Internal rotation (IR) to 45° at 30° of abduction • External rotation (ER) in the plane of the scapula from 0-25°; begin at 30-40° of abduction; ○ Respect anterior capsule tissue integrity with ER range of motion; (seek guidance from intraoperative measurements of ER ROM) • Scapular clock exercises progressed to scapular isometric exercises • Ball squeezes • Frequent cryotherapy for pain and inflammation	• Sleep with sling supporting operative shoulder, place a towel under the elbow to prevent shoulder hyperextension • Patient education regarding posture, joint protection, positioning, hygiene, etc. **MILESTONES TO PROGRESS TO PHASE II** • Appropriate healing of the surgical repair • Adherence to the precautions and immobilization guidelines • Achieved at least 100° of passive forward elevation and 30° of passive external rotation at 20° abduction • Completion of phase I activities without pain or difficulty

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PHASE II (Week 4-9) Intermediate Phase/ROM	**GOALS:**
	• Minimize shoulder pain and inflammatory response
	• Protect the integrity of the surgical repair
	• Achieve gradual restoration of (AROM)
	• Start weaning sling after week 3 (completely out of sling by week 5).
	• Begin light waist level activities
	
	TREATMENT RECOMMENDATIONS
	
	Early Phase II (approximately week 4):
	• Progress shoulder PROM (do not force any painful motion)
	• Forward flexion and elevation to tolerance
	• Abduction in the plane of the scapula to tolerance
	• IR to 45° at 30° of abduction
	• ER to 0-45°; begin at 30-40° of abduction;
	  ○ Respect anterior capsule tissue integrity with ER range of motion; seek guidance from intraoperative measurements of external rotation ROM)
	• Glenohumeral joint mobilizations as indicated (Grade I, II) when ROM is significantly less than expected.
	  ○ Mobilizations should be done in directions of limited motion and only until adequate ROM is gained.
	• Address scapulothoracic and trunk mobility limitations.
	• Scapulothoracic and thoracic spine joint mobilizations as indicated (Grade I, II, III) when ROM is significantly less than expected.
	  ○ Mobilizations should be done in directions of limited and only until adequate ROM is gained.
	• Begin incorporating posterior capsular stretching as indicated
	• Cross body adduction stretch
		PRECAUTIONS
		• No active movement of shoulder till adequate PROM with good mechanics
		• No lifting with affected upper extremity
		• No excessive external rotation ROM / stretching
		• Do not perform activities or strengthening exercises that place an excessive load on the anterior capsule of the shoulder joint (i.e. no pushups, pec flys, etc..)
		• Do not perform scaption with internal rotation (empty can) during any stage of rehabilitation due to the possibility of impingement

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	• Side lying internal rotation stretch (sleeper stretch)
	• Continued Cryotherapy for pain and inflammation
	• Continued patient education: posture, joint protection, positioning, hygiene, etc.
	
	Late Phase II (approximately Week 6):
	• Progress shoulder PROM (do not force any painful motion)
	• Forward flexion, elevation, and abduction in the plane of the scapula to tolerance
	• IR as tolerated at multiple angles of abduction
	• ER to tolerance; progress to multiple angles of abduction once >/= 35° at 0-40° of abduction
	• Glenohumeral and scapulothoracic joint mobilizations as indicated (Grade I-IV as appropriate)
	• Progress to AA/AROM activities of the shoulder as tolerated with good shoulder mechanics (i.e. minimal to no scapulathoracic substitution with up to 90-110° of elevation.)
	• Begin rhythmic stabilization drills
	• ER/IR in the scapular plane
	• Flexion/extension and abduction/adduction at various angles of elevation
	• Continue AROM elbow, wrist, and hand
	• Strengthen scapular retractors and upward rotators
	• Initiate balanced AROM / strengthening program
	  ○ Initially in low dynamic positions
	  ○ Gain muscular endurance with high repetition of 30-50, low resistance 1-3 lbs)
	  ○ Exercises should be progressive in terms of muscle demand / intensity, shoulder elevation, and stress on the anterior joint capsule
		MILESTONES TO PROGRESS TO PHASE III
		• Passive forward elevation at least 155°
		• Passive external rotation within 8-10° of contralateral side at 20° abduction
		• Passive external rotation at least 75° at 90° abduction
		• Active forward elevation at least 145° with good mechanics
		• Appropriate scapular posture at rest and dynamic scapular control with ROM and functional activities
		• Completion of phase II activities without pain or difficulty

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	○ Nearly full elevation in the scapula plane should be achieved before beginning elevation in other planes ○ All activities should be pain free and without substitution patterns ○ Exercises should consist of both open and closed chain activities ○ No heavy lifting or plyometrics should be performed at this time • Initiate full can scapular plane raises to 90° with good mechanics ○ Initiate ER/IR strengthening using exercise tubing at 0° of abduction (use towel roll) Initiate sidelying ER with towel roll ○ Initiate manual resistance ER supine in scapular plane (light resistance) ○ Initiate prone rowing at 30/45/90° of abduction to neutral arm position • Continued cryotherapy for pain and inflammation • Continued patient education: posture, joint protection, positioning, hygiene, etc.	

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PHASE III (Week 10 – Week 15) Strengthening Phase	**Goals:**
	• Normalize strength, endurance, neuromuscular control
	• Return to chest level full functional activities
	• Gradual and planned buildup of stress to anterior joint capsule
	
	TREATMENT RECOMMENDATIONS
	• Continue A/PROM as needed/indicated
	• Initiate biceps curls with light resistance, progress as tolerated
	• Initiate gradually progressed strengthening for pectoralis major and minor; avoid positions that excessively stress the anterior capsule
	• Progress subscapularis strengthening to focus on both upper and lower segments
	  ○ Push up plus (wall, counter, knees on the floor, floor)
	  ○ Cross body diagonals with resistive tubing
	  ○ IR resistive band (0, 45, 90° of abduction
	  ○ Forward punch
		PRECAUTIONS
		• Do not overstress the anterior capsule with aggressive overhead activities/ strengthening
		• Avoid contact sports/activities
		• Do not perform strengthening or functional activities in a given plan until the patient has near full ROM and strength in that plane of movement
		• Patient education regarding a gradual increase to shoulder activities
		
		MILESTONES TO PROGRESS TO PHASE IV
		• Passive forward elevation WNL
		• Passive ER at all angles of abduction WNL
		• Active forward elevation WNL with good mechanics
		• Appropriate rotator cuff and scapular muscular performance for chest level activities
		• Completion of phase III activities without pain or difficulty

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PHASE IV (Week 16-20) Overhead Activities Phase / Return to Activity Phase	**GOALS** • Continue stretching and PROM as needed/indicated • Maintain full non-painful AROM • Return to full strenuous work activities • Return to full recreational activities **TREATMENT RECOMMENDATIONS** • Continue all exercises listed above • Progress isotonic strengthening if patient demonstrates no compensatory strategies, is not painful, and has no residual soreness • Strengthening overhead if ROM and strength below 90° elevation is good • Continue shoulder stretching and strengthening at least four times per week • Progressive return to upper extremity weight lifting program emphasizing the larger, primary upper extremity muscles (deltoid, latissimus dorsi, pectoralis major) ○ Start with relatively light weight and high repetitions (15-25) • May do pushups as long as the elbows do not flex past 90° • May initiate plyometrics/interval sports program if appropriate/cleared by PT and MD • Can begin generalized upper extremity weight-lifting with low weight, and high repetitions, being sure to follow weight lifting precautions. • May initiate pre injury level activities/ vigorous sports if appropriate / cleared by MD	**PRECAUTIONS** • Avoid excessive anterior capsule stress • With weight lifting, avoid tricep dips, wide grip bench press, and no military press or lat pulls behind the head. Be sure to “always see your elbows” • Do not begin throwing, or overhead athletic moves until 4 months post-op or cleared by MD **MILESTONES TO RETURN TO OVERHEAD WORK AND SPORT ACTIVITIES:** • Clearance from MD • No complaints of pain or instability • Adequate ROM for task completion • Full strength and endurance of rotator cuff and scapular musculature for task completion Regular completion of continued home exercise program