

PHYSIOTHERAPY GUIDELINES

Shoulder Replacement

These can involve replacement of the glenoid and humeral components (Total Shoulder Replacement) or just the humeral component (Hemiarthroplasty). The hemiarthroplasty may be chosen due to lack of glenoid bone stock, &/or the rotator cuff musculature is not functional. Normally most of subscapularis will have been detached and resutured & this needs protection. The operation is done primarily for pain relief. Active movement regained will be dependent on the status of the rotator cuff.

CONTRAINDICATIONS:

To protect subscapularis repair & to avoid the danger of dislocation (rare) avoid:

- a) Abduction with external rotation for 6 weeks.
- b) Isometric/isotonic medial rotation exercises for 4 weeks
- c) Care with external rotation for 4 weeks (check ROM in surgery)
- d) Forced extension (eg. pushing on arm with BODY forward getting out of chair)

Pre-op assessment clinic – passive and active range, status and strength of cuff, functional difficulties?
Check able to do auto assisted exercise (multi-joint problems), get pulleys organised.

Inpatient – 3 to 5 days

Day 1

Booklet

Pain relief – cryocuff may be helpful

Sling information (no body strap required but can be used if more comfortable)

Resting positions for comfort (eg. Towel/block under humerus)

Maintenance exercises: fist, wrist and hand & neck

Scapulothoracic movements & elbow (out of sling)

Day 2 onwards – add as tolerated

Pendular exercises

Assisted external rotation (within range obtained at surgery).

- If unsure,
- a) try and find out what was obtained
 - b) take to neutral
 - c) never force passively

Supine; flexion (support at elbows or wrist)

Pulleys – into elevation through flexion not abduction – short lever

Arrange Outpatient Physiotherapy appointment before discharge

Outpatient shoulder & elbow team clinic appointment will be made 6 weeks post operatively

0–3 weeks post operation – main emphasis on regaining passive range (protecting excessive lateral rotation), & facilitating active assisted movement.

- a) wean out of sling (as pain and control allows)
- b) continue with hospital exercise programme

Pendular F/E, ABD/ADD

Supine; auto-assisted flexion – support at elbows or wrist

Pulleys - into elevation through flexion/scaption not abduction– with short lever

Assisted external rotation (within range obtained at surgery). If unsure, take to neutral and never force passively

- c) begin passive abduction (maintain shoulder in medial rotation)
- d) progress to active assisted flexion – supine to sitting. Short lever
- e) begin isometric strengthening all muscle groups except medial rotation

3 weeks post operation – main emphasis is on active assisted to active range of movement. Start gentle muscle rehabilitation. Facilitate movements.

- a) wean out of sling (if not already)
- b) active assisted movements progressing to active -- lying, sit/standing – short lever
- c) start isometric medial rotation (if pain-free)
- d) exercises in water
- e) functional use of arm at waist height – light tasks

6 weeks post operation – main emphasis is on improving quality of movement and endurance with reference to functional activities

- a) maximise active movements – correct abnormal movement patterning if able
- b) start on isotonic inferior cuff exercises – if pain-free (med/lat rotation > abduction)
- c) regain external rotation range
- d) increase use of arm for functional tasks gradually
- e) progress strengthening – all groups, if indicated (function)

Patients may be on treatment for over 4 months, to help regain maximum range and activity from the shoulder. Appointments may be infrequent but contact to assess and progress the exercise programme is indicated to optimise the effect of surgery. Many will have had many months or years of problems with pain & disuse contributing to stiffness and muscle atrophy. Rehabilitation can be slow.

General points of rehabilitation:

Work towards functional goals.

Pain relief is the main indication for surgery & is normally successful.

Antigravity elevation may take 4–6 weeks to achieve.

Active range of movement will be dependent on the status of the rotator cuff and soft tissues.

Some patients may have 'limited goals' as a result.

People with primary OA will tend to do better (often no cuff damage).

Improvement can continue for up to two years.

Encourage people to continue until they find no further improvement (or are fully functional).

Guidelines for returning to activities:

After four weeks, nothing prohibited in normal ADL. Pain is the guide.

Minimum times:

Driving – six to eight weeks

Swimming – breaststroke – 6 weeks

Golf – 3 months

Off work six to eight weeks if light work

Off work six months if heavy work