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1.0 Policy Statement
   1.1 It is the policy of Cappagh National Orthopaedic Hospital to provide a patient focused physiotherapy service delivered by chartered physiotherapists and support staff working in a well-equipped environment.

   1.2 It is the policy of Cappagh National Orthopaedic Hospital to provide health professionals and the public with the necessary advice and guidance on physiotherapy rehabilitation.

2.0 Purpose
   2.1 The purpose of this guideline is to advise health professionals and patients on the physiotherapy rehabilitation of a person undergoing a Rotator Cuff Repair (Surgeon - Hannan Mullett).

3.0 Scope
   3.1 This guideline applies to all staff involved in the care of a person undergoing a Rotator Cuff Repair (Surgeon - Hannan Mullett), community staff involved in the pre and post-operative care of the patient, the patient and their family.

4.0 Health & Safety
   4.1 There are health and safety risks involved in patient care, namely risk of physical injury to patient and staff, risk of infection.

   4.2 Physiotherapists have the necessary qualifications and clinical experience to carry out this guideline and to supervise unqualified support staff.

   4.3 They must be eligible for membership of their professional body, the Irish Society of Chartered Physiotherapists (ISCP).

   4.4 They undertake mandatory manual handling, basic life support training, fire safety, infection prevention and control and risk management.

   4.5 They complete a minimum of 100 hours continuing professional development every three years as required by the ISCP.

5.0 Responsibilities
   5.1 It is the responsibility of physiotherapists to implement this guideline.
6.0 Definitions and Abbreviations

6.1 The rotator cuff is a group of tendons that insert on the superior lateral aspect of the upper arm. The tendons are what permit the shoulder muscles (subscapularis, supraspinatus, infraspinatus, teres minor) to attach to bone, and therefore raise and lower the arm, and rotate it in and out. The tendons are broad and form a cuff encapsulating the articular surface of the top of the humerus. The rotator cuff runs under a bony and ligamentous arch formed by the acromion. Due to the narrowness of the space provided for the cuff, any inflammation or swelling of the tissue leads to pain. Any significant tearing of the cuff weakens the ability of the muscles to move the arm, and eventually permits the articular cartilage in the shoulder joint to impact against the bony confines of the space, leading to pain and arthritis. In some cases surgical repair of the rotator cuff is indicated.

6.2 Classification of a Rotator Cuff Tear:

- Minor: Less than 1 cm
- Medium: 1cm - 3cm
- Major: 3cm-5cm
- Massive: Greater than 5cm

6.3 Rehabilitation depends not only on the size of tear, but also the shape of the tear, strength of repair and general tissue & joint condition. Always check with the surgeon.

6.4 Most surgical repairs of the rotator cuff are now performed arthroscopically so there is less tissue trauma and reduced risk of adhesions. Post-operative stiff shoulder is now rarely a problem, so the priority is to protect the repair from breaking down.

7.0 Guideline

7.1 Pre-Operative

7.1.1 Assessment as appropriate, to include shoulder, neck and scapular range of movement, muscle strength and general upper limb function. Educate patients about basic rotator cuff function and lever principles to reduce the risk of stressing the repair prematurely.

7.2 Post-Operative

7.2.1 Protocol selection will be determined not just by the size of tear, but also the shape of the tear, strength of repair and general tissue and joint condition. Always check the operation notes and discuss post-operative physiotherapy instructions with the surgeon.

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7.2.2 Shoulder immobiliser fitted for 3-6 weeks (Check tear size - minor tears will be immobilised for 3 weeks, medium and major tears for up to 6 weeks). To be worn day & night.

7.2.3 Teach axillary hygiene.

7.2.4 Teach postural awareness.

7.2.5 Teach active shoulder girdle, elbow, wrist and finger movements.

7.2.6 Commence passive flexion, abduction and external rotation of the surgical shoulder (This may be delayed with major tears - discuss with the surgeon).

7.2.7 Patient positioned in supine and passive movements performed within comfortable limits. Always be guided by the patient’s pain.

7.2.8 Do not force, stretch or stress the repair before 6 weeks (minor tears) to 8 weeks (larger tears). Check theatre notes for exact tendon repair site and avoid tensioning repair site.

  e.g. Supraspinatus - avoid full passive Medical Rotation Adduction
        Subscapularis - avoid full passive External Rotation and Abduction

7.2.9 Passive movements can also be carried out in PNF patterns by the physiotherapist.

7.2.10 Discharge Criteria

  7.2.10.1 When patient’s pain is controlled.

  7.2.10.2 When the patient’s family member is independent with passive shoulder movements as part of patients home program.

  7.2.10.3 When a follow up out patient physiotherapy appointment is arranged.

7.3 Minor Tear: Less than 1cm

  7.3.1 2-3 Weeks

    7.3.1.1 When patient’s pain is controlled.

    7.3.1.2 Review by Consultant.
7.3.1.3 Commence rehabilitation:
- Wean out of shoulder immobiliser
- Progress from active-assisted to active flexion, extension & abduction as is comfortable. Caution with internal and external rotation. Do not force or over stretch the repair

7.3.1.4 Commence isometric rotator cuff exercises as comfort allows.

7.3.1.5 Commence gentle activities of daily living at waist level.

7.3.2 6 Weeks
7.3.2.1 Restore full active movements in the shoulder. Stretch into limited end range.

7.3.2.2 Progress rotator cuff strengthening programme. Include scapular stability exercises.

7.3.2.3 Commence gentle hydrotherapy where available.

7.3.2.4 Encourage functional movements

7.4 Medium Tear: 1cm – 3cm / Major-Massive Tear: 3cm-5cm and greater
7.4.1 3 Weeks
7.4.1.1 Review by Consultant.

7.4.1.2 Continue with passive movements.

7.4.1.3 Commence pendulum exercises (if instructed by consultant).

7.4.2 6 Weeks
7.4.2.1 Wean off shoulder immobiliser as comfortable.

7.4.2.2 Begin active-assisted exercises and progress to full active exercises in all ranges.

7.4.2.3 Commence isometric rotator cuff exercises as comfort allows.

7.4.2.4 Commence hydrotherapy where available.

7.4.2.5 Progress scapula stability and closed chain exercises.

7.4.2.6 Encourage normal function around waist level.
7.4.3 8-12 Weeks
7.4.3.1 Restore full active movements in the shoulder. Stretch into limited end range.
7.4.3.2 Progressive rotator cuff strengthening after 8 weeks as appropriate.
7.4.3.3 Anterior deltoid strengthening as range of movement allows.
7.4.3.4 Strengthen humeral head depressors-rotator cuff, latissimus dorsi and biceps brachii.
7.4.3.5 Attention needs to be given to strengthening and setting of scapula.

7.4.4 Returning to Functional Activities

Driving: 6 weeks (+) depending on patient’s ability and type of repair.

Lifting: No heavy lifting for 3 months. After this be guided by strength.

Swimming: Breaststroke - Minor/Medium 6 weeks, Major 12 weeks
Freestyle - Minor/Medium 3 months, Major unlikely to progress to this stage

Golf: 3 months

Return to work: Minor tears with sedentary jobs may return at 6 weeks.
Major tears may take 12 weeks.
Manual workers should be guided by the surgeon

Activities of daily living: With major repair no active movements for the first 6 weeks. Then light activities e.g. dressing, washing, feeding and light household activities.

Note:
• Consideration should always be given to the individual patient’s ability.
• The protocol is based on maintaining range of movement in the first phase while protecting the repair. Then the protocol gradually builds strength in the middle and last phase.
• Progression should be tailored to individual patients but the times quoted should be the earliest that active and further strengthening begins.
Studies have shown for small and medium tears recovery of strength was almost complete during the first year. Larger and massive tears are much slower and less consistent.

8.0 Related Documents
Individual physiotools exercise sheet

9.0 Appendices
N/A

10.0 References
N/A