

Non-operative MDI Protocol

Name _____ Date _____

Frequency 1 2 3 4 5 times/week Duration 1 2 3 4 5 6 weeks

PHASE 1

Goals

- Minimize shoulder pain
- Increase strength and endurance
- Increase functional activities

Interventions to Avoid

- Do not perform stretching significantly beyond "At risk" ROM (avoid 90/90, end range flexion, ABD or Rotation in opposite direction of vulnerable areas)
- Do not perform any stretch to gain end range external rotation or external rotation at 90° of abduction unless significant tightness is present
- Do not allow the patient to use arm for heavy lifting or any activities that require end range or painful range positions
- Do not perform any strengthening exercises that place a large load on the shoulder in the position of horizontal abduction or the combined position of abduction with external rotation (eg, no push-ups, bench press, pectoralis flys)
- Do not perform scapular plane abduction with internal rotation (empty can) at any stage of rehabilitation due to the likelihood of impingement Specific Interventions Activities of primary importance

Suggested Interventions

- Patient education. Counsel about using the upper extremity for appropriate ADLs in the pain-free ROM (starting with waist-level activities and progressing to shoulder-level and finally to overhead activities over time)
- Basic mobility (active preferred) of thoracic spine, neck and shoulder. Address scapulothoracic and trunk mobility limitations. Ensure normal cervical spine ROM and thoracic spine extension to facilitate full upper extremity ROM
- Establish basic rotator cuff and scapular neuromuscular control within the allowed ROM (bands, in all planes with good scapular stability, I M T Y, rows and isolated rotations with arm buy side)
- Address abnormal scapular alignment and mobility PRN - Strengthen scapular retractors and upward rotators - Increase pectoralis minor flexibility if limited - Biofeedback by auditory, visual, or tactile cues - Weight-bearing exercises with a fixed distal segment. Examples: quadruped position while working to maintain proper position of the scapula, quadruped with scapula protraction, progressing from quadruped to tripod position, no push-ups
- Address core stability deficits PRN
- Activities to improve neuromuscular control of the rotator cuff and shoulder girdle such as use of unstable surfaces, Bodyblade, manual resistance exercises

- Introduction of functional patterns of movement (PNF diagonals , active or with with bands)
- Progressive Strength/endurance:
- Scapula and core strengthening
- Balanced rotator cuff strengthening to maintain the humeral head centered within the glenoid fossa during progressively more challenging activities
- Should be initially performed in a position of comfort with low stress to the glenohumeral joint, such as less than 45° elevation in the plane of the scapula (eg, elastic band or dumbbell external rotation, internal rotation, forward flexion)
- Exercises should be progressive in terms of shoulder elevation (eg, start with exercises performed at waist level progressing to shoulder level and finally overhead activities)
- Exercises should be progressive in terms of muscle demand. It is suggested to use activities that have muscle activity levels documented with EMG
- Elevation activities may progress from assistive exercises (eg, rope and pulley, wall walks) to active, to resistive upright exercises, then, finally, to prone exercises
- Nearly full active elevation in the plane of the scapula should be achieved before progressing to elevation in other planes
- Exercises should be progressive in terms of adding stress to the anterior capsule, gradually working towards a position of elevated external rotation in the coronal plane, the “90-90” position PRN
- Rehabilitation activities should be pain free and performed without substitutions or altered movement patterns
- Rehabilitation may include both weight-bearing and non-weight-bearing activities
- Rehabilitation may include both isolated and complex movement patterns
- Depending upon the goals of the exercise (control versus strengthening), rehabilitation activities may also be progressive in terms of speed once the patient demonstrates proficiency at slower speeds
- The rotator cuff and scapula stabilizer strengthening program should emphasize high repetitions (typically 30-50 reps) and relatively low resistance (typically 1-2 kg)
- No heavy lifting or plyometrics should be performed during this stage
- Elbow flexion/extension strengthening with elbow by the side can begin in this phase
- Ok to use arm bike close to body

Milestones to Progress to Phase 2

- Full active ROM goals achieved with minimal to no pain (NPRS, 0-2/10) and without substitution patterns
- Appropriate scapular posture at rest and dynamic scapular control during ROM and strengthening exercises
- Strengthening activities completed with minimal to no pain (NPRS 0-2/10)

PHASE 2

Goals

- Normalize strength, endurance, neuromuscular control, and power
- Gradual and planned build-up of stress to anterior capsulolabral tissues
- Gradual return to full ADLs, work, and recreational activities

Interventions to Avoid

- Do not increase stress to the shoulder in a short period or in an uncontrolled manner
- Do not perform advanced rehabilitation exercises (such as plyometrics or exercises requiring end range ROM) if the patient does not perform these activities during ADLs, work, or recreation
- Do not progress into activity-specific training until patient has nearly full ROM and strength
- Do not perform weightlifting activities that place excessive stress on the anterior capsule. For instance, latissimus pull-downs, and military press performed with the hands behind the head stress the anterior capsule with no additional benefit in terms of muscle activity. Similarly, activities that encourage end range shoulder extension, such as dips, should also be avoided

Suggested Interventions

- Progressive strengthening and endurance exercises
- Progressive neuromuscular control exercises
- Activity-specific progression: sport, work, hobbies

Supplementary activities:

- Normalize core and scapular stability Patient education:
 - Counsel in importance of gradually increasing stress to the shoulder while returning to normal ADLs, work, and recreational activities, including heavy lifting, repetitive activities, and overhead sports
- Passive ROM, stretching, and joint mobilizations as needed to address any remaining deficits
- Neuromuscular re-education: Address any remaining deficits of the rotator cuff, scapula musculature, or trunk musculature •Strength/endurance/power: Continue shoulder-strengthening program as initiated in phase 1, with increasing emphasis on high-speed multiplanar activities that incorporate the entire kinetic chain
- Gradually progress rehabilitation activities to replicate demanding ADL/work activities
- Progressive return to weight-lifting program emphasizing the larger, primary mover upper extremity muscles (deltoid, latissimus dorsi, pectoralis major)
- Start with relatively lightweight and high repetitions (sets of 15-25 repetitions), and gradually decrease repetitions and increase weight after several months

Suggested upper extremity exercises for EARLY phase 2

- Biceps curls, shoulder adducted (added in phase 1)
- Triceps press-downs or kick-backs, shoulder adducted (added in phase 1)
- Shoulder shrugs
- Rows (scapular retraction), shoulder adducted
- Latissimus bar pull-downs, with hands in front of the head
- Dumbbell overhead shoulder press with hands starting in front of the shoulders (not in the abducted/externally rotated position)
- Push-ups as long as the elbows do not flex past 90°

Suggested upper extremity exercises to be added in INTERMEDIATE phase 2

- Isotonic pressing activities (eg, flat or incline presses **using machines, barbells, or dumbbells**)
- Dumbbell shoulder raises to 90°

- Rows (scapular retraction), shoulders elevated
- Machine or barbell shoulder presses that do not require end range abduction/external rotation

Suggested upper extremity exercises to be added in LATE phase 2

- Overhead presses with shoulders in abduction with external rotation (military press)
- Pectoralis major flys
- Dead lift
- Power cleans

Upper extremity exercises that are not advisable for this patient population

- Dips
- Latissimus pull-downs or military press with the bar behind head

Criteria to initiate PHASE 3 (plyometric program)

- Adequate strength (4+/5) of entire shoulder girdle musculature
- Pain free with basic ADLs and current strengthening program
- At least 3 weeks of tolerance to high-speed multiplanar activities that progressively mimic functional demands

PHASE 3 (plyometric program)

Goals of returning to overhead athletics, work or recreational activities requiring large amounts of upper extremity power

Parameters

- Due to the explosive nature of this type of exercise, emphasis of plyometrics exercises should be on quality not quantity
- Perform a few times a week and utilize moderate repetitions (eg, 3-5 sets of 15-20 repetitions)
- Begin with unweighted balls and progress to lightly weighted balls (plyoballs)

Interval sport programs for activities such as throwing, swimming, and golf, once approved by physician

Milestones to Return to Work, Hobbies, Sport

- Clearance from physician
- No complaints of pain at rest and minimal to no pain (NPRS 0-2/10) with activities
- No or minimal sensation of instability with activities
- Restoration of sufficient ROM to perform desired activities
- Adequate strength and endurance of rotator cuff and scapular muscles to perform activities with minimal to no pain (NPRS 0-2/10) or difficulty
- If the patient struggles with confidence or shoulder stability, a stabilizing brace may be considered for return to activity, but is most commonly used only for collision sports

Comments:

Teach HEP _____

Modalities PRN

Every patient's therapy progression will vary to a degree depending on many factors. Please use your best clinical judgment on advancing a patient. If other ideas are considered to improve patient's outcome do not hesitate to call.

Patient's recovery is a team approach: Patient, family/friend support, therapist, and surgeon. Every team member plays an important role in recovery.

Signature _____ **Date** _____