UPPER LIMB PHYSIOTHERAPY PROTOCOLS

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VERSION 3 (Feb 2021)

BANKART REPAIR – ARTHROSCOPIC
LATARJET PROCEDURE - OPEN

Aim of surgery: to repair the detached antero-inferior labrum (Bankart lesion) to the glenoid.
Possible complication: tight inferior capsule.

With more traumatic injuries, often there is also an avulsion of the anterior/inferior glenoid as well as the labrum and therefore surgery must re-establish the bony congruency. During a 'Latarjet procedure' part of the coracoid process is dissected and attached to the antero-inferior gleniod as a 'bone graft'.

Post-op rehabilitation is the same following a Bankart repair and a Latarjet procedure – although as the Latarjet procedure is more extensive this may be more uncomfortable initially.

Pre-op
- Teach scapula stabilising programme if indicated.
- Document range of movement.

In patient
- Polysling applied in theatre and retained for 3 weeks. Strap round the waist to be kept on for 4 weeks, at night.
- Instructions given regarding the removal of the sling correctly for washing and dressing.
- Commence **passive** flexion to tolerance (90 degrees), abduction to 60°, external rotation to 20° (unless directed otherwise by surgical team).
- Teach elbow, wrist and hand exercises
- Isometric rotator cuff exercises if arthroscopic procedure only.
- Arrange out-patient physio appointment with in one week of discharge from ward.

3 Weeks
- Initiation of **active** mobilisation programme; flexion as tolerated (90 degrees plus), external rotation 20°, abduction full as able(unless directed otherwise by surgical team).
- Avoid passive stretch of external rotation beyond 20° or abduction beyond 90° until 4 weeks post-op.
- Scapula stabiliser programme if indicated
- **No terminal stretches into external rotation in abduction until 8 weeks**.

6 Weeks
- Correct abnormal movement pattern.
- Progress scapula stabilisation programme.
- Rotator cuff rehabilitation.
- Abduction beyond 90 degrees, and external rotation beyond 20 degrees.

12 weeks
- Full exercise programme and strengthen the rotator cuff, through range of active movement.
- No limits on external rotation
- Check scapula control through full range of movement.

- Commence terminal external rotation in abduction stretches.

16 Week
Graduated return to full activity e.g. contact sport after 6 months.

Driving: after sling removed if patient has good ROM and strength to ensure safety. Patient must inform insurance company of surgery.

Milestones

Week 2
- Pre-op level of passive range of movement maintained, exclusion of external rotation/abduction.

Week 6
- Range of motion at least 75% of pre-op level, exclusive of external rotation.

Week 16
- Pre-operative range of external rotation gained.
- Remaining active ranges of motion regained with power.

Options in the case of a failure to achieve milestone
- Outpatient physiotherapy review
- Referral to ZS clinic

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CAPSULAR RELEASE / MUA

Aim of surgery: to restore functional range of motion at the shoulder following a primary or secondary frozen shoulder.

Pre-op
- Range of motion documented
- Instruction in pulleys and active assisted regime

In patient
- Same day treatment with in-patient team with end of range capsular stretches. Patient instructed to perform stretches frequently i.e. 2 hourly, throughout the day
- Pulley exercises
- Passive mobilisation techniques
- External rotation exercises (against wall or with stick)
- Arrange immediate out-patient physio. appointment with in 3 working days of discharge from ward. Patient must be seen frequently during the following 6 weeks. For the first 2 weeks post- surgery / MUA, should ideally be seen 2-3 x weekly

Out Patient
- Check wounds where appropriate
- Advice re oedema control
- Capsular stretches to end of available range in all planes of motion
- Active exercises to restore full ROM as quickly as possible
- Check home exercise programme – quality and frequency of exercises
- Improve power through a graduated exercise programme

2 Weeks
- Wound check if appropriate
- Ensure continuation of physiotherapy and home exercise programme

6 Weeks
- Correct abnormal movement pattern.
- Continue home capsular stretches
- Rotator cuff rehabilitation.

12 weeks
- Asses maintenance of range of motion
- Advise may need to continue with daily stretches for 6 months+

Milestones
Week 6
- Range of motion equal to that gained in theatre

Week 12

- Functional range of motion gained

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CAPSULAR SHIFT

Aim of surgery: to decrease capsular volume of GHJ in order to increase stability. Used in patients with recurrent instability/dislocation due to multidirectional joint laxity rather than a localised defect.

Inpatient

- Teach elbow, wrist and hand exercises. **No** movement of shoulder for 2 weeks.
- Immobilise for 4 weeks in polysling.
- Patient instructed on correct removal of sling.
- Scapula stabiliser programme in neutral.
- Isometric rotator cuff exercises.
- Arrange out-patient physiotherapy appointment for **two weeks** post-op.

2 Weeks Post op

- Review wound
- Initiation of active mobilisation programme (in physiotherapy) inclusive of flexion to 90°, abduction to 90° and external rotation to 20° only.
- Avoid passive stretch of flexion beyond 90° or external rotation beyond 20°.
- Progress scapula stabiliser programme.
- No combined external rotation in abduction for 12 weeks.

4 Weeks Post op

- Progress with rotator cuff rehabilitation and scapula stabilization through the range of motion.
- Proprioceptive work and functional range of motion.
- Active flexion and elevation exercises beyond 90°.
- Wean from sling.
- Correct abnormal movement pattern.
- Commence external rotation work beyond 20°.

Milestones

Week 2

- ROM to 90° flexion.

Week 8

- Range of motion at least 75% of pre op level exclusive of external rotation.

Week 16

- Pre op active range of external rotation, extension and abduction regained with power.

Options in the case of a failure to achieve Milestones

- Hydrotherapy.
- Early referral to ZS clinic (or Sports Injury Clinic for ZS to see)
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DISTAL BICEPS REPAIR

The distal biceps may rupture following a traumatic injury to the upper limb which causes a rapid contraction of the biceps muscle/sudden loading, e.g. catching a heavy load, falls etc.
This may occur more easily if the tendon is weakened due to degeneration or previous steroid use.

Signs and Symptoms: proximal biceps bulge, decreased supination strength^{++}.

Repair needs to take place usually within 6 weeks of the initial injury – the earlier the better. Diagnosis of a distal biceps rupture requires an **urgent** referral to an Upper Limb Surgeon.

Post-operatively

In patient
Post operatively the patient should have their elbow placed in POP or elbow brace locked at 90° flexion for 2 weeks.

2-Weeks Orthopaedic Clinic
Wound check
POP removed and placed in a hinged brace set at 60-120°.
To keep brace on at all times except to wash the skin – during this time the arm must be kept relaxed and flexed at 90°.

4-Weeks Orthopaedic Clinic
Brace altered to allow 30-120° of elbow movement.

6-Weeks Orthopaedic Clinic
Brace altered to allow 0-120° of elbow movement.

8-Weeks Orthopaedic Clinic
Brace removed, free elbow ROM allowed.

NB. Avoid eccentric loading of biceps until 12 weeks post-op.

The patient must be warned they may not gain full elbow extension.
A referral to physiotherapy may be made if at any point the patient is struggling with range of movement.

Return to orthopaedic clinic urgently if evidence of re-rupture.

Driving: once brace removed as long as they have good arm function.
Return to light work: when comfortable in brace.
Return to heavy/manual work: 3-4 months post-op.
Full contact sports: 4 months post-op.

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ELBOW ARTHROLYSIS

The aim of surgery is to improve the functional range of motion at the elbow joint in patients who have less than 100 degrees through range flexion /extension. Usually undertaken after 1 year post-injury.

Pre-operatively

- Document available range of active and passive elbow motion

In-patient

- CPM for up to 5 days after surgery
- Decrease swelling with ice, cryocuff, elevation etc
- Active assisted progressing to active exercises for elbow flexion, extension, pronation and supination. Document range
- Shoulder, wrist and hand exercises
- Give home exercise programme and **stress need for frequency with stretches i.e. 2 hourly**
- Arrange urgent out-patient physiotherapy within 1 week prior to discharge

1 week post-op

- Commence active and passive mobilisation techniques with physiotherapist
- Isometric elbow exercises commenced
- Progress home exercise regime. Must be advised of the need to continue with home exercises for 6 months+
- Reiterate need for frequent stretches

2 weeks post-op

- Review wound
- Check active and passive range and document

6 weeks

- Strengthening through full range of motion
- O.T. review in cases of functional difficulty

12 weeks

- Asses active and passive range of motion and document
- Continuation of physiotherapy
- Final review at 12 months

Milestones
2 weeks
Passive range of motion equal to that gained at surgery

6 weeks
Active range of motion equal to that gained at surgery

Failure to meet milestones
Increased frequency of physiotherapy
Early referral to ZS clinic
Refer to O.T. for night splints
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TOTAL SHOULDER REPLACEMENT
HEMIARTHROPLASTY
SHOULDER RESURFACING

Aim of surgery: primarily for pain relief, although hopefully ROM will also improve.
Possible complications: risk of dislocation if moved into forced extension or combined abduction/lateral rotation in early stages. Also risk of developing stiffness, infection, nerve damage.

Pre-op

- Assess and document the pre-operative range of motion and rotator cuff function.
- Optimise capsular mobility where applicable.
- Teach scapula setting in neutral and if pain allows, an isometric rotator cuff exercise.

In patient

- Exercise programme begins post op:
  - i) Pulleys as tolerated.
  - ii) Gentle pendular exercises.
  - iii) External rotation exercise with a stick to 20°.
  - iv) Elbow, wrist and hand exercises
  - v) Gentle passive flexion to 45 degrees
  - vi) Passive abduction to 45 degrees.
- Must wear polysling initially (including waist strap at night for 4 weeks). A sling must be worn for 4 weeks when not exercising.
- Instruct regarding positioning for pain relief.
- Arrange out-patient physiotherapy for with in one week of discharge from ward.

At 3 Weeks

- Continue onto active assisted exercise (including flexion and abduction) within the limits of tolerance.
- **External rotation to 20 degrees only (to prevent stress on subscapularis repair)**
- Passive elevation to limit of tolerance
- Pain relieving modalities.
- Change polysling to collar and cuff to allow more movement at rest, if comfortable with the patient.
- Correct any abnormal movement patterns.
- Continue the exercise programme at home and introduce **active** exercises.
- Progress scapula stability programme.

At 6 Weeks

- Progress external rotation beyond 20 degrees.
- Commence rotator cuff isometric work
- Strengthening of deltoid throughout the active range of motion
- Occupational therapy review in cases of functional difficulty

- Emphasise correct movement pattern in activities of daily living
- Build upto full range as tolerated.

Driving: not before 6 weeks; only if comfortable and safe. Must notify insurance company of operation.

Milestones

Week 3
50% of pre-op level of active assisted range of motion gained

Week 6
Passive range of motion at least the pre-operative level, exclusive of external rotation. Should have 90 degrees passive flexion

Week 12
Active range of motion at least the pre-operative level. Should have 120 degrees active flexion

Any acute loss of active movement refer to the next upper limb unit clinic

Options in the case of failure to achieve milestones
Hydrotherapy
Early referral to ZS clinic

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ROTATOR CUFF REPAIRS

During the first 4-6 weeks the main aim is to maintain passive GHJ range within limitations (see below), followed by a *gradual* emphasis on strengthening.
Common complication: impingement of the repair, re-tear, stiffness.
It may take 12-18 months to regain full strength of the rotator cuff.

Most repairs are performed **arthoscopically** however a few are still performed with an open incision.

With an **open incision**, deltoid is reflected off the acromium to improve access to the cuff and then sutured down again. Due to this, care must be taken to prevent deltoid being pulled off the acromium before it has healed – therefore **passive** flexion and abduction must only be performed to **90°** for the first 4-6 weeks.

Pre-op
- Asses and document pre-operative range of motion and power
- Teach scapula stabiliser exercises
- Optimise capsular extensibility

In patient
- Half lever pulley exercises (flexion in the scapula plane) to limits of tolerance
- **Passive range of motion exercises** with therapist / carer. (Passive Flexion to limits of tolerance (if arthroscopic), passive abduction to 45 degrees, external rotation to 20 degrees).
- Polysling to be **worn for 4 - 6 weeks** unless exercising or washing/dressing (at surgeons discretion – 4 weeks if small tear with secure repair, 6 weeks if large/difficult repair)
- Elbow, wrist and hand exercises.
- Arrange OP physio appointment for within 1 week post ward discharge.

2 weeks post-op
- Review wound
- Remove sutures as required
- Continue with half lever pulley work in scapular plane
- Continue scapula stability work
- Continue passive mobilisations at limit of tolerance (if arthroscopic) in flexion, 90 degrees abduction and 20 degrees external rotation
- **No combined abduction/external rotation for 12 weeks.**

4-6 weeks post-op
- Active assisted progressing to active range of motion exercises
- Correction of movement pattern
- No combined abduction/external rotation
- Progress dynamic control of scapula through range

- Emphasise inferior cuff control and endurance
- Refer to O.T
- Proprioceptive re-education

12 weeks post-op
- Ensure scapula control through active range of motion
- Emphasise correction of movement pattern during A.D.L.
- Commence combined abduction/external rotation

Driving: 6-8 weeks post op if comfortable, safe and has good ROM and strength. Patient must notify insurance company.

Milestones

Week 4
Passive range of flexion at least 50% of pre-operative level

Week 8
Passive range of motion equal to pre-operative level
Active range of motion at least 50% of pre-operative level

Week 12
Active range of motion equal to pre-operative level

Any acute loss of active movement refer to the next ZS clinic

Options in the case of a failure to achieve milestones
Hydrotherapy
Early referral to ZS clinic

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SLAP REPAIR – ARTHROSCOPIC

Aim of surgery: to repair the detached superior labrum to the glenoid. This involves the long head of biceps tendon, therefore initially there should be **no** bicep loading.
Possible complications: tight superior capsule causing stiffness into external rotation, long head biceps rupture.

Pre-operatively

- Optimise posterior complex flexibility.
- Teach scapula stabilisation exercises.

Inpatient

- Polysling applied in theatre and retained for 4 weeks.
- Teach elbow, wrist and hand exercises.
- Initiate **passive** flexion to tolerance, abduction to 45°, ER to 20°; all with short lever to decrease load on bicep-labral complex.
- Scapula stability exercises in neutral.
- Instructions given for the correct removal of sling for washing and dressing.
- Patient advised to avoid loaded elbow flexion and supination for 4 weeks.
- Arrange out-patient physiotherapy appointment for within one week of discharge from ward.

At 2 Weeks Post-op

- Initiate **active-assisted** mobilisation programme; flex to tolerance, abd 90°, with the elbow passively flexed to 90° (to decrease load on biceps-labral complex).
- External rotation stretches in neutral to 20° until 4 weeks post-op.
- Active unloaded elbow flexion
- Patient must be warned **not** to perform loaded active elbow flexion or supination by themselves for 4 weeks.
- Progress scapula stability programme
- **No terminal stretches in combined external rotation with abduction for 12 weeks.**

At 4 weeks Post-op

- Wean from sling.
- Gradually increase abduction range.
- Progress to active range of movement.
- Increase external rotation past 20° in neutral only.

At 6 Weeks Post-op

- Correction of abnormal movement pattern.
- Rotator cuff rehabilitation.
- Posterior complex stretching.
- Avoid eccentric loading of the biceps.
- Check scapula dynamic control through full range of movement.

- Build up to full range of movement except terminal stretches in combined abduction/external rotation

12 Weeks Post-op
- Progress rotator cuff rehabilitation.
- Eccentric biceps exercises for scapula control.
- Can commence combined abd/external rotation terminal stretches

16 weeks Post-op
Return to contact sports following sport specific rehab.

Driving: not before 6 weeks. Must have adequate ROM. Patient must inform insurance company.

Milestones

Week 6
- Full active range of shoulder movement, initially with elbow flexed.

Week 8
- Full active range of shoulder and elbow.

Options in the case of a failure to achieve milestones
- Outpatient physiotherapy.
- Hydrotherapy.

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SUBACROMIAL DECOMPRESSION +/- AC EXCISION - ARTHROSCOPIC

This procedure is carried out for symptoms of sub-acromial impingement, and therefore post-operatively the patient must be assessed for all other causes of impingement which may prevent full recovery; i.e. scapula stability, capsular mobility, inferior cuff strength/endurance….

Post op treatment aims to restore normal movement ASAP and there are **no restrictions** however it is normal for the patient to be sore initially.

Pre-op

- Teach scapula setting and postural correction.

In patient/Pre-assessment

- If sling applied in theatre, patient advised to remove it over first 1-2 days as able.
- Teach active assisted exercise of the gleno-humeral joint, progressing to active including flexion and abduction with a stick.
- Pulley work.
- External rotation exercises with a stick.
- Postural correction.
- Document passive range of motion.
- Isometric rotator cuff work.
- Elbow, wrist and hand exercises.
- Scapula setting in neutral

2 Weeks

- Check active and passive range of motion.
- Check home exercise regime and progress to include rotator cuff and scapula stability exercises as appropriate.
- Refer for outpatient physiotherapy if milestones have not been met.
- Ensure scapular control to full range of movement.
- Advice re: active range of movement exercise if indicated.
- Emphasise inferior cuff control and endurance.
- Review wound portals.

6 Weeks

- Check active and passive range of motion.
- Check and progress home exercise regime as appropriate.
- Check scapular control through full range of movement.

- Sports/work specific training if indicated.

At 3 Months - See Surgeon
- Assess active and passive range of movement + or – continuance with physiotherapy.

Milestones

Week 2
- Pain restricting range of motion to no less than 75% of pre-op.

Week 6
- Range of motion equal to the pre-operative range of motion.

Options in the case of a failure to achieve Milestones
- Outpatient physiotherapy.
- Hydrotherapy.

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TENNIS ELBOW RELEASE

Surgery is only undertaken in the small percentage of patients who have not responded to all forms of conservative treatment.

Pre-operatively

- Document available range of active and passive elbow motion
- Document pain free grip strength

In-patient

- Decrease swelling with ice, cryocuff, elevation etc
- Active assisted progressing to active exercises for elbow flexion, extension, pronation and supination. Document range
- Shoulder, wrist and hand exercises

2 weeks post-op

- Review wound
- Remove sutures where applicable
- Check active and passive range and document
- Refer to physiotherapy if range of motion is reduced from the pre-operative level

6 weeks

- Strengthening through full range of motion
- Start to include low load eccentric work

12 weeks

- Asses active and passive range of motion and document
- Document pain free grip strength

Milestones

2 weeks
Passive range of motion equal to pre-operative range of motion

Options in the case of failure to achieve milestones
Out patient physiotherapy

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TOTAL ELBOW REPLACEMENT

The aim of surgery is to replace the articular surfaces of the elbow joint with prosthetic implants. Usually undertaken in patients with inflammatory arthropathy, or in elderly patients with complex fractures that it is not possible to internally fix.

In-patient

CHECK XRAY

- Decrease swelling with ice, cryocuff, elevation etc
- Active assisted flexion exercises progressing to active as pain allows
- Passive/gravity assisted extension exercises
- **NO RESISTED ELBOW EXTENSION FOR 12 WEEKS**
- Pronation and supination exercises in 90 degrees flexion
- Shoulder, wrist and hand exercises
- Back slab worn for 48 hours
- Patients must avoid lifting permanently so as to minimise risk of prosthetic loosening.
- Check neuro-vascular status of the upper limb
- Need out patient physio only if marked difference in post-op range compared to pre-operative levels

2 weeks post-op

- Review wound
- Check active and passive range and document
- Progress active extension exercises as long as wound healing is established
- Continue active flexion exercises
- Pronation and supination exercises through active range flexion/extension
- Refer urgently to out-patient physio if has persistent swelling or decreasing range of motion, compared to range at surgery

6 weeks

- Pronation and supination exercises in extension
- Check muscle control through full range of motion
- Ensure anti-gravity control triceps

12 weeks

- Asses active and passive range of motion and document
- Continuation of physiotherapy if required
- Check x-ray

6 months

- Asses active and passive range of motion and document
- Check x-ray

12 Months

- Assess active and passive range of motion
- Check x-ray for position of the components

Milestones
Pre-operative level of passive range of motion gained in the patients with inflammatory arthropathy between 6-12 weeks
In post – traumatic patients should be aiming for 80 - 100 degrees through range motion by 12 weeks

Failure to meet milestones
Increased frequency of physiotherapy
Early referral to ZS clinic
Hydrotherapy
CPM

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PECTORALIS MAJOR RUPTURES

1 - 2 weeks
• Shoulder immobiliser
• No Shoulder Exercises
• Wrist/hand/finger exercises
• Elbow flex/ext, pro/supination
• Scapula setting exercises

2-4 weeks:
• Do not force or stretch
• Gentle **passive** exercises in painless zone with gentle build up (no more than 20 degrees external rotation, 90 degrees forward flexion, abduction 45 degrees)**.**

6 weeks +:

Progress to full range of movement

• Progress to open chain exercises in all ranges as tolerated
• progressive resistance
• sports-specific rehabilitation
• Avoid hyperextending in bench press or flyes or pec-deck.
• Avoid high weights with low reps and warm up slowly

3-6 months

Full range of movement –
No restrictions

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ARTHROSCOPIC POSTERIOR STABILISATION

Day 1 - 3 weeks

- **External Rotation brace** for 6 weeks (can remove for washing and exercise; wear on outside of clothes).
- Teach postural awareness and scapular setting,
- PASSIVE ROM as comfortable (abduction 30 degrees, forward flexion 20 degrees, external rotation – 20 degrees to full – pendular exercises)
- **No combined forward flexion and Internal rotation exercises**

Do not force or stretch

3 -6 Weeks

- Continue with Brace and sling
- Continue with Passive ROM, and build up.
- Commence proprioceptive exercises (minimal weight-bearing below 90 degrees)
- **No combined forward flexion and Internal rotation exercises**

Do not force or stretch

6 - 12 Weeks

- **The sling is removed by 6 weeks**
- ACTIVE- ASSISTED ROM, then build up to FULL RANGE OF ACTIVE MOVEMENT, by 9 weeks.
- Full exercise programme and strengthen the rotator cuff, through range of active movement.
- No limits on external rotation
- Check scapula control through full range of movement.
- Commence terminal external rotation in abduction stretches.

16 Week
Graduated return to full activity e.g. contact sport after 6 months.

Driving: after sling removed if patient has good ROM and strength to ensure safety. Patient must inform insurance company of surgery.

Milestones

Week 6

- Range of motion at least 75% of pre-op level, exclusive of internal rotation.

Week 16

- Pre-operative range of internal rotation gained.
- Remaining active ranges of motion regained with power.

Options in the case of a failure to achieve milestone

- Outpatient physiotherapy review
- Referral to ZS clinic

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ACROMIOCLAVICULAR JOINT RECONSTRUCTION USING THE SURGILIG (LOCKDOWN) SYSTEM

0 - 4 weeks

- Shoulder immobiliser for 4 weeks 24 hours a day
- No Shoulder Exercises
- Wrist/hand/finger exercises
- Elbow flexion/extension exercises
- Scapula setting exercises

It is very important to convey the importance of wearing the sling at all times because the **weight of the arm hanging can pull the repair apart**.

Important to show how to **support the weight of the arm with other arm or a pillow / table before taking sling off or altering to wash etc**.

Arm should **not be actively lifted at any point**, at this stage

4-6 weeks:

Passive exercises in painless zone with gentle build up (no more than 20 degrees external rotation, 90 degrees forward flexion, abduction 90 degrees initially, but build upto full passive range of movement by the end of 6 weeks)**.**

- Can wean off the sling, but it still needs to be worn for a further 2 weeks at night to sleep.

6 weeks +:

Progress to full **Active** range of movement (starting actively assisted then full active)

- Progress to open chain exercises in all ranges as tolerated
- progressive resistance
- sports-specific rehabilitation

No Horizontal flexion/cross body adduction or elevation/abduction above 90 degrees elevation until 8 weeks post surgery.

3-6 months

Full range of movement –
No restrictions

Milestones –

Driving 6-8 weeks
Cycling (non-competitive road) - 8-12 weeks
Swimming - 12 weeks
Racquet Sports/ Golf – 3-6 months
Contact Sport e.g. rugby, football, mountain biking, hockey, climbing – 3-6 months

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OPEN REDUCTION AND INTERNAL FIXATION OF CLAVICLE

0 - 4 weeks

- Shoulder immobiliser for 4 weeks 24 hours a day
- No Shoulder Exercises
- Wrist/hand/finger exercises
- Elbow flexion/extension exercises
- Scapula setting exercises

It is very important to convey the importance of wearing the sling at all times because the **weight of the arm hanging can pull the repair apart**.

Important to show how to **support the weight of the arm with other arm or a pillow / table before taking sling off or altering to wash etc**.

Arm should **not be actively lifted at any point**, at this stage

4-6 weeks:

Passive exercises in painless zone with gentle build up (no more than 20 degrees external rotation, 90 degrees forward flexion, abduction 90 degrees initially, but build upto full passive range of movement by the end of 6 weeks)**.**

- Can wean off the sling, but it still needs to be worn for a further 2 weeks at night to sleep.

6 weeks +:

Progress to full **Active** range of movement (starting actively assisted then full active)

- Progress to open chain exercises in all ranges as tolerated
- progressive resistance
- sports-specific rehabilitation

No Horizontal flexion/cross body adduction or elevation/abduction above 90 degrees elevation until 8 weeks post surgery.

3-6 months

Full range of movement –
No restrictions

Milestones –

Driving 6-8 weeks
Cycling (non-competitive road) - 8-12 weeks
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