

**Jourdan M. Cancienne, M.D.**  
Sports Medicine  
Shoulder, Hip, Knee Arthroscopy  
Shoulder Replacement Surgery



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## **DISCHARGE INSTRUCTIONS & PHYSICAL THERAPY PROTOCOL: Anterior Stabilization of the Shoulder: Latarjet Procedure**

- ❖ Initial recovery after shoulder surgery entails healing, controlling swelling and discomfort and regaining some shoulder motion. The following instructions are intended as a guide to help you achieve these goals until your 1<sup>st</sup> postoperative visit.
- ❖ **COMFORT**

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  - **Ice** – Ice controls swelling and discomfort by slowing down the circulation in your shoulder. Place crushed ice in plastic bag over your shoulder for no more than 20 minutes, 3 times a day.
  - If you elected to receive the **circulating cooling device**, this can be used continuously for the first 3 days, (while the initial post-op dressing is on). After 3 days, the cooling device should be applied 3 times a day for 20-30 minute intervals.
  - **Sling** – A sling has been provided for your comfort and to stabilize your shoulder for proper healing. Continue wearing the sling for a period of approximately six weeks or until Dr. Cancienne directs you to stop
  - **Medication**
    - **Pain Medication-** Take medications as prescribed, but only as often as necessary. Avoid alcohol and driving if you are taking pain medication.
    - Over the counter NSAIDs (Advil, Aleve, Ibuprofen) can be used for additional pain relief if needed.
  - **Driving** – Driving is NOT permitted as long as the sling is necessary.

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- ❖ **ACTIVITIES**
  - You are immobilized with a sling and abductor pillow, full time, for approximately the first 6 weeks. Your doctor can tell you when you can discontinue use of the sling at your 1<sup>st</sup> postoperative visit. The sling may be removed for exercises.
  - **Range-of-Motion Exercises**
    - While your sling is off you should flex and extend your elbow and wrist – (3x a day for 15 repetitions) to avoid elbow stiffness
    - You can also shrug your shoulders.
    - Ball squeezes should be done in the sling (3x a day for 15 squeezes).
    - You may NOT move your shoulder by yourself in certain directions. NO active flexion (lifting arm up) or abduction (lifting arm away from body) until Dr. Cancienne or your therapist gives permission. These exercises must be done by someone else (Passive Range of Motion).

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- Physical therapy will begin approximately 1 week after surgery. Make an appointment with a therapist of your choice for this period of time. You have been given a prescription and instructions for therapy. Please take these with you to your first therapy visit.
- Athletic activities such as throwing, lifting, swimming, bicycling, jogging, running, and stop-and-go sports should be avoided until cleared by Dr. Cancienne.

#### ❖ WOUND CARE

- **Bathing** - Tub bathing, swimming, and soaking of the shoulder **should be avoided** until allowed by your doctor - Usually 2-3 weeks after your surgery. Keep the dressing on, clean and dry for the first 3 days after surgery.
  - You may shower 5 days after surgery with a water proof bandage on. Apply new dressing after showering.
- **Dressings** - Remove the dressing 3 days after surgery. Leave the white strips in place until they fall off.

#### ❖ EATING

- Your first few meals, after surgery, should include light, easily digestible foods and plenty of liquids, since some people experience slight nausea as a temporary reaction to anesthesia

#### ❖ CALL YOUR PHYSICIAN IF:

- Pain in your shoulder persists or worsens in the first few days after surgery.
- Excessive redness or drainage of cloudy or bloody material from the wounds (Clear red tinted fluid and some mild drainage should be expected). Drainage of any kind 5 days after surgery should be reported to the doctor.
- You have a temperature elevation greater than 101°
- You have pain, swelling or redness in your arm or hand.
- You have numbness or weakness in your arm or hand.

#### ❖ RETURN TO THE OFFICE

- Your first return to our office should be within the first 1-2 weeks after your surgery. You can find your appointment for this first post-operative visit in the post op instruction folder.

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## **DISCHARGE INSTRUCTIONS & PHYSICAL THERAPY PROTOCOL: Anterior Stabilization of the Shoulder: Latarjet Procedure**

### **Rehabilitation Considerations**

One must recall that the purpose of the Latarjet procedure is to reinstate anterior stability to the glenohumeral joint. While this is primarily a bony procedure, specific attention must be directed towards the soft tissues which play a critical role in maintaining stability. Early post-operative therapy must protect the repair of the subscapularis as well as the developing bony union of the coracoid process.

Since it will take approximately 6-8 weeks to form an osseous union of the newly reconstructed glenoid, the biceps and coracobrachialis attachment to the coracoid needs to be protected during the initial postoperative period. Aggressive shoulder extension and combined extension and external rotation stretching is not indicated. Once strengthening commences, a gradual progressed program of biceps and coracobrachialis strengthening needs to be followed to minimize undue stress and tension on their muscular origins.

In addition, isolated external rotation range of motion needs to be gradually regained after surgery to allow the anterior capsule and subscapularis to heal appropriately. For that reason, external rotation range of motion is advanced in a protected fashion, with early emphasis on external rotation work being done in an open packed position (i.e. scapular plane at about 45 degrees of abduction) and then progressed to positions that gradually tension the subscapularis (i.e. full adduction and then at 90 degrees of abduction and above). Please refer to protocol below for more detail. (In the case of a subscapularis take down and repair, external rotation gains need to be progressed slower and one should avoid aggressive external rotation stretching and internal rotation strengthening until the subscapularis is well healed. In these cases it is helpful to get a 'safe zone' of initial external rotation range of motion from the referring surgeon, as determined from intraoperative inspection from either the operative note or discussion with surgeon.)

Due to the surgical technique and early immobilization required to promote healing, the subscapularis may not only be impacted in terms of length, but in terms of force production and proprioception. Hence, specific subscapularis proprioception and strengthening needs to be incorporated to enhance subscapularis function postoperatively. The clinician needs to tailor the rehabilitation program to address the unique structure of the subscapularis to enhance both the upper and lower subscapularis fibers. This is warranted due to the fact that the subscapularis is innervated by both the upper and lower subscapular nerves, along with the presence of two different muscular fiber alignments; hence, its action has been described as being like that of two different muscles depending upon the functional activity. The upper fibers are primarily aligned in a horizontal fashion and the lower fibers are arranged in more of an oblique alignment. One must therefore be selective in the rehabilitation protocol to maximally stimulate the appropriate portion of the subscapularis with the correct exercise.

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## **Anterior Stabilization of the Shoulder: Latarjet Protocol**

*The intent of this protocol is to provide the clinician with a guideline of the post-operative 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 post-operative complications. If a clinician requires assistance in the progression of a post-operative 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 – Immediate Post Surgical Phase (approximately Weeks 1- 3)**

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
- **NO PENDULUMS**

Precautions/Patient Education:

- No active range of motion (AROM) of the operative shoulder
- No excessive external rotation range of motion (ROM) / stretching.
- Remain in sling, only removing for showering. 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

Activity:

- Arm in sling except when performing distal upper extremity exercises
- (PROM)/Active-Assisted Range of Motion (AAROM)/ (AROM) elbow and wrist/hand
- 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 degrees at 30 degrees of abduction
  - External rotation (ER) in the plane of the scapula from 0-25 degrees; begin at 30-40 degrees of abduction; respect anterior capsule tissue integrity with ER

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range of motion; (seek guidance from intraoperative measurements of external rotation ROM)

- Scapular clock exercises progressed to scapular isometric exercises
- Ball squeezes
- Sleep with sling supporting operative shoulder, place a towel under the elbow to prevent shoulder hyperextension
- Frequent cryotherapy for pain and inflammation
- Patient education regarding posture, joint protection, positioning, hygiene, etc.
- Begin deltoid and cuff **isometrics**

Milestones to progress to phase II:

- Appropriate healing of the surgical repair
- Adherence to the precautions and immobilization guidelines
- Achieved at least 100 degrees of passive forward elevation and 30 degrees of passive external rotation at 20 degrees abduction
- Completion of phase I activities without pain or difficulty

### **Phase II – Intermediate Phase/ROM (approximately Week 4-9)**

Goals:

- Minimize shoulder pain and inflammatory response
- Protect the integrity of the surgical repair
- Achieve gradual restoration of (AROM)
- To be weaned from the sling by the end of week 4-5
- Begin light waist level activities

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 flies, etc..)
- Do not perform scaption with internal rotation (empty can) during any stage of rehabilitation due to the possibility of impingement

### **Early Phase II (approximately week 4):**

- Progress shoulder PROM (do not force any painful motion)
  - Forward flexion and elevation to tolerance

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- Abduction in the plane of the scapula to tolerance
  - IR to 45 degrees at 30 degrees of abduction
  - ER to 0-45 degrees; begin at 30-40 degrees 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
    - 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  $\geq 35$  degrees at 0-40 degrees 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 degrees 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)

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- Exercises should be progressive in terms of muscle demand / intensity, shoulder elevation, and stress on the anterior joint capsule
  - 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 degrees 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 degrees of abduction to neutral arm position
  - Continued cryotherapy for pain and inflammation
  - Continued patient education: posture, joint protection, positioning, hygiene, etc.

#### Milestones to progress to phase III:

- Passive forward elevation at least 155 degrees
- Passive external rotation within 8-10 degrees of contralateral side at 20 degrees abduction
- Passive external rotation at least 75 degrees at 90 degrees abduction
- Active forward elevation at least 145 degrees 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

#### **Phase III - Strengthening Phase (approximately Week 10 – Week 15)**

##### Goals:

- Normalize strength, endurance, neuromuscular control
- Return to chest level full functional activities
- Gradual and planned buildup of stress to anterior joint capsule

##### 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 plane until the patient has near full ROM and strength in that plane of movement

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- Patient education regarding a gradual increase to shoulder activities

**Activity:**

- 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 degrees of abduction)
  - Forward punch

**Milestones to progress to phase IV:**

- Passive forward elevation WNL
- Passive external rotation 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

**Phase IV - Overhead Activities Phase / Return to activity phase (approximately Week 16-20)**

**Goals:**

- Continue stretching and PROM as needed/indicated
- Maintain full non-painful AROM
- Return to full strenuous work activities
- Return to full recreational activities

**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



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**Activity:**

- 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 degree 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 degrees
- 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

**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