NYU Langone MEDICAL CENTER

Michael J. Alaia, MD
Professor of Orthopaedic Surgery
Division of Sports Medicine
Tel: (646) 501-7223

Rehabilitation Protocol: Arthroscopic Posterior Shoulder Stabilization

Name: _____ **Date:** _____

Diagnosis: _____ **Date of Surgery:** _____

☐ **Phase I (Weeks 0-6)**

- Sling immobilization at all times (**in flexion, abduction and 0° of rotation**) except for showering and rehab under guidance of PT
- Range of Motion – **None for Weeks 0-3**
  - **Weeks 3-6:** Begin passive ROM - Restrict motion to 90° of Forward Flexion, 90° of Abduction, and 45° of Internal Rotation
- Therapeutic Exercise
  - Elbow/Wrist/Hand Range of Motion
  - Grip Strengthening
  - **Starting Week 3:** Begin passive ROM activities: Codman's, Anterior Capsule Mobilization
- Heat/Ice before and after PT sessions

☐ **Phase II (Weeks 6-12)**

- Sling immobilization for comfort only
- Range of Motion – Begin AAROM/AROM
  - Goals: 135° of Forward Flexion, 120° of Abduction, Full External Rotation
- Therapeutic Exercise
  - Continue with Phase I exercises
  - Begin active-assisted exercises – Deltoid/Rotator Cuff Isometrics
  - **Starting Week 8:** Begin resistive exercises for Rotator Cuff/Scapular Stabilizers/Biceps and Triceps (keep all strengthening exercises below the horizontal plane during this phase – utilize exercise arcs that protect the posterior capsule from stress)
- Modalities per PT discretion

☐ **Phase III (Weeks 12-16)**

- Range of Motion – Progress to full AROM without discomfort
- Therapeutic Exercise – Advance Phase II exercises
  - Emphasize Glenohumeral Stabilization, External Rotation and Latissimus eccentrics
  - Begin UE ergometer/endurance activities
- Modalities per PT discretion

☐ **Phase IV (Months 4-6)**

- Range of Motion – Full without discomfort
- Therapeutic Exercise – Continue with strengthening
  - Sport/Work specific rehabilitation – Plyometric and Throwing/Racquet Program
  - Continue with endurance activities
  - Return to sports at 6 months if approved
- Modalities per PT discretion

Comments:

Frequency: _____ times per week **Duration: _____ weeks**

Signature: _____ **Date:** _____