PHYSIOTHERAPY PATHWAY
WAHT-TP-011

Worcestershire Acute Hospitals NHS Trust

Rotator Cuff Repair Pathway
Rotator cuff repairs

Owner:	Benjamin Thomas Physiotherapy and Orthotics Manager
Approved by	Therapies Clinical Governance Group
Approval Date	19th July 2023
Review Date	19th July 2026 This is the most current document and should be used until a revised version is in place

Key Amendments

Date	Amendments	Approved by:
25th January 2023	Document extended to 30th June 2023 whilst under review.	Dr J Trevelyan/ Benjamin Thomas
23rd June 2023	Document extended for another 3 months whilst under review.	Benjamin Thomas
19th July 2023	Document reviewed and approved for 3 years	Therapies Governance Group

Rotator cuff repairs may be on patients with tears from one acute traumatic event or chronic rotator cuff tears, which have failed conservative treatments. Some repairs are performed arthroscopically, however they may be open or 'mini-open' so there is less tissue trauma and reduced risk of adhesions.
Post op stiff shoulder is less of a problem; the priority is to protect the repair from breaking down.

Grading of Tears

MASSIVE TEARS	greater than 5cms
LARGE TEARS	3-5cms
SMALL/ PARTIAL	less than 2cm

Therapists should check operation notes of individual patients for information on procedure, tissue quality of the tendons involved, the size of the tear, whether a secure (watertight repair) was gained and any other associated procedures performed.

At all times rehabilitation should be relatively comfortable, as increased pain;

- Limits active range of movement preventing functional use of arm,
- Increases muscle tightness as a protective response leading to reduced flexibility
- Prevents muscles working efficiently limiting strengthening programmes.

The rotator cuff protocol is based on maintaining pain free range of movement in the first phase and then gradually building strength in the middle to last phase.

DO NOT FORCE, STRETCH, OR STRESS THE REPAIR BEFORE 8 WEEKS (6 WEEKS FOR SMALL TEARS)

Massive rotator cuff tears

Tendon quality may be poor and many massive tears are irreparable. Options include;

1. Sub-acromial decompression to relieve pain and then facilitate physiotherapy to rehabilitate compensatory muscles (eccentric deltoid programme), Rehabilitate deltoid muscle and other shoulder girdle muscles that are still functioning to regain functional use of arm - no post-op restrictions.

2. Reconstructing the anterior and posterior tendon pillars to form a functional repair. **In this option a protocol for large cuff tear should be used.**

Large Tears

Pre-Op:
Teach scapular stabiliser exercises.
Optimise capsular extensibility if appropriate.

Post-op (Large Tears)

Day 1

- Polysling - (with body belt if indicated by surgeon)
- Wrist, hand and finger exercises.
- Elbow range of movement exercises
- Shoulder girdle exercises.
- Pendular exercises as comfortable, gentle closed chain as comfortable – unless specifically restricted in operation notes.
- Cervical spine stretching
- Scapular setting exercises.

2-4 Weeks

- Patient attends for review at clinic (3-4weeks).
- Maintain immobiliser for four weeks.
- Passive flexion in the scapular plane, external rotation into neutral.
- Begin active assisted exercises as comfortable following removal of immobiliser
- DO NOT FORCE OR STRETCH

4-8 Weeks

- Progress active assisted exercises to active exercises in all ranges
- Ensure scapula dynamic control through active ROM
- Initiate gentle isometric exercises in neutral as pain allows with particular attention to activation of infraspinatus and lower trapezius
- Progress closed chain exercises and proprioceptive re-education
- May start strengthening after 8 weeks if good range and control of movement
- Begin hydrotherapy – if available.

Small tear

Pre-Op:
Teach scapular stabiliser exercises.
Optimise capsular extensibility if appropriate

Post-op Small
Day 1

- Polysling - (with body belt for 3-4 weeks if indicated by surgeon)
- Wrist, hand and finger exercises.
- Elbow range of movement exercises
- Shoulder girdle exercises.
- Scapular setting exercises.
- Cervical spine stretching
- Pendular exercises.
- Passive flexion in scapular plane as pain allows and external rotation to neutral

3 Weeks

- Patient attends for review at clinic (3-4 weeks).
- Patient encouraged to wean off sling.
- DO NOT FORCE OR STRETCH
- Progress active assisted to active range of movement as comfort permits
- Initiate gentle isometric exercises in neutral as pain allows with particular attention to activation of infraspinatus and lower trapezius
- Encourage normal function around waist level to gain full proprioceptive skills.

6 Weeks

- Progress active exercises in all ranges. Ensure scapula dynamic control through active ROM.
- Rotator cuff strengthening (eccentric and then concentric) through range, within pain free limits.
- Start stretching
- Progress closed chain strengthening exercises working on endurance first and then on strength.
- Return to Activities

These are approximate and will differ depending upon the individual. They should be seen as the earliest that these activities may commence.

Activity

Driving	4-8 weeks dependent upon progress
Swimming	SMALL 6 weeks. LARGE 12 weeks
Golf	3 months
Lifting	Avoid heavy lifting for 3 months After this be guided by the strength of patient
Return to work	Dependent on patients, occupation. With small and medium tears, patients in sedentary jobs may return at 6 weeks. large tears may take at least 8 -12 weeks. Manual workers should be guided by their surgeon.