

Rehabilitation Guidelines for Anterior Shoulder Reconstruction with Arthroscopic Bankart Repair

The anatomic configuration of the shoulder joint (glenohumeral joint) is often compared to a golf ball on a tee (Figure 1). This analogy is used because the articular surface of the round humeral head (upper most part of the arm) is approximately four times greater than that of the relatively flat shoulder blade face (glenoid fossa). The stability and movement of the shoulder is controlled by the rotator cuff muscles, ligaments and the capsulolabral complex of the shoulder. The labrum is a fibrocartilaginous ring which attaches to the bony rim of the glenoid fossa. The labrum doubles the depth of the glenoid fossa to help provide stability. An analogy would be a parked car on a hillside with a chop block under the tire – the round tire being the humeral head, the road being the glenoid fossa and the chop block being the labrum.

The anatomy of the shoulder allows for great mobility yet sacrifices stability. For this reason the shoulder is one of the most commonly dislocated joints in the body. Shoulder dislocations can occur from trauma or from hyperlaxity (genetic or acquired looseness of the capsule and ligaments).

Traumatic anterior shoulder dislocations (in which the humeral head is displaced towards the front) most often occur when significant force is placed on the hand or lower part of the arm when the shoulder

is abducted and externally rotated (Figure 2) or the arm is stretched straight out from the body, such as falling on an outstretched hand. When the shoulder dislocates anteriorly the capsule, ligaments and labrum are often torn. The anterior inferior part of the labrum (located between the 3 o'clock to 6 o'clock positions on the glenoid) is the area torn with this type of injury (Figure 3). In more severe cases when the labrum is torn a portion of the glenoid may be fractured and this is referred to as bony Bankart lesion.

Studies have shown that traumatic shoulder dislocations result in recurrent instability. The degree of recurrent instability is related to the patient's age and sport or activity level. Younger patients are more likely to have recurrent instability. Studies report recurrence rates from 65-95% for patients less than 20 years of age. Simonet reviewed 128 patients who suffered a shoulder dislocation and found that two years after the initial dislocation, 66% of patients who were less than 20 years old suffered a second dislocation while 40% of patients who were between 20 and 40 years old suffered a second dislocation. None of the patients older than 40 years old had suffered subsequent dislocations. Pevny studied 125 patients with shoulder dislocation over the age of 40 and found that while only 4% of these patients had recurrent instability, 35% of the patients had a rotator cuff tear.

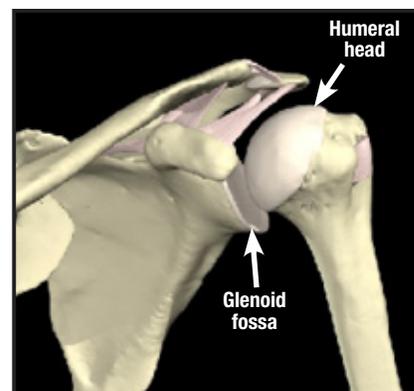


Figure 1 Anterior (looking from the front) bony anatomic shoulder model.

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Figure 2 Abducted—externally rotated position of the left shoulder

It is likely the injury pattern for dislocation changes as people age.

Simonet also compared recurrent dislocations with athletes and nonathletes, with athletes having

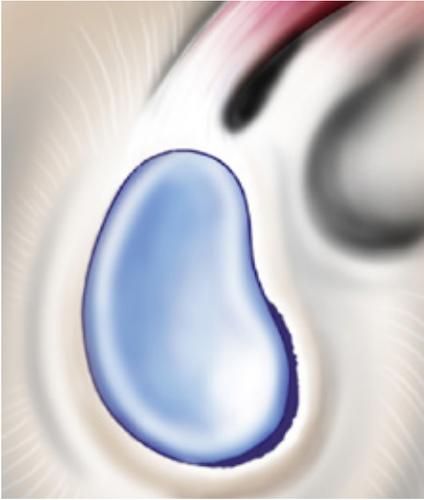


Figure 3 Bankart tear (anterior labral tear)
When looking at a right shoulder it would normally extend from 3 o'clock to 6 o'clock if imagining the glenoid as the face of a clock

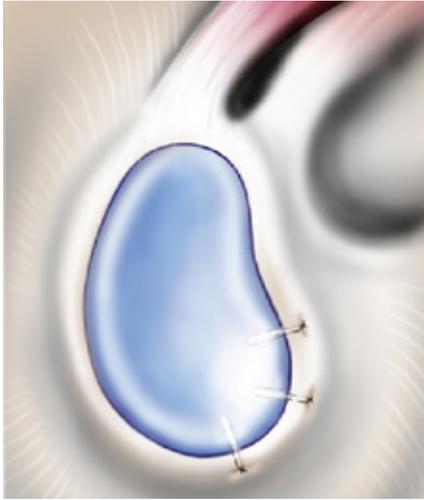


Figure 4 Fixation of the Bankart tear using three suture anchors in the bony glenoid and sutures approximating the labrum back to the bony glenoid

This is called a Bankart repair. This can be done surgically with an arthroscopic technique or an open technique. The arthroscopic technique involves making three small incisions and using a camera to “see” inside the shoulder joint. The torn tissue is identified then suture anchors or bio-absorbable tacks are used to repair the torn tissue back to its anatomic locations. (Figure 4). Arthroscopic anterior stabilization has a similar rate of failure to open stabilization after two years. The proposed advantage of arthroscopic repair include less surgical trauma to the adjacent tissue in the shoulder and improved outcomes.

an 82% recurrence rate and non-athletes having a 30% recurrence rate. The athletic group also has different recurrent risk based on the type of sport, with overhead and contact sports being more likely to have recurrent dislocations.

Restoring the normal anatomy of the shoulder is the most effective way of preventing recurrent instability and improving function in the young and athletic population. Restoring the anatomy primarily means repairing the torn labrum back to the rim of the glenoid.

PHASE I (surgery to 6 weeks after surgery)

<p>Appointments</p>	<ul style="list-style-type: none"> • Rehabilitation appointments begin 4-10 days after surgery
<p>Rehabilitation Goals</p>	<ul style="list-style-type: none"> • Protect the post-surgical shoulder • Activate the stabilizing muscles of the gleno-humeral and scapula-thoracic joints • Full active and passive range of motion (ROM) for shoulder flexion, abduction, internal rotation (IR) and external rotation (ER) to neutral
<p>Precautions</p>	<ul style="list-style-type: none"> • Sling immobilization required for soft tissue healing for 3-4 weeks. Remove sling during the 4th week in safe environmentsHypersensitivity in axillary nerve distribution is a common occurrence • No shoulder ER with abduction for 6 weeks to protect repaired tissues

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Suggested Therapeutic Exercise	<ul style="list-style-type: none"> • Begin week 3, sub-maximal shoulder isometrics for IR and ER, flexion, extension, adduction and abduction. Take caution to start gradually especially with IR to protect the subscapularis repair • Active assisted and passive ROM for shoulder flexion, abduction and IR in pain-free ROM. ER to neutral. Progress to active ROM at week 5 • Hand gripping • Elbow, forearm and wrist active ROM • Cervical spine and scapular active ROM • Desensitization techniques for axillary nerve distribution • Postural exercises
Cardiovascular Exercise	<ul style="list-style-type: none"> • Walking, stationary bike - sling on. • No swimming or treadmill • Avoid running and jumping due to the distractive forces that can occur at landing
Progression Criteria	<ul style="list-style-type: none"> • Full active ROM in all cardinal planes • 5/5 IR and ER strength at 0° of shoulder abduction • Negative apprehension and impingement signs

PHASE II (begin after meeting Phase I criteria, usually 6 weeks after surgery)

Appointments	<ul style="list-style-type: none"> • Rehabilitation appointments are once every 1-2 weeks
Rehabilitation Goals	<ul style="list-style-type: none"> • Full shoulder active ROM in all cardinal planes • Progress shoulder ER ROM gradually to prevent overstressing the repaired anterior tissues of the shoulder • Strengthen shoulder and scapular stabilizers in protected position (0- 45° abduction) • Begin proprioceptive and dynamic neuromuscular control retraining
Precautions	<ul style="list-style-type: none"> • Avoid passive and forceful movements into shoulder ER, extension and horizontal abduction
Suggested Therapeutic Exercise	<ul style="list-style-type: none"> • Active assisted and active ROM in all cardinal planes – assessing scapular rhythm. • Gentle shoulder mobilizations as needed • Rotator cuff strengthening in non-provocative positions (0-45° abduction) • Scapular strengthening and dynamic neuromuscular control • Cervical spine and scapular active range of motion • Postural exercises • Core strengthening
Cardiovascular Exercise	<ul style="list-style-type: none"> • Walking, stationary bike, Stairmaster • No swimming or treadmill • Avoid running and jumping until athlete has full rotator cuff strength in a neutral position due to the distractive forces that can occur at landing

Rehabilitation Guidelines for Anterior Shoulder Reconstruction with Arthroscopic Bankart Repair

Progression Criteria	<ul style="list-style-type: none"> • Full shoulder active ROM • Negative apprehension and impingement signs • 5/5 shoulder IR and ER strength at 45° abduction
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PHASE III (begin after meeting Phase II criteria, usually 10-11 weeks after surgery)

Appointments	<ul style="list-style-type: none"> • Rehabilitation appointments are once every 2-3 weeks
Rehabilitation Goals	<ul style="list-style-type: none"> • Full shoulder active ROM in all cardinal planes with normal scapulohumeral movement • 5/5 rotator cuff strength at 90° abduction in the scapular plane • 5/5 peri-scapular strength
Precautions	<ul style="list-style-type: none"> • All exercises and activities to remain non-provocative and low to medium velocity • Avoid activities where there is a higher risk for falling or outside forces to be applied to the arm • No swimming, throwing or sports
Suggested Therapeutic Exercise	<p>Motion</p> <ul style="list-style-type: none"> • Posterior glides if posterior capsule tightness is present. More aggressive ROM if limitations are still present <p>Strength and Stabilization</p> <ul style="list-style-type: none"> • Flexion in prone, horizontal abduction in prone, full can exercises, D1 and D2 diagonals in standing • TheraBand/cable column/ dumbbell (light resistance/high rep) IR and ER in 90° abduction and rowing • Balance board in push-up position (with rhythmic stabilization), prone Swiss ball walk-outs, rapid alternating movements in supine D2 diagonal. Closed chain stabilization with narrow base of support
Cardiovascular Exercise	<ul style="list-style-type: none"> • Walking, biking, Stairmaster and running (if Phase II criteria has been met) • No swimming
Progression Criteria	<ul style="list-style-type: none"> • Patient may progress to Phase IV if they have met the above stated goals and have no apprehension or impingement signs

PHASE IV (begin after meeting Phase III criteria, usually 15 weeks after surgery)

Appointments	<ul style="list-style-type: none"> • Rehabilitation appointments are once every 3 weeks
Rehabilitation Goals	<ul style="list-style-type: none"> • Patient to demonstrate stability with higher velocity movements and change of direction movements • 5/5 rotator cuff strength with multiple repetition testing at 90° abduction in the scapular plane • Full multi-plane shoulder active ROM

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Precautions	<ul style="list-style-type: none"> Progress gradually into provocative exercises by beginning with low velocity, known movement patterns
Suggested Therapeutic Exercise	<p>Motion</p> <ul style="list-style-type: none"> Posterior glides if posterior capsule tightness is present <p>Strength and Stabilization</p> <ul style="list-style-type: none"> Dumbbell and medicine ball exercises that incorporate trunk rotation and control with rotator cuff strengthening at 90° abduction. Begin working towards more functional activities by emphasizing core and hip strength and control with shoulder exercises TheraBand/cable column/ dumbbell IR and ER in 90 abduction and rowing Higher velocity strengthening and control, such as the inertial, plyometrics, rapid TheraBand drills. Plyometrics should start with 2 hands below shoulder height and progress to overhead, then back to below shoulder with one hand, progressing again to overhead Begin education in sport specific biomechanics with very initial program for throwing, swimming or overhead racquet sports
Cardiovascular Exercise	<ul style="list-style-type: none"> Walking, biking, Stairmaster and running (if Phase III criteria has been met) No swimming
Progression Criteria	<ul style="list-style-type: none"> Patient may progress to Phase V if they have met the above stated goals and have no apprehension or impingement signs

PHASE V (begin after meeting Phase IV criteria, usually 20 weeks after surgery)

Appointments	<ul style="list-style-type: none"> Rehabilitation appointments are once every 3 weeks
Rehabilitation Goals	<ul style="list-style-type: none"> Patient to demonstrate stability with higher velocity movements and change of direction movements that replicate sport specific patterns (including swimming, throwing, etc) No apprehension or instability with high velocity overhead movements Improve core and hip strength and mobility to eliminate any compensatory stresses to the shoulder Work capacity cardiovascular endurance for specific sport/work demands
Precautions	<ul style="list-style-type: none"> Progress gradually into sport specific movement patterns

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Suggested Therapeutic Exercise	<p>Motion</p> <ul style="list-style-type: none"> Posterior glides if posterior capsule tightness is present <p>Strength and Stabilization</p> <ul style="list-style-type: none"> Dumbbell and medicine ball exercises that incorporate trunk rotation and control with rotator cuff strengthening at 90° abduction and higher velocities. Begin working towards more sport specific activities Initiate sport specific programs (throwing program, overhead racquet program or return to swimming program) depending on the athlete's sport High velocity strengthening and dynamic control, such as the inertial, plyometrics, rapid TheraBand drills
Cardiovascular Exercise	<ul style="list-style-type: none"> Design to use sport specific energy systems
Progression Criteria	<ul style="list-style-type: none"> Patient may return to sport after receiving clearance from the orthopedic surgeon and the physical therapist/athletic trainer

These rehabilitation guidelines were developed collaboratively by UW Health Sports Rehabilitation and the UW Health Sports Medicine Physician group.

Updated 2/2018

REFERENCES

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