

Arthroscopic capsular release (ACR)/ Manipulation under anaesthetic (MUA)

Post Op Care Plan

The RNOH Shoulder Physiotherapy Service follows this care plan prior to discharge.

Procedures: Capsular Release/Manipulation under Anesthetic (MUA) Subacromial Decompression (SAD/ASAD)

Goals:

1. To educate the patient on post operative instructions and expected outcomes following surgical procedure.
2. To demonstrate application/removal of sling/brace as well as education on resting positions within post-operative restrictions.
3. To assess shoulder post operative ROM and to provide exercises/stretching within the post - op guidelines/restrictions.

Teach scapular setting and hand/wrist/elbow ROM exercises (where appropriate).

4. To teach and ensure that the patient and/or carers are competent with the post operative exercise programme and can maintain the program post discharge.
5. To ensure all patients requiring further physiotherapy are given a copy of their outpatient referral prior to discharge and are aware that they can contact the Shoulder Service if local services fail to provide a timely appointment.

NOTE:

A. Patients who are having difficulty or are considered to be at high risk of losing ROM (Pain/Psychological state/Pre-op condition/existing pathology) should be considered for a delayed discharge and an URGENT referral to local outpatient and/or community services (if appropriate) must be provided.

B. Capsular release patients should achieve 90% of sedated ROM prior to discharge from hospital. Some patients may also require a roller towel regime to be continued post discharge.

Initial Rehabilitation Phase One discharge - 6 weeks

Goals: 1. Ensure Wound/Tissue Healing

2. Encourage effective pain control

3. Maintain/Increase Passive/Active Assisted ROM as documented on patient specific referral.

(Note: Patients who have had a MUA/capsular release should achieve 90% of sedated shoulder ROM prior to discharge from hospital)

4. Initiate early isometric cuff and scapular control

5. Wean out of Sling as documented on patient specific referral (normally 1-3 weeks maximum)

Restrictions:

1. No hand behind back
2. No unsupported active elevation above shoulder height
3. Exercise should remain relatively pain-free

Education: Patient education on anatomy of shoulder complex, post-op restrictions, progression of short/long term goals in conjunction with guidelines,

postural advice/retraining, advise on functional activities (light waist-level, driving when comfortable, and return to work within early guidelines).

Treatment options:

Ice and resting positions

Stick exercises for passive and active assisted stretches

Waist level isometric cuff control (patient must be in a supported position)

Scapular setting and postural control

Capsular stretches and manual joint mobilizations (mainly after 2 weeks)

MUA/Capsular release patients may be required to use a roller towel regime at home to maintain ROM (will be arranged pre-discharge if appropriate)

Encourage hand/wrist/elbow ROM ex's to avoid secondary stiffness

Milestones to progress to Phase Two:

1. Adequate pain control

2. Adequate scapula control

3a. ASAD - 90° passive flexion in neutral rotation

b. MUA/ACR - achieving at least 90% of PROM documented at inpatient discharge

4. Achieved time specific individual goals if specified on individual referral.

Failure to meet milestones:

1. Refer to 'Failure to progress' table

2. Delay progression to next phase of rehabilitation

3. Refer to/discuss with Shoulder and Elbow Unit

Late Rehabilitation Phase Three: Weeks 6-24+

Goals: 1. To restore full active range of movement (patient specific).

2. To progress cuff control through range to the exclusion of deltoid and without inappropriate muscle patterning (Pecs, Lat, Traps, etc).

3. To develop power and endurance of appropriate muscle groups (patient specific) and relate to functional tasks.

4. Ensure appropriate scapulo/humeral rhythm.

Restrictions:

1. Where possible minimize exercises that may exacerbate pain.

2. Ensure the rotator cuff is functioning well at a low level and the humeral head is "snugging" into the glenoid (i.e. subtle caudad movement is seen of humeral head on initiation of isometric abduction) and the patient is no longer hitching the shoulder before progressing to active exercises above shoulder level.

Education: Patient education around pacing of activity, exercise caution with previously aggravating activities, ongoing postural education, Normal movement with functional activities and realistic expectations.

Treatment options:

Build up rotator cuff control through range to the exclusion of deltoid, then with deltoid supported and then finally with deltoid unsupported.

Use a closed and open chain exercise programme.

Capsular stretches as required for anterior and posterior capsule

Address proprioceptive deficits. Consider Kibler et al, 2001. Principles of Kinetic chain and the incorporation of lower limb exercises.

Failure to Progress: If a patient is failing to progress, then consider the following: Possible Problem	Action
Pain Inhibition	Adequate analgesia Maintain pain free exercises Return to passive stretches Slow rehab programme If severe night/resting pain then refer to Shoulder Unit
Poor Rotator Cuff Control	Ensure passive range is gained Isometrics through range Rotation dissociation through range with decreasing levels of support and increasing resistance Slow progression through theraband resistances (e.g. Yellow/white tend to bias cuff and green tend to incorporate deltoid).
Poor Scapular Control	Work on scapular setting through range without pec and/or lat overactivity. Consider prone lying to develop control/awareness
Poor Core Stability	Develop patient appropriate stability programme.
Secondary 'frozen' shoulder	Maintain passive ROM as able Use manual mobilizations
Unable to gain strength	May need to increase ROM first
Patient exercising too vigorously	Education on pacing, risks of flare-up scenario
Poor patient compliance with HEP	Set functional based goals
Return to ADL to soon	Reduce activity levels
Cervical/thoracic referred pain	Assess and treat
Altered neurodynamics	Assess and treat