UNISPORTS ORTHOPAEDICS
UniSports Orthopaedics,
Leaders in Sports Medicine
261 Morrin Road,
St Johns, Auckland 1072

OPEN ANTERIOR STABILISATION GUIDELINES FOR PATIENT

Indications / Contra-Indications

Patients who have recurrent anterior subluxation or dislocation and have a functional disability may be subjected to an anterior repair for that instability. The instability in these patients is usually activity-related and particularly disabling related to sports. Strengthening is often unsuccessful in these types of patients as a conservative means of treatment.

Procedure Description

The patient is admitted to hospital for general anaesthetic and through an anterior delto-pectoral approach the subscapularis and capsule are incised, ie the window to the shoulder is open. The surgery to repair the instability is based on the pathology present and usually consists of a repair of the anterior labrum to the anterior glenoid rim and / or the capsule to the anterior glenoid rim with tensioning of the subscapularis as required. It is hoped that the patient will have at least neutral rotation on the operative table at the completion of the operative procedure.

Estimated Length of Hospital Admission

The patient would normally stay 1 night in hospital following surgery.

Post-Op Rehabilitation Protocol

1. Shoulder exercises are performed while the patient is in hospital following surgery at the surgeon's discretion, ie:

    a. passive assisted elevation
    b. passive assisted internal rotation
    c. passive assisted external rotation to 20 degrees

    This continues for 2 weeks while the patient is in a sling most of the time.

2. The patient is immobilised for the first few weeks for comfort and protection. The degree of immobilisation depends on:

    a. the tightness at the time of the repair – the tighter the repair, the lesser degree of immobilisation
    b. the general looseness of the tissues in the patient – the looser their tissue, the longer they are immobilised
    c. whether there is a tendency to multidirectional instability – maximum instability leads to longer immobilisation)

3. Exercise Protocol and Outpatient Progression

   At 2 weeks the sling is removed and the patient is encouraged to undergo full active elevation and full internal rotation with terminal stretch. External rotation is carefully monitored and if tight, it is stretched. If not, it is protected and limited to approximately 20 degrees (including terminal stretch).

   At 4 weeks the patient continues with active and terminal stretch re: elevation, internal rotation and external rotation (external rotation is limited to 45 degrees at this point).

   At the 4 week mark, the patient is also progressed to resisted exercises, elevation, external rotation and internal rotation.

   The crucial issue in anterior repairs is external rotation. It must be regained by approximately 6 months and, if initially tight, should be stretched; if initially loose, should be limited. This is the key aspect of rehabilitation in anterior repairs.

4. Discharge Planning

   The patient returns to the clinic for follow up appointments at 2 weeks, 4 weeks and 12 weeks, at which times exercises are progressed.