
**Post-op PATIENT Instructions: MULTIDIRECTIONAL INSTABILITY
LABRAL REPAIR**

Dressing: A dressing has been applied to your shoulder to absorb any fluid/blood. A small amount of blood on the dressing is to be expected. Begin dressing changes 24-48 hours following surgery. Remove the OR dressing, apply sterile gauze to the surgical site and re-tape. A small amount of soap/water or alcohol cleansing adjacent to the incisions is permitted with the first dressing change. Unless directed by your surgeon, **no salves, balms, or ointments to the incisions.** Band-Aids over the small incisions are recommended until they are completely sealed. Soreness and bruising is expected for several days afterward. **Showering is permitted 72 hours following surgery. Soaking the incisions should be avoided. No swimming pools/bathtubs/hot-tubs/beach water for 4 weeks or until cleared by your surgeon.**

Ice: Ice is a powerful anti-inflammatory. Cold compression (“ice machines”) are important to reducing pain and swelling. Use liberally (20-30 min./session) but protect the skin from direct contact (and frostbite).

Activity: Wear the immobilizer/sling. Remove the sling at least 3 times per day for hand, wrist, and elbow range of motion which decreases swelling. Sleeping in a recliner with pillows behind the elbow may provide additional comfort. **No driving until permission is given by your surgeon.**

Pain: A nerve block has been performed for immediate post-op pain control by the anesthesiologist. It typically “wears off” at about 8-12 hrs following surgery. **Begin taking pain medications as soon as you BEGIN to experience pain!** These meds can take 45-60 minutes to start “working”. You do not want to play “catch-up” by letting your pain get out of control. Nausea, drowsiness, and constipation are common side effects of narcotics. **Adequate fluid intake and a stool softener obtained over the counter from your local pharmacy is important to minimize constipation.** Call the office if you are unable to tolerate your medication.

***NARCOTIC MEDICATIONS ALONE WILL NOT PROVIDE COMPLETE PAIN RELIEF. COLD COMPRESSION (ICE MACHINES), TENS USE, AND REGULAR TYLENOL AND ANTI-INFLAMMATORIES (ALEVE/IBUPROFEN, IF MEDICALLY OK) ARE CRITICAL PARTS OF YOUR PAIN CONTROL PLAN.**

REQUEST FOR NARCOTIC REFILL WILL ONLY BE ACCEPTED DURING BUSINESS HOURS. PLEASE GIVE 24-48 HOURS FOR MEDICATION REFILL REQUESTS TO BE ADDRESSED*.

Precautions: Call the office (813)-754-1199 if you develop: temperatures >101°F, shortness of breath, chest pain, uncontrolled pain, marked redness/hives, persistent drainage, new onset numbness, significant incisional/calf swelling, or any other concerns. **Call 911 or report to the nearest emergency room with any concerns for medical emergencies**

PT/OT PRESCRIPTION: MULTIDIRECTIONAL INSTABILITY
LABRAL REPAIR

(Revised 3.30.16)

MD Orders for the Therapist:

- Physical Therapy/Occupational Therapy Prescription: 2-3 times per week x 6 weeks
- Follow this protocol without substitution. Contact my office with any questions.

Christopher T. Donaldson, MD

Precautions: Sling will be placed in OR and worn for 6 weeks. The sling may be removed for dressing, hygiene, and PT supervised exercises.

****No isolated biceps activation for eight weeks****

(0-6 Weeks)

- **ROM**
 - Immediate scapular retraction exercises. Successful post op rehab depends squarely on the patient's ability to regard scapular control and kinetics!! This should above all be the primary focus of the MDI patient in the post op period.
 - **NO PASSIVE STRETCHING BY THE THERAPIST FOR 6 MONTHS!!**
 - Pendulum – gentle (2-3x/day)
 - Elbow ROM – may be AROM/PROM – no resistance
 - AAROM and AROM with limits ER:40, FE:140 in the supine position
 - Kinesiotaping to assist with scapular control and cueing
 - Modalities to tolerance
 - Full hand/wrist ROM
 - May use pulleys/supine wand in all planes to patient tolerance
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- **Strength**
 - Scapular stabilization (scapular clock and manual resisted scapular PNF patterns)
 - Submaximal isometrics – No elbow flexion
- **Goals to Progress to Next Phase**
 1. Control pain and inflammation
 2. Good clinical endpoint
 3. Correct scapular position (without verbal cueing) strengthening can begin
 4. BE ALERT TO SCAPULAR FATIGUE AND REBOUND DYSKINESIS.

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(6-12 Weeks)

- **ROM**
 - Towel and side-lying internal rotation (sleeper) stretch
- **Strength**
 - Initiate prone and side-lying exercise with light resistance
 - Initiate supine rhythmic stabilization at 90° flexion
 - Initiate IR/ER at neutral (0° of Abduction) with tubing
 - Use towel roll between elbow and side
 - Supine punches with light resistance
 - UBE for endurance
 - Strength and stability progression with increased ROM
 - Stress high reps/low resistance
 - Initiate biceps strengthening at 8 weeks
 - Initiate plyotoss chest pass
 - Initiate PNF patterns with tubing
 - Initiate IR/ER exercises at 90° of abduction
- **Goals to Progress to Next Phase**
 - Achieve full AROM by 8 weeks **except ER**
 - Full AROM External Rotation by 12 wks
 - 5/5 rotator cuff strength
 - 65-70% IR/ER isokinetic testing

(3-6 Months)

- **ROM**
 - Continue with all AROM activities from previous phases if goals were not met
- **Strength**
 - Light tossing – Up to 45 ft. with emphasis on proper mechanics and follow through. (Only if ROM has been normalized in all planes)
 - Initiate single arm plyotoss
 - Progress eccentric strengthening of posterior cuff and scapular musculature
 - Begin throwing progression and sport-specific activities can start at **6 months**
 - **Sports are not expected to be initiated until 6-12 MONTHS post-op!!**
 - **May begin posterior capsule/internal rotation (sleeper) stretches at 6 months**

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