TITLE: **Limited Goals Program (Examples Include: Cuff Tear Arthropathy, Massive Ir-repairable Rotator Cuff Tear, Selected Revision Surgeries)**

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All information contained in this protocol is to be used as general guidelines only. Specific variations may be appropriate for each patient and may be specified by the physician. In all cases, it is acceptable to advance the program more slowly than stated. If excessive pain is experienced by the patient, discontinue exercise until the physician is contacted.

The general purpose of the limited goals rehabilitation program is to result in a stable glenohumeral joint with low pain. ROM and strength goals are of secondary importance. Good waist level function is generally the goal while overhead AROM and function of the arm is not expected. Shoulder level function is variable.

** = Adjunctive exercises

Staged ROM Goals = Approximate ROM targets, ***Specific limits may be specified by the physician***

	PFE	PER at 20° abd	PER at 90° abd	AFE
POD 1	60°	0°	NA	NA
POW1	75°	0°-10°	NA	NA
POW 3	75°-90°	10°-20°	NA	NA
POW 6	95°-110°	20°-30°	NA	NA
POW 12	110°-125°	30°-50°	NA	75°-90°
POM 5	135°	30°-50°	NA	90°-120°

Phase 1

Goals: Maximally protect the surgical repair
Assure stable prosthesis / joint stability
Minimize pain and inflammatory response
Achieve staged ROM goals
Patient education in post-operative precautions

POW 1- POW 3

- Elbow, wrist, and hand AROM with no weight (EWH).
- Scapula elevations and retractions (no weight) done in or out of the sling
- Passive forward elevation in plane of scapula (PFE) to minimal discomfort; 5-10 reps 2 x day. (Patient sitting w/ family member or therapist lifting the arm) *ROM limits may often be specified by the physician.*
- Sitting passive external rotation (PER) in slight abduction and forward elevation; to minimal discomfort, 5-10 reps, 2 x day. (Patient sitting w/ family member or therapist rotating the arm). *ROM limits may often be specified by the physician.*
- Pendulum exercise (lean over table a comfortable amount, let the arm hang down being relaxed and keeping the body still. As able, keep body still and move arm in small comfortable circles only).
- Ice for pain reduction

- Patient education
  - Sling use full-time in community, PRN use in the home, or as instructed by the physician.
  - Ok to use arm for ONLY light waist level activities as comfortable. Make sure pain level is not increasing due to excessive use of arm for ADL's.
- Continue to sleep in chair.Positioning full time in sling. Assure sling supports arm adequately and wrist is supported
- ** C-spine AROM
- ** Moist heat before exercise
- ** Modalities for pain control PRN

Cautions:
- Make sure PROM is gentle enough to minimize / eliminate muscle guarding / splinting muscles.
- *Do not force PROM*
- *ROM limits may often be specified by the physician for PFE, PER*
- Assure that there is no severe pain w/ PFE, PER exercises

POW 3-6
- Same as above except ok to add
- Supine PROM by therapist w/ in comfort ROM to achieve staged PROM goals (no mobilizations)
- ** Aquatic therapy for gentle painfree AAROM (no swimming strokes)

Phase 2

Goals Assure stable prosthesis / joint stability
Minimize pain
Achieve staged ROM goals
Increase AROM and use of arm for waist level activities

POW 6 – POW 9
- Continue PFE to staged ROM goals sitting w/ family member progressing to rope and pulley AAFE and supine / sitting AAFE as tolerated once approximately 120° FE is achieved.
- Achieved staged ROM goals in ER at 20°
- Initiate posterior capsular stretching via gentle horizontal adduction stretch, no sleeper stretch
- Muscle activation exercises (Exercises that activate shoulder girdle muscles to a low level w/out creating significant muscular force)
  - Dusting: patient sits in chair w/ hand grasping a cloth on a table which is at about waist level. Slide hand forward / back in painfree motion while working to maintain scapula stability
  - Sitting active ER/ IR small painfree motion keeping elbow near waist level
- PROM by therapist to achieve staged ROM goals. Light mobilizations PRN with caution
- Beginning scapula strengthening
- ** Moist heat / ice
- ** Modalities PRN
- ** Aquatics for AAROM (phase 1), AROM, and light strengthening (phase 2)
- ** Spine therapy assessment / mobilization if non neurogenic cervical or scapula pain or if limitation in end–range shoulder FE

Cautions:
- Assure that muscle activation exercises do not increase signs and symptoms.

POW 9 – POM 3
- Same as above except also ok to add
- Yellow T-band IR; use 3-4 ft length of band, light to no pretension in a 3-6 inch arc of motion
- Light scapula strengthening

Cautions:
- *No prone strengthening exercises*
- *Often ½ width of yellow theraband is needed for resistance*
- *Frequency made need to be decreased to QD or QOD for patient tolerance*

Phase 3

<u>Goals:</u> Assure stable prosthesis / joint stability
Minimize pain
Achieve staged ROM goals
Increase AROM and use of arm for waist and shoulder level activities

<u>POM 3 – 5</u>
- PROM / Stretching PRN or warm-up stretching
- Functional IR AAROM / stretching as tolerated
- Initiate base strengthening progression (BSP) (standard rotator cuff, deltoid, and scapula strengthening program *1-3 weeks after muscle activation exercises*). Performed with light resistance and low repetitions, 2 x day at most
  - Yellow T-band ER, IR; use 3-4 ft length of band, light to no pretension in a 3-6 inch arc of motion
  - Yellow T-band anterior deltoid (AD); use 3-4 ft length of band; light to no pretension in a 3-6 inch arc of motion. Start w/ elbow bent and by the side, band tied behind patient, reach forward w/ hand at waist level, over time reach forward to hand at chest level
  - Scapula strengthening
  - Low level closed chain strengthening
  - *No prone forward elevation, abduction, or external rotation*
  - *Often ½ width of yellow theraband is needed for resistance*
  - *Frequency made need to be decreased to QD or QOD for patient tolerance*
- Elevation strengthening progression (ESP) *(usually start 4-6 weeks after successful initiation of base strengthening program)* **(Once approved by physician)**
  - Definition: A stepwise progression in difficulty of strengthening exercises to progress from PFE to
    AFE against gravity.
  - All exercises are done in the plane of the scapula (FE)
  - Strengthening cuff, deltoid, and scapula upward rotators for overhead elevation
  - Some scapula or glenohumeral substitutions are allowed in the limited goals program
  - There is some variability in the exercise sequence
  - *Exercises:*
    - Dusting
    - Rope and Pulley AAFE
    - Side lying gravity eliminated AFE (lie on uninvolved side, involved arm on ironing board slide hand on board)
    - T-band supine FE (start in 90°, pull involved arm into FE)
    - Wall walk AAFE (assure the patient is in FE not flexion)
    - Ball roll on the wall at 90° FE
    - T-bar AAFE w/ assisted or independent eccentric lowering
    - Overhead wall taps
    - Active forward elevation
- ** Aquatics for AAROM (phase 1), AROM, and light strengthening (phase 2)
- ** Return to golf progression
- ** Modalities PRN

- ** Therapist stretching / mobilizations PRN

- ** Spine therapy assessment / mobilization if non neurogenic cervical or scapula pain or if limitation in end–range shoulder FE
- ** Trunk stabilization / strengthening

Cautions:

- Do not initiate base strengthening program or overhead strengthening progression until overall pain level is low and assure these exercises do not increase signs and symptoms.
- Strengthening program should progress only without signs of increasing inflammation
- No strengthening in abduction
- Pain level high enough for modalities = decrease exercise or ADL intensity

DISCLAIMER

These general rehabilitation guidelines are created by physical and occupational therapist for the rehabilitation of various shoulder and elbow pathologies. These are to simply be used as guidelines. This information is provided for informational and educational purposes, only. Specific treatment of a patient should be based on individual needs and the medical care deemed necessary by the treating physician and therapists. The University of Kentucky and The American Society of Shoulder and Elbow Therapists take no responsibility or assume no liability for improper use of these protocols. We recommend that you consult your treating physician or therapist for specific courses of treatment.

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