



## **NONOPERATIVE REHABILITATION OF SHOULDER DISLOCATIONS AND INSTABILITY**

***Please note:** This document is intended to provide guidelines for the nonoperative rehabilitation of a patient who has suffered a shoulder dislocation. The intent of this protocol is to not to supplant the decision making of the clinician, but to suggest a structure and progression of rehabilitation.*

*If the clinician requires assistance in the progression of a postoperative patient, please contact Dr. O'Donnell's office.*

### **SUMMARY:**

- Sling immobilization, 1-2 weeks as symptoms dictate
- PROM/AAROM weeks 0-3
- AROM with progression to strengthening weeks 3-6
- Advanced strengthening and RTS after 7 weeks

### **PHASE I: ACUTE PHASE POST INJURY (Weeks 0-3 post dislocation):**

#### Goals:

- Control muscle spasm, pain, and guarding
- Minimize deconditioning
- Maintain range in joints around the effected region (wrist, hand, and neck)
- Protect healing tissues and minimize further injury to the capsulolabral complex
- Re-establish joint stability and proprioception

#### Intervention:

- Sling immobilization based on symptoms (typically 1-2 weeks)
- Modalities: such as TENS and ice, for pain control
- Gentle range of motion exercises of the neck, wrist, and hand
- Early PROM in the plane of the scapula and diagonal patterns for maximal protection of the joint capsule.

- PROM ER and IR in lower abduction angles and avoid exercises at 90\* of abduction.
- Muscle recruitment exercises: submaximal isometrics, rhythmic stabilization drills to facilitate muscular contraction in the scapular plane below 30\*.
- Neuromuscular electrical stimulation of the rotator cuff.
- Progress to AAROM in restricted arcs.

**PHASE II: IMMEDIATE PHASE AFTER INJURY (Weeks 3-6):** When pain has diminished and the patient is less apprehensive.

Keys for progression to Phase II:

- Reduced pain
- Satisfactory static shoulder stability
- Adequate neuromuscular control

Goals:

- Full PROM and AROM
- Flexion and ER/IR exercises can be initiated at 90\* of abduction, although ER at 90\* of abduction is limited to 45\* until 4-8 weeks.

Intervention: in addition to above

- Isotonic exercises with emphasis on internal and external rotators and scapular muscles at 0\* of shoulder abduction.
- Rotator cuff exercises may be started above 90\* of abduction once a stable arc below 90\* is achieved.
- Closed kinetic chain exercises may be able to be progressed to hand-wall stabilization drills within scapular planes.
- Push-up exercises can be introduced; initiated first on a stable surface, then unstable surface.
- Scapular, core, and hip exercises for posture during exercises.

**PHASE III: ADVANCED STRENGTHENING AND RETURN TO SPORT (Weeks 7-12):**

Keys for progression to Phase III:

- Minimal to no pain in the shoulder
- Full shoulder motion
- Good strength (4/5 on manual test)
- Endurance and dynamic stability of the scapulothoracic and upper extremity musculature
- Satisfactory static shoulder stability
- Adequate neuromuscular control

Goals:

- Continue to control pain and neuromuscular control

- Improve strength

Intervention:

- Progression of isotonic exercises particularly in 90\* of abduction
- Gradual increase in resistance with isotonics such as bench press, seated row, lat pull-downs.
- Plyometric exercises that help stimulate neuromuscular control and train the extremity to dissipate force.

Criteria for return to sport:

- Full functional range of motion
- Satisfactory strength and endurance
- Adequate static and dynamic shoulder stabilizers
- Pain free
- ER/IR strength 70% or greater than the contralateral side
- Contact athletes who do not need their arm in significant abduction can consider a shoulder-stability brace



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