CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

REHABILITATION PROTOCOL

Anterior Stabilisation & Latarjet

Guided early movement after anterior stabilisation or a Latarjet procedure.

This protocol guides your recovery after anterior stabilisation or a Latarjet procedure with Dr Kieran Hirpara at Mater Private Hospital Rockhampton. Each phase below opens with a plain-English explanation of what is happening and what matters most, followed by the structured protocol written **for your physiotherapist** – bring this page or its PDF to your first physiotherapy visit so your rehabilitation stays coordinated. Your physiotherapist may adjust the plan on a case-by-case basis depending on how your rehabilitation progresses.

If you have any concerns about your wound after surgery, get in touch with the rooms. It is often helpful to take a photo of the wound and email it for review.

What to expect

This protocol covers two related operations for shoulder instability – arthroscopic anterior stabilisation and the Latarjet procedure. The rehabilitation pathway is the same for both, and has been designed to provide a safe and predictable return to full function.

Bankart or Latarjet – what is different? Although the rehabilitation pathway is the same, the two operations protect different structures. An arthroscopic anterior (Bankart) stabilisation repairs the torn labrum and capsule with sutures. The Latarjet transfers a small block of bone (the coracoid, with its attached tendon) to the front of the socket, and this bone block needs time to knit to the socket; the operation also passes through the subscapularis muscle at the front of the shoulder. For both reasons, rotating the arm outwards (external rotation) is progressed deliberately and gradually after a Latarjet, and a small permanent reduction in external rotation compared with the other shoulder is common – it rarely affects everyday function. The early-week rules below protect the front of the shoulder after both operations.

There is always the temptation to do exercises very early, but there is plenty of evidence to show that the increased range of motion from early mobilisation is temporary, and there is no difference between early motion and delayed motion by one year. Patience in the early weeks costs you nothing in the long run.

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You will wear a simple sling instead of an abduction sling, as there is no proven difference in outcomes, and abduction slings are much more complicated and awkward to use.

Return to activity at a glance:

- **Return to work** – sedentary job: as tolerated; manual job: at least 3 months
- **Driving** – approximately 6–8 weeks
- **Swimming** – breaststroke: from 6 weeks; freestyle: 12 weeks
- **Golf** – can start from 3–6 months
- **Lifting** – light lifting can begin at 3 weeks; avoid lifting heavy items for 3 months
- **Contact sport** (for example horse riding, football, martial arts, racket sports and rock climbing) – from 5 months, once return-to-sport criteria are met

Wearing your sling

Your sling (shoulder immobiliser) supports the repair while it heals. The rules are simple:

- Wear it for **6 weeks**, especially when out of the house. You don't need to sleep in it.
- Take it off only for showers and for your exercises, once you have been shown how – and whenever the sling is off, keep your arm by your side.
- Resting at home, it can come off if you are sensible about it: arm supported on a pillow while sitting.
- Use ice if the shoulder is swollen or sore, especially after exercise.

Fitting it correctly matters – a loose sling does not support you properly:

1. Position your elbow right into the corner of the sling, well supported.
2. The end of the sling should rest comfortably at the knuckle of your little finger. If your hand extends too far out of the sling, it will not provide you with adequate support.
3. The sling has two Velcro straps – one for your neck, one for your waist.
4. With your elbow and forearm positioned, use your non-operated arm to swing the upper strap around your neck and attach it through the upper loop.
5. Attach the lower strap around your waist through the lower loop the same way.

While you are in the sling, watch your posture. Keep your ears, shoulders and hips in line and avoid letting your shoulders slump – good posture protects your back and helps prevent your shoulder stiffening. A rolled-up towel in the small of your back when sitting is a useful reminder.

Your first days in hospital

While you are in hospital, the physiotherapy team will fit your sling and start you on the gentle exercises below. Three terms are used to describe how much of the movement your own shoulder muscles do:

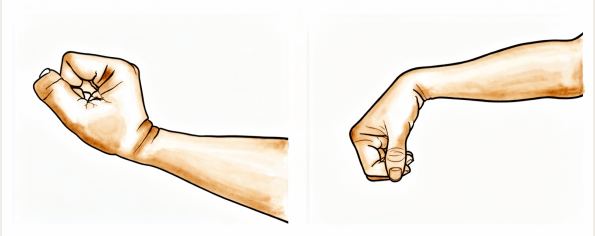
- **Active range of motion (AROM)** – movement is allowed without aid or help.
- **Active-assisted range of motion (AAROM)** – using the other arm or an object to assist with moving the arm.
- **Passive range of motion (PROM)** – completely relaxed, using the other arm or an outside force to do 100% of the work.

A few practical points for these early days:

- Use ice for pain relief if needed.
- When wearing your sling, relax your shoulder and let the sling take the weight of your arm.
- Take your painkillers before you do your exercises, and before your physiotherapy appointments.
- You are allowed to take your arm out of the sling for your exercises and showering.
- Unless you have chosen to arrange your own physiotherapy, an appointment has been made for you and is detailed in your discharge pack.
- If you have any problems, contact the office or let your physiotherapist know.

These are the exercises you will be shown in hospital – start them as guided by your physiotherapist, and stop anything that causes sharp shoulder pain.

Your hospital exercises



Wrist movement

Keep your hand moving by bending your wrist forwards, backwards and side to side.

10 times, 3 times per day

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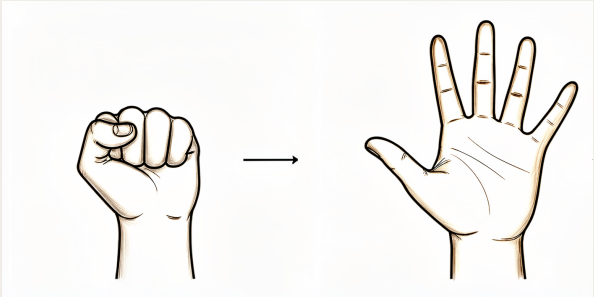

Hand and fingers

Keep your hand and fingers moving by opening and closing them, or by squeezing a stress ball.

10 times, 3 times per day

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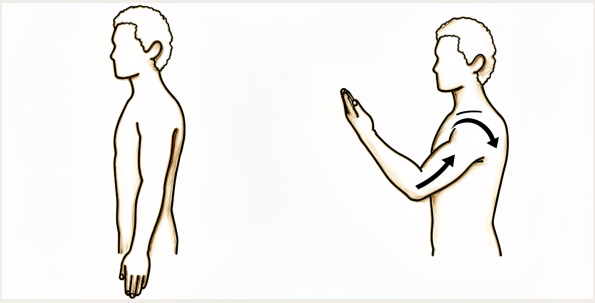

Elbow bending

Bend and straighten your elbow.

10 times, 3 times per day

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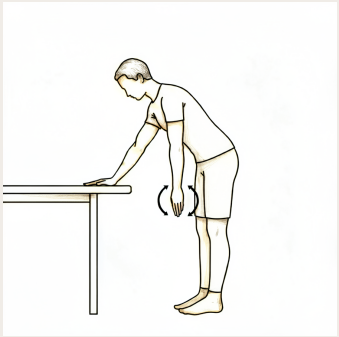

Pendulums

This is a passive exercise. Lean forward and let your arm relax down. Use your body to move the arm gently either clockwise or anti-clockwise, along with forwards, backwards and side to side.

Approximately 30 seconds each way, 3 times per day

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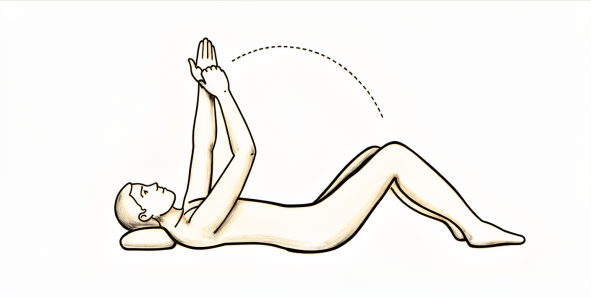

Assisted forward flexion

Sitting on a chair and leaning forward, cradle your operated arm with the other arm and gently move your arm upwards in front of you. Lower it back down with the assistance of your non-operated arm. You could also try lying on your back in bed and helping the arm upwards if you would prefer.

10 times, 3 times per day

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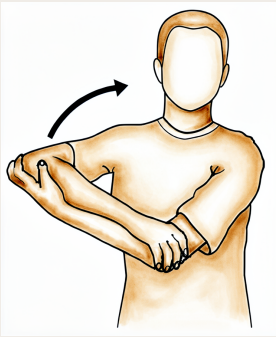

Assisted abduction

Sitting on a chair and leaning forward, cradle the arm again and help it out to the side (like rocking a baby).

10 times, 3 times per day

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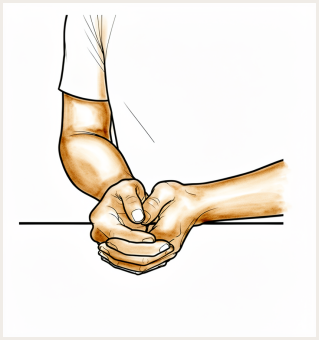

External rotation

Sitting on a chair, only move your arm from where it would be in the sling to pointing straight in front of you. Do NOT go further outwards.

Gently, 10 times, 3 times per day

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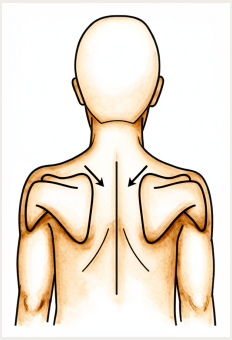

Lower trapezius setting

Squeeze your shoulder blades downwards and together.

Hold for 5 seconds, 5 times; repeat 3 times daily

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Upper trapezius stretch

Use your non-operated arm to bring your ear towards your shoulder, away from the operated side.

Hold 10 seconds, 3 times; repeat 3 times per day

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Levator scapulae stretch

Use your non-operated arm to bring your nose towards your nipple or armpit area.

Hold 10 seconds, 3 times; repeat 3 times per day

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Phase I – Level 1 exercises (Weeks 1–3)

The first three weeks are about letting the repair settle while keeping the shoulder gently moving within a comfortable "safe zone". You will be in the sling, and your physiotherapist will guide you through gently assisted movements, posture and shoulder-blade work, and the Level 1 exercises listed at the end of this protocol. Two rules matter most: never force or stretch the shoulder, and never combine lifting the arm out to the side with rotating it outwards (combined abduction and external rotation) – that is the position the repair must be protected from. In this phase the safe zone has firm boundaries: the arm rotates outwards only as far as pointing straight ahead (neutral), and is lifted forwards only as far as is comfortable without forcing.

For your physiotherapist:

Goals

- Protect the repair while preventing the negative effects of immobilisation
- Settle pain and swelling
- Establish postural awareness, scapular setting and protected range of motion within the safe zone

Management

- Sling for 6 weeks (athletes can wean off sooner under the guidance of a club therapist)
- Teach axillary hygiene
- Teach postural awareness and scapular setting
- Core stability exercises as appropriate

- Proprioceptive exercises (minimal weight-bearing below 90 degrees)
- Active-assisted flexion as comfortable (in a “safe zone”)
- Active-assisted external rotation (ER) as comfortable (in a “safe zone”)
- Safe-zone guide: assisted flexion to approximately 90–120 degrees as comfortable; ER with the elbow at the side to neutral (0 degrees) and no further; internal rotation (IR) to approximately 45 degrees in the scapular plane

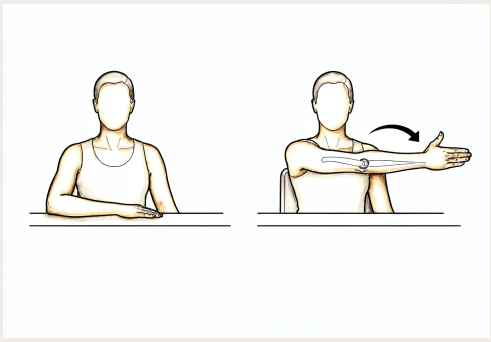
Precautions

- Do not force or stretch
- No combined abduction (ABD) and external rotation — the apprehension position
- No external rotation past neutral in this phase
- No active shoulder movement against resistance, no lifting with the operated arm, and no supporting of body weight through the hand beyond the minimal-load proprioceptive work above

Criteria to progress

- Comfortable assisted flexion approaching 90 degrees or more, with ER to neutral
- Pain and swelling settling, with minimal night pain
- Active scapular setting with a palpable muscle contraction and no substitution patterns

Phase II — Level 2–3 exercises (Weeks 3–6)



Seated external rotation (windscreen wiper)

Sitting with your elbow by your side and bent to 90 degrees, sweep your forearm outwards from pointing straight ahead, like a windscreen wiper, then return. Progress the range gradually from neutral towards 45 degrees by week 6, as your physiotherapist guides. Never force the movement, and never combine it with lifting the arm out to the side.

As guided by your physiotherapist

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From week 3 the aim is for the shoulder to do more of the work itself: assisted movements progress to active movement — your own muscles, without help from the other arm — as comfort allows, and the exercises step up to Levels 2–3. The same two rules still apply: no forcing or stretching, and no combined abduction and external rotation. From this phase your physiotherapist will also progress your outward rotation gradually — from pointing straight ahead towards about 45 degrees by week 6 — and begin gentle muscle-setting (isometric) strengthening with your arm by your side. The milestone for the end of this phase is being able to lift your arm as high as you could before the operation.

For your physiotherapist:

Goals

- Progress assisted movement to active movement without substitution patterns
- Gradually expand range of motion while protecting the anterior repair
- Introduce submaximal strengthening

Management

- Progress active-assisted range of motion (AAROM) to active range of motion (AROM) as comfortable
- ROM guide: progress assisted elevation towards 135–140 degrees; progress ER at the side gradually from neutral towards 45 degrees by week 6; IR to approximately 50 degrees in the scapular plane
- Begin submaximal, pain-free isometrics with the arm at the side in neutral rotation (flexion, abduction, extension, ER, IR)
- Continue scapular, postural, proprioceptive and core work from Phase I

Precautions

- Do not force or stretch
- No combined abduction and external rotation
- No ER stretching beyond the limits above, and no ER in abduction yet
- Light lifting only (from week 3)

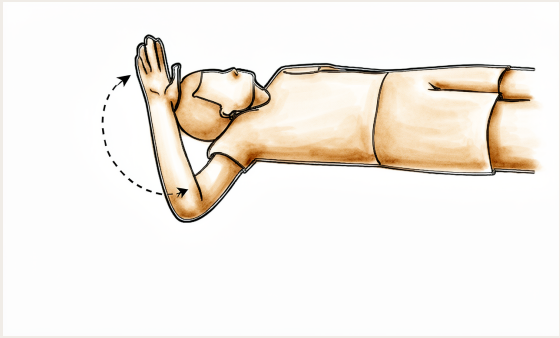
Criteria to progress

- Active elevation to pre-operative level
- ER of approximately 45 degrees at the side without pain or apprehension
- Good scapular control through the available range, with minimal pain during phase activities

Milestone — week 6

- Active elevation to pre-operative level

Phase III — Level 3+ exercises (Weeks 6–12)



External rotation in abduction (lying)

From about week 8. Lie on your back with the upper arm supported out to the side and the elbow bent to 90 degrees. Let the forearm rotate gently back towards the bed, then return. Build the range gradually, starting below shoulder height, and do not stretch at the end of the range before week 12.

As guided by your physiotherapist

From week 6 the focus shifts to control and strength: training the shoulder blade and the ball-and-socket (glenohumeral) joint to work steadily together — control first, range second — then building strength, balance-and-position sense (proprioception), and core work, with sport-specific rehabilitation for those returning to sport. Range of motion is increased gradually rather than pushed. Outward rotation keeps building beyond 45 degrees towards full range, and rotation with the arm lifted away from the body — the "throwing" position — is the last range to be restored: it is introduced gradually from about week 8 and is not stretched at its end limit before week 12. The milestones for week 12 are at least 80% of the external rotation of your other shoulder, with normal movement patterns throughout the range.

For your physiotherapist:

Goals

- Regain scapular and glenohumeral stability, working for joint control rather than range
- Gradually restore full functional range of motion (external rotation may lag, particularly after a Latarjet)
- Restore strength, proprioception and endurance, and prepare for sport-specific demands

Management

- Regain scapular and glenohumeral (GH) stability, working for shoulder joint control rather than range
- Gradually increase range of motion (ROM) — ROM guide: progress ER at the side beyond 45 degrees towards full range as comfortable; introduce ER in abduction gradually from about week 8, working below 90 degrees of abduction before progressing to 90 degrees

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- Strengthen – begin isotonic rotator cuff and scapular strengthening from weeks 6–7 as active range allows, progressing resistance in line with the Level 3 exercises
- Increase proprioception through open- and closed-chain exercise
- Progress core stability exercises
- Assess and treat posterior tightness, if required
- Incorporate sports-specific rehabilitation
- Plyometrics and perturbation training

Precautions

- Avoid aggressive overhead strengthening or stretching that overloads the anterior capsule
- No forced end-range stretching into combined abduction and external rotation before week 12
- After a Latarjet, progress heavier resisted work in consultation with Dr Hirpara while the bone block unites

Milestones – week 12

- Minimum 80% range of external rotation compared with the asymptomatic side
- Normal movement patterns throughout range
- Satisfactory stability with no apprehension on testing

Returning to sport

Return to contact sport (for example horse riding, football, martial arts, racket sports and rock climbing) is from 5 months at the earliest – and the date alone is not the test. Before going back, your shoulder should feel and test stable, move through the range your sport needs without apprehension, and be strong enough to protect itself. Your physiotherapist will guide a graded, sport-specific build-up rather than a straight return to full play.

For your physiotherapist:

Criteria for return to sport

- Full, pain-free functional range of motion for the sport (accepting a small residual ER deficit after a Latarjet)
- No instability symptoms and no apprehension on testing
- External and internal rotation strength of at least 80% of the contralateral side, building towards 90% for collision and overhead athletes
- A graded, interval return is preferred for throwing and overhead sports

Exercise levels

The phases above refer to graded exercise levels. Each exercise is tagged with what it trains — range of motion, strengthening, proprioception or core stability. Not all of the exercises have been investigated, and the information is intended only as a guide when choosing exercises.

Level 1 — under 20% intensity

- Pendulum exercise — range of motion
- Flexion in side lying — range of motion, proprioception
- Abduction using the physio ball — range of motion, proprioception
- Flexion in standing — range of motion, proprioception
- Abduction in standing — range of motion, proprioception
- Prayer position — proprioception
- Balance point in lying flexion — range of motion, strengthening, proprioception
- Balance point in lying abduction — range of motion, strengthening, proprioception
- External rotation in standing — range of motion, proprioception
- Internal rotation (IR) in standing — range of motion, proprioception
- External rotation lying — range of motion, proprioception

During Phase I, the rotation and abduction exercises in this level stay within the safe zone — external rotation not past neutral, abduction kept comfortable and below shoulder height, and the two never combined.

Level 2 — 21–40% intensity

- Isometric exercises in sitting: external rotation — strengthening
- Isometric exercises in sitting: abduction — strengthening
- Isometric exercises in sitting: internal rotation — strengthening
- Isometric exercises in sitting: external rotation through range — strengthening
- Unilateral shoulder flexion in four-point kneeling — strengthening, proprioception, core

Level 3 — over 40% intensity

- Theraband isometric external rotation, long lever — strengthening, proprioception
- Diagonal pattern exercise with theraband — strengthening, proprioception
- Diagonal pattern exercise with free weights and step — strengthening, proprioception, core
- Dynamic hug with theraband and ball — strengthening, proprioception, core
- Diagonal pattern abduction in elevation to adduction with exercise band — strengthening, proprioception

The long-lever and diagonal-pattern exercises that load the arm in elevation belong to Phase III — start them once the week-6 criteria are met, and leave loaded combined abduction and external rotation positions until late in the phase.

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The exercise protocol and exercises are based on those described by Professor Lennard Funk and his team from the Wrightington Shoulder Unit and his practice in Manchester, UK. They can be found at shoulderdoc.co.uk, and the exercises are illustrated in his freely available shoulder rehabilitation book. The phase goals, range-of-motion limits and criteria to progress have been updated with reference to current published rehabilitation protocols and reviews: the Massachusetts General Brigham Sports Medicine rehabilitation protocols for Bankart repair and for the Latarjet procedure; Bradley et al., *Latarjet procedure for the treatment of anterior glenohumeral instability in the athlete – key considerations for rehabilitation*, International Journal of Sports Physical Therapy (2021); and Kelley et al., *Functional rehabilitation and return to play after arthroscopic surgical stabilization for anterior shoulder instability*, Sports Health (2021).

After your protocol

This protocol works alongside the practice's general recovery advice – see managing post-operative pain and wound care. For the operations themselves and the condition they treat, see the Latarjet procedure and shoulder instability.

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5. Funk L. Shoulder Rehabilitation. Wrightington Shoulder Unit / shoulderdoc.co.uk.

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