UNSTABLE SHOULDER: NON-SURGICAL MANAGEMENT CLINICAL PRACTICE GUIDELINE

Background: The most commonly seen pathology within the unstable shoulder realm is a subluxation or dislocation event. Less common pathology may revolve around an underlying condition such as Ehler-Danlos (EDS) or general laxity. Anterior subluxations and dislocations are most prevalent with trauma being the primary cause. Posterior laxity or dislocations are seen primarily in football lineman and other contact sports due to the nature of the specific positional demands. Focus early on reducing apprehension by avoiding vulnerable positions, reducing pain, and restoring ROM. Unique to the lax shoulder population, scapular control and rotator cuff activation (similar to quad activation for the knee) are paramount to the success of these patients. Consultation with the referring provider is important throughout the plan of care.

Progression is time and criterion-based, dependent on soft tissue healing, patient demographics and clinician evaluation. Contact Ohio State Sports Medicine at 614-293-2385 if questions arise.

Phase 1: Weeks 0-2

ROM	• AAROM progressing to AROM (avoid ER and ABD initially)
Strength	• RTC isometrics in pain-free positions for ER and IR • Periscapular musculature ○ Prone series (if tolerated), sidelying progression if needed
Neuromuscular Control	• ER/IR rhythmic stabilization
Goals to Progress to Next Phase	1. Reduce pain 2. Increase ROM

Phase 2: Weeks 2-6

ROM	• Normalize AROM

Strengthening	• RTC/Scapular Strengthening
	  ○ Gradual progression of strengthening and stability exercise towards position of instability
	  ○ Multi-angle isometrics
	  ○ Prone exercises (focusing on proper retraction control, cueing and feedback)
	  ○ Scaption, abduction and extension
	  ○ PNF (manual and T-band) and functional strengthening
	  ○ Perturbations with all exercise (Progress proximal to distal)
	  ○ Initiate closed kinetic chain (i.e. wall or table taps)

Neuromuscular Control	• Proximal to Distal Perturbations • PNF and functional strengthening • Progress from stable to unstable surface (BOSU, Dynadiscs) • Consider joint position sense/proprioceptive focused interventions (i.e. therapist moves arm or scap into a position then ask patient to reproduce position; tape on a wall in random positions asking patient to touch with eyes open/closed)
Goals to Progress to Next Phase	1. Normalize movement 2. Strengthen and stabilize RTC and scapular stabilizers 3. Correct glenohumeral and scapulothoracic mechanics

Phase 3: Weeks 6-12

ROM	• Maintain ROM

Strength	• RTC and Scapular Strengthening
	  ○ Thrower's Ten Exercise
	  ○ ER at 90 abduction
	  ○ Emphasis on eccentric control
	• Continue and progress trunk and LE strengthening

Stability	• Continue neuromuscular re education interventions
	• WB Plyometrics
	• NWB Plyometrics at 90º abduction
	  ○ With perturbations
	  ○ Increase speed and change accuracy of tosses
	  ○ Increase reps to improve endurance

Goals to Progress to Next Phase	1. Increased dynamic functional strength 2. Improved neuromuscular control at multiple angles towards unstable position 3. No signs of instability or biomechanical impingement

Phase 4: Weeks 12+

Initiate Sport Specific Training	• Full functional ROM • Symmetrical HHD testing (5/5 MMT if HHD not available) • Completion of plyometric program without apprehension • Emphasis on good scapular mechanics

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References

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