



SLAP Protocol

Pathology & Treatment: The shoulder consists of three gross anatomic structures that create stability within the joint: the rotator cuff muscles, ligaments and the cartilaginous labrum. The labrum is a rubbery cartilaginous ring that surrounds the shoulder socket (glenoid). It creates a greater surface area on the glenoid for the head of the humerus to sit comfortably. It is a very important stabilizing structure secondary to its ligamentous attachments and a superior attachment of the long head of the biceps. If there is a lesion of the labrum, the shoulder may become unstable and/or painful with chest level, rotational, or overhead activities such as throwing. If the tear occurs in the superior portion of the labrum it is deemed a SLAP (Superior Labral Anterior Posterior) tear. SLAP tears are further classified into types I-IV and surgical repair is usually performed for type II tears that destabilize the long head of the biceps anchor.

Goals and Guidelines: The goals of the labral repair are to regain full range of motion of the operative shoulder while emphasizing both static (ligamentous) and dynamic (muscular) stability for a pain-free return to activity or sport. If the patient is an overhead athlete, then focusing on lower extremity strength, flexibility, and core stabilization are vital components in ability to return to sport. Overhead activities such as the serve in tennis, throwing a baseball or football, or swinging a golf club involves the funneling of energy from the feet, through the legs, pelvis, trunk, into the shoulder, through the elbow out of the hand. The patient will usually begin therapy within 3-5 days after surgery. Phase I is obtaining ROM and is about 6 weeks and the second phase is strengthening and transitioning to function training for sport. The patient is allowed to use the operative arm for waist level and midline activities such as personal hygiene care but is to do no lifting, pushing or pulling with the arm. Shoulder immobilizer only needs to be worn when outside the home for the first six weeks. If the patient feels more comfortable with the sling, then he/she may wear it at home as well but it is not necessary. For the first couple weeks, most patients are more comfortable sleeping in their sling and a recliner but they may move to a bed when comfortable. While sleeping in bed, the patient is to place a pillow or a stack of blankets under the elbow and arm of the operative extremity in order to have the arm/shoulder in the plane of the body (extension of the shoulder is both painful and stresses the repair). Therapists should teach patient how to perform proper axillary hygiene by bending over at the waist (like doing pendulum exercises).

0-2 weeks

-Immediately start Pendulums when comfortable, start Supine Active Assisted Forward Elevation (SAAFE), and External Rotation With Stick. It is imperative that the patient understands the exercises and are able to demonstrate that they can perform the exercises

properly, as they are responsible for performing these at home. Stretching exercises should be performed once a day.

-Also start internal rotation in the supine position. In the supine position, position the arm in about 30° of abduction. External and internal rotation can be performed in this position.

-All ranges of motion should be taken to tolerance and focus on long slow stretches with appreciable gains being realized each week.

2-4 weeks

- Begin scapular depression, retraction, protraction and elevation.

-Start IR, ER and abduction isometrics

-Start Functional Internal Rotation using a towel or belt to pull the operative arm up behind the back.

4-6 weeks

- Patient may begin sub-max 4 Way TheraBand Strengthening

6-8 week

- May begin posterior capsule stretching at this point. Joint Mobilizations to stretch the posterior capsule may be appropriate to prevent or address glenohumeral Internal Rotation Deficit (GIRD) leading to SLAP tears.

- Start Active Range of Motion in all planes (flexion, scaption, abduction) for deltoid strengthening.

- May increase tension for 4 Way Shoulder Rubber-Band Strengthening (punches, extension, internal and external rotation).

8-12 weeks

- Begin more aggressive peri-scapular strengthening exercises that focus on the inferior trap and serratus anterior strengthening. TVA's exercises— named because of the position the arms are in when performing the exercises (T=prone horizontal Abduction, V=MMT position for inferior trap—focus on scapular depression and retraction during the movement, A= the patient is prone with arms straight and in 30°-45° of abduction, focus on scapular retraction and depression.

- Standing Horizontal Abduction with TheraBand

- Rhythmic Stabilization beginning with patient's arm in 90° of flexion and manual resistance given by the therapist in different planes and with different resistances. The patient's goal is to try and prevent the therapist from moving his/her arm. Progressions can include increase in tempo and resistance. Further progression would be into a PNF pattern. Progress to standing and move into flexion, scaption, abduction and PNF patterns.

- Start more aggressive strengthening @ 10 wks. May begin lat. pulldowns, seated rows and pull throughs or lower rows. AVOID behind the neck lat pulldowns, military pressing, and bench pressing.

- Push-up into wall with ball under uni-lateral hand focusing on scapular retraction. Progress to stability ball on a table while performing a push-up. Progress to stability ball on the floor. Do not forget to set shoulder blades into the correct position.

12-16 weeks

- Start more sport specific or work hardening rehab
- May begin light bench pressing but do not let bar down to chest to avoid elbows passing the plane of the body. Place a phonebook or block on chest to avoid contact of bar to the chest.
- Work on neuromuscular control with body blade (sagittal plane, scapular plane, frontal plane, internal rotation, external rotation at waist level progressing to 90° of abduction, then to a PNF pattern)
- Internal and external rotation plyometrics with trampoline/rebounder
- May begin light interval throwing program outlined by therapist or athletic trainer if internal rotators and external rotators have an equal strength ratio. A normal ratio is when the external rotators are at 2/3 ratio of the internal rotators.

16-20 weeks

- Gradual return to sport. If the sport requires overhead throwing then the patient should follow the throwing program.