

LATARJET Post-op Protocol

Phase 1 — Maximal protection (0–3 weeks)

Goals

- Protect graft fixation and subscapularis repair; wound and pain control
- Full distal ROM (elbow, wrist, hand) and normal cervicothoracic mobility
- Early pain-free AAROM within the safe zone; scapular setting and postural control
- Establish proprioceptive input and maintain systemic conditioning

Precautions

- **No forced or end-range ER**
- No combined abduction + ER; no end-range extension or hand-behind-back
- No resisted IR, no weight-bearing through the arm, nothing lifted

Intervention

- Sling full-time except for exercise, showering, dressing
- Pendulums; AAROM flexion/scaption/ER/IR in supine within a comfortable, unforced range, progressing towards sitting
- Scapular setting, cervical ROM, thoracic mobility, grip and distal ROM
- Submaximal deltoid and periscapular isometrics as pain allows; low-load proprioceptive drills
- Lower limb and trunk conditioning maintained throughout

Gateway to next phase: Pain $\leq 3/10$ at rest, wound settled, neurologically intact, AAROM flexion $\geq 120^\circ$ with acceptable scapular control, ER achievable to the permitted limit without guarding.

Phase 2 — Restore motion and activation (3–6 weeks)

Goals

- Wean sling; full active elevation by 6 weeks
- Progressive restoration of ER at 0° abduction
- Re-establish cuff and periscapular activation and basic dynamic stability

Precautions

- No forceful stretching into ER or extension; no combined ABD + ER until 6/52
- No loaded pressing or pulling; no impact or fall risk activity
- Resisted IR remains out if subscapularis was taken down

Intervention

- Wean sling over weeks 3–4; restore normal arm swing and resting posture
- AAROM → AROM, supine to incline to upright; scaption before pure abduction; pulleys/stick as needed
- Multi-angle submaximal isometrics ER/IR/ABD, progressing to light band work
- Rhythmic stabilisation in scapular plane at low elevation, progressing angle as control allows
- Address posterior capsule and soft tissue restriction; manual therapy to shoulder and thoracic spine as indicated
- Driving typically resumes weeks 4–6 with surgeon clearance

Gateway to next phase: Active elevation within 10–15° of the contralateral side with normal scapulohumeral rhythm below 90°, ER at 0° abduction ≥60% of contralateral, pain-free isometrics at moderate effort, sling discarded.

Phase 3 — Strength and neuromuscular control (6–12 weeks)

Goals

- Full ROM, including ER in abduction, by 12 weeks
- Restore cuff, periscapular and global upper limb strength
- Rebuild proprioception and reactive stability under load

Precautions

- Introduce ER in abduction progressively — end-range apprehension positions are unloaded until ~10 weeks
- No contact or collision, no maximal-effort lifting, no overhead plyometrics
- Avoid end-range horizontal extension in pressing (elbows stay anterior to the trunk)

Intervention

- Progressive ER in increasing abduction (0° → 45° → 90°); treat posterior tightness as the usual limiter
- Gradually progress isotonic exercises
- Gradually progress closed-chain push-up progression
- **Objective baseline at 12 weeks:** HHD for ER, IR and abduction

Gateway to next phase: Full pain-free ROM, ER ≥80% of contralateral, cuff strength ≥80% symmetry on HHD, normal movement patterns throughout range, no apprehension on relocation testing.

Phase 4 — Return to activity (3–6 months)

Goals

- Full overhead capacity, unrestricted work duties, criterion-based return to sport

Precautions

- Long-term weight training modifications: avoid triceps dips, wide-grip bench, behind-neck press and behind-neck lat pulldown; keep elbows visible in front
- No throwing or collision exposure until criteria met and surgeon has cleared

Intervention

- Overhead strengthening once below-90° strength and full ROM are established

- Plyometric progression: chest pass → overhead → ballistic and decelerative catches; interval throwing program from ~4 months in throwers
- Progressive return to full gym programming; sport-specific drills, then controlled contact, then unrestricted training
- Collision sport typically 5–6 months; overhead throwing sport 6+ months

Return-to-sport criteria

- ≥90% limb symmetry for ER, IR and abduction on HHD
- Functional testing: CKCUEST, upper quarter Y-balance
- Psychological readiness: SIRSI; patient-reported function: WOSI
- Completed sport-specific progression without symptoms; surgeon clearance (± CT union in collision athletes)

Escalate to the surgeon

- Increasing pain, night pain, fever, wound breakdown or discharge
- **Loss of previously achieved ER, or mechanical clicking/catching** — consider hardware prominence, graft lysis or fixation failure
- **Progressive increase in passive ER with positive belly-press or lift-off** — consider subscapularis failure
- New or unresolving neurological deficit
- Recurrent apprehension or subluxation symptoms at any stage

*Things to consider: Everyone heals at a different pace; So, your timeline may look slightly different from the one above; If you have a **rotator cuff repair or other structures repaired** alongside your surgery, your physiotherapist will adjust this program to suit your needs.*

Always contact your physiotherapist or surgeon if you notice increasing pain, swelling, redness, fever or any new or worsening symptoms