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Latarjet Shoulder Protocol

(open anterior stabilisation involving coracoid transfer)

Procedure Summary

The Latarjet coracoid transfer is used to stabilise the shoulder when an arthroscopic labral repair is not indicated or possible; for example, when there are large bony defects of the glenoid, large Hill-Sachs defects in the humeral head, revision cases or for certain patient subgroups, e.g. extremely hyperlax. The procedure is usually done with open surgery using a deltopectoral approach. Arthroscopic techniques are currently being developed but are still in the experimental phase, extremely technically difficult and yet to be shown to be as effective.

Technique: the deltopectoral approach involves spreading the interval between pec major and deltoid, followed by splitting subscapularis in line with its fibres. This allows access to the anterior glenoid. The tip of the coracoid process (2cm) is removed with the conjoined tendon still attached and is fixed to the anterior glenoid (where the bone is deficient), using one or two screws. The bone acts to restore the articular arc of the glenoid while the transferred conjoined tendon acts as a musculo-tendinous sling that supports the humeral head and stops it displacing antero-inferiorly when the arm is in a position of abduction/external rotation.

Notes: Muscles and tendons are split or retracted, rather than cut or detached.
Main concern in rehab is to protect the fixation of the coracoid process. This is usually quite solid using screws so rehab can progress quite quickly, unless specified otherwise in the op note.

AIM: At 3 months patient should FROM and starting sports specific rehab

Sling

4-6/52

Day 1 to 2 weeks:

- Importance of pain control.
- Ice pack use + +
- Sling use.
- Sleeping position (e.g remove sling and use body strap for support).
- Washing and dressing.
- AROM of unaffected joints eg fingers, wrist and elbow.
- Postural advice and scapular setting.
- Encourage waist level ADL's (e.g. brushing teeth, eating).

Start phase 1 passive ROM (controlled by the patient) then active assisted ROM.
RESTRICTIONS
Limit flexion to 90˚ and ER to neutral for 2/52.

Exercises taught on ward:
Pendulum
PROM/AA shoulder flexion to 90˚
PROM/AA shoulder ER to neutral

Hand, wrist and elbow AROM.

Follow-up Physiotherapy
Usually 2/52 post op.

2 - 6 weeks: Progress to AROM as tolerated.

NOTE - encourage SCAPTION rather then pure abduction.
- progress using short to long lever principles.

No IR HBB until at least phase 2 dependant on procedure.

6 weeks to 3 months:

Phase 2 Aim: Stretching at end of range and strengthening

2a Stretches at end of range
- encourage stretches to be done by the patient using a broom handle etc rather than by physiotherapist
- attention to posterior capsule stretch (within relevant restrictions).

2b Strengthening against resistance only once patient is achieving functional AROM and no pain to resisted muscle testing.
- include strengthening of rotator cuff, UFT, LFT, serratus anterior, biceps, triceps, deltoid as per assessment.

3 months:

Phase 3 Aim: full active rehab/ higher level function

Start sport specific rehab.
Patients can return back to competitive sports when achieving full AROM and normal strength.

General guidelines

Consultant post op follow up
All patients are normally followed up in clinic with consultant at 2-6/52 post op

Driving
Usually possible post op at 6/52 for repairs and stabilisation procedures.

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