

Arthroscopic biceps tenotomy protocol

This protocol provides the therapists with a general guideline for patients after this type of procedure. Each patient's surgery and postoperative progress may be different, and this protocol is not intended to substitute for one's clinical decision making based on exam findings, individual progress, and/or the presence of post-operative complications. If a clinician requires assistance in the progression of a post-operative patient they should consult with the referring surgeon.

Progression to the next phase is based on Clinical Criteria and/or Time Frames as Appropriate.

A biceps tenotomy procedure involves cutting of the long head of the biceps just prior to its insertion on the superior labrum. A biceps tenotomy is typically done when there is significant chronic long head of the biceps dysfunction or for definitive treatment of labral pathology with biceps anchor instability or for pain relief with irreparable massive rotator cuff tears.

Weeks 1-2

- Shoulder immobilizer most of the time, except shoulder PROM, showering, dressing, elbow/wrist exercises
- Begin shoulder PROM all planes to tolerance /do not force any painful motion
- Scapular retraction and clock exercises for scapula mobility progressed to scapular isometric exercises
- No active range of motion (AROM) of the elbow
- No excessive external rotation range of motion (ROM) / stretching.
- PROM elbow flexion/extension and forearm supination/pronation; AROM wrist/hand
- Ball squeezes
- Frequent cryotherapy for pain and inflammation
- Patient education regarding postural awareness, joint protection, positioning, hygiene, etc.
- May return to computer based work
- Wean sling around day 10

Week 3-4

- Sling is weaned completely by beginning of week 3. Beginning
- Continue PROM of shoulder, and begin AROM of shoulder and elbow
- No lifting of objects with operative shoulder
- No friction massage to the proximal biceps tendon / tenodesis site
- Begin incorporating posterior capsular stretching as indicated; Cross body adduction stretch; side lying internal rotation stretch (sleeper stretch)
- Continued Cryotherapy for pain and inflammation
- Appropriate scapular posture at rest and dynamic scapular control with ROM and functional activities

Week 5-8:

- Restore full AROM of shoulder and elbow
- Begin rhythmic stabilization drills
- all activities should be pain free and without compensatory/substitution patterns
- no heavy lifting should be performed at this time
- continued cryotherapy for pain and inflammation as needed
- Do not perform strengthening (including Thera-bands)

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Weeks 9-12

- Continue shoulder AROM and PROM
- Initiate balanced strengthening program
- Initiate biceps curls with light resistance, progress as tolerated
- Initiate resisted supination/pronation
- Gain muscular endurance with high repetition of 30-50, low resistance 1-3 lbs
- Exercises should be progressive in terms of muscle demand / intensity, shoulder elevation, and stress on the anterior joint capsule
- By Week 11-12, more advanced strengthening can start (weight lifting)
 - Progressive return to upper extremity weight lifting program emphasizing the larger, primary upper extremity muscles (deltoid, latissimus dorsi, pectoralis major)
 - Start with relatively light weight and high repetitions (15-25)
 - avoid military press and wide grip bench press
- Strengthening overhead if ROM and strength below 90 degree elevation is good

Week 13 and beyond

- May initiate pre injury level activities/ vigorous sports if appropriate / cleared by MD