Delaware Physical Therapy Clinic

540 S. College Ave., Suite 160
University of Delaware
Newark, Delaware 19713
Ph: (302) 831-8893
Fax: (302) 831-4468

Rehab Practice Guidelines for:

Adhesive Capsulitis of the Shoulder

Clinical Decision making

1. IR/ER arc of motion <70°, IR <25°, ER <45°, Abd <75°
   a. Manipulation under anesthesia
   b. Regional scalene block for > 6 hours
   c. Directly from OR to PT
2. IR/ER arc of motion >70°
   a. Distention with manipulation in office
   b. This is not used for the last 15° of motion
   c. Used primarily when ADLs are limited

Procedure Day 1:

M.D. Performs procedure in this order:

1. Posterior & posterior inferior glenohumeral joint mobs
2. Horizontal adduction stretch (scapula stabilized)
3. Inferior glenohumeral joint mobs
4. Abduction stretch (scapula stabilized)
5. Flexion stretch
6. Internal rotation @ 90° abduction stretch
7. External rotation @ 90° abduction stretch
8. External rotation @ 0° abduction stretch
9. Horizontal adduction with internal rotation stretch

Expected # of visits: 10-15

Precautions and other considerations	
Precautions	▪ None
Considerations	▪ Increased chance of recurrent adhesive capsulitis with patients who have diabetes. (Due to increased scar formation)
Overall Goals	▪ ROM full or back to at least 80% of uninvolved side and strength great enough to be functional with ADLs
At Discharge	▪ Continue stretches 2-3 times a day. If one notices they are getting stiff, and cannot change this in a week after increasing their stretching time, consider a call to the doctor to return to PT. ▪ Also have pt. place mark on wall in Flexion and Abd. ▪ If pt's ROM drops 2 inches below that line, they need to increase stretching and if this does not improve in a week, return to M.D. for prescription for PT ▪ Have patient check every 2-3 weeks.

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Adhesive Capsulitis of the Shoulder Rehab Protocol		
Timeline	**Treatment**	**Milestones**
Week 1-2 Week 1: PT 4-5x/week Week 2: PT 3x/week	▪ Glenohumeral joint mobs at end range and stretching in order as listed as procedure day 1 ▪ Ice only for pain (may otherwise increase stiffness) ▪ 1st week, (TENS/noxious PRN) ▪ After 3 days, moist heat may be used ▪ Isolation of glenohumeral motion (i.e. codmans exercises) ▪ Pt's often show guarding with PROM; AAROM may help get the person to relax with ROM	▪ 80% to full ROM & glenohumeral joint mobility
Weeks 3-4 1-2x/week	▪ Continue glenohumeral joint mobs and stretching where needed. ▪ IR stretch behind the back ▪ Add isometrics and scapular strengthening exercises if near full ROM.	▪ 80% to full AROM, PROM & glenohumeral joint mobility ▪ Normal scapulo-humeral meaning no compensations seen with raising arm overhead.
Week 5-6 1-2x/week	▪ Progress strengthening program to isotonics. ▪ Sport/work specific rehabilitation ▪ If functional with ADL's, progress to a HEP of strengthening exercises	▪ Should have 80% or full range of motion and be functional with ADL's

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