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Short Communication

# Updates in Shoulder Rehabilitation

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In rotator cuff repairs we have different techniques, among them transtendinous rotator cuff repair is being done for symptomatic partial-thickness rotator cuff tears. This is especially to have better biomechanical outcomes. In spite of that one of the hindrances we face is early postoperative stiffness and slower recovery. McBroom et al. did a study of 61 patients in which accelerated physical therapy protocol (passive and active-assisted range of motion at 2 to 4 weeks, active range of motion as early as 4 to 6 weeks, strengthening at 6 to 8 weeks, and earlier discontinuation of obligatory sling wear) and found significant improvement in active range of motion at 6 weeks and 3 months postoperatively compared with standard physical therapy [1]. So accelerated PT gave good results. There were no higher rates of retear among the cohort.

In case of massive rotator cuff tears electromyographic biofeedback-guided rehabilitation is being done. A study was done by Tiryaki., et al. to know the effectiveness of electromyographic biofeedback-guided rehabilitation. 46 adults were divided into 2 groups one of them as control group. Then at the end of 1-year outcome measured by American Shoulder and Elbow score, shoulder flexion strength, shoulder range of motion, Numeric Pain Rating Scale, and Global Rating of Change Scale showed significant difference in the change in shoulder flexion strength and patient satisfaction from baseline. Hence concluded that electromyographic biofeedback can be used as an alternative method that increases patient satisfaction in exercise protocols [2].

Another is commonly seen primary adhesive capsulitis of the glenohumeral joint. Although it is considered a self-limiting condition recovery is not full. So manipulation under anesthesia (MUA) can be considered. Van der Stok et al. did a study comparing with diving in 3 groups MUA alone, MUA with capsular distension, and MUA with capsular distension and countertraction. At 6 months evaluated with re-MUA rate, Constant-Murley shoulder score, and visual analog scale score and found that MUA with capsular distension and countertraction reduced the need for a second MUA and resulted in a faster improvement in functional outcome and reduction of pain compared with the other 2 groups [3].

## Bibliography

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