

Latarjet (Coracoid Transfer) for Anterior Instability



Physical Therapy Protocol · Bone-Healing and Subscapularis-Protective Progression

Synthesized from the Ohio State University Wexner Medical Center Open Latarjet Clinical Practice Guideline (2020; accelerated and traditional pathways), Massachusetts General Hospital, and Brigham and Women's Hospital Latarjet protocols. Progression is gated by coracoid osseous union (~6–8 weeks) and by the subscapularis approach (split vs. tenotomy/repair).

AT A GLANCE

TIMELINE	20–28 weeks structured rehab; osseous union of the coracoid graft expected ~6–8 weeks
IMMOBILIZATION	Sling 6 weeks including while sleeping (confirm duration with surgeon); off for hygiene and HEP
KEY MILESTONES	Staged ER limits weeks 0–6 · full ROM in all planes by weeks 10–12 · strength ≥80% of uninvolved side before return-to-sport phase
RETURN TO ACTIVITY	Jogging weeks 10–12 with clearance; throwing program ~month 4; non-contact sport 5–6 months; contact/collision sport and climbing minimum 6 months (throwers return to competition ~9 months)

KEY PRECAUTIONS

- Protect the healing coracoid graft: no ER past 20–30° and no combined abduction + ER for the first 6 weeks; no cross-body adduction; no aggressive extension or extension + ER stretching until osseous union (~6–8 weeks).
- Subscapularis approach dictates IR loading: traditional (tenotomy and repair) — no active IR, no IR behind the back, and no resisted IR isometrics early; accelerated (subscapularis split) — submaximal IR isometrics may begin in Phase 1 per surgeon.
- No supporting body weight through the operated arm and no lifting in Phase 1; limit active biceps work for 6–8 weeks (conjoint tendon originates on the transferred coracoid) and avoid heavy biceps loading for 12 weeks.
- Avoid military press, pull-ups, behind-the-neck pull-downs, and overhead triceps extensions when overhead strengthening begins; no barbell bench press or Olympic lifting before 6 months.

PHASED REHABILITATION

PHASE 1 — PROTECTION & STAGED PASSIVE MOTION		Weeks 0–6
GOALS	• Protect coracoid graft and subscapularis while soft tissue and bone heal • Achieve staged ROM targets without excess stretch • Control pain and inflammation	
INTERVENTIONS	• Sling 6 weeks including sleep; remove for hygiene and prescribed exercises • Weeks 0–3 PROM limits: forward elevation to 90°, ER in scapular plane to 20°; no abduction or IR range work • Weeks 4–6 PROM progression: forward elevation to 135°, ER to 30°, IR to 50°, abduction to 115° • Pendulums; AROM elbow (limit active biceps), wrist, and hand; scapular retraction and clocks • Traditional: submaximal isometrics for ER, abduction, flexion, extension only (no IR). Accelerated: add submaximal IR isometrics, progressing toward maximal and light band work by week 6 • No cross-body adduction, no active IR or IR behind the back (traditional), no weight bearing through the arm • Cryotherapy and pain management	
CRITERIA TO ADVANCE	• Appropriate radiographic/clinical healing per surgeon • Staged PROM targets achieved without forcing end range • Minimal pain with protected motion	

PHASE 2 — INTERMEDIATE: FULL MOTION & EARLY STRENGTH		Weeks 7–12
GOALS	• Restore full ROM in all planes by weeks 10–12 • Initiate progressive isotonic strengthening including IR • Normalize scapular control	
INTERVENTIONS	• ROM progression: weeks 7–9 forward elevation to 155°, ER at 90° abduction to 75°, IR at 90° abduction to 60°; weeks 10–12 ROM within normal limits all planes • Week 7: light upper-body ergometer; week 8: IR and ER resistance band work • Week 9: serratus anterior punches; rhythmic stabilization and scapular strengthening • Weeks 10–12: biceps curls, light dumbbell program, push-up progression in neutral position • Weeks 10–12: initiate jogging with physician clearance	
CRITERIA TO ADVANCE	• Full ROM achieved painlessly without substitution • Dynamic scapular control demonstrated • No anterior apprehension or instability symptoms	

PHASE 3 — ADVANCED STRENGTHENING		Weeks 12–20
GOALS	- Build strength and power toward $\geq 80\%$ of the uninvolved side - Introduce controlled overhead and plyometric loading - Prepare for sport-specific demands	
INTERVENTIONS	- Advanced isotonic program; keep elbows at or in front of the body midline early in the phase - Two-handed plyometrics progressing to ball catch/toss at 90° abduction - Week 16: initiate overhead strengthening; continue to avoid military press, pull-ups, and behind-the-neck loading - Neuromuscular and perturbation training for anterior stability - Month 4: initiate interval throwing program with surgeon clearance (overhead athletes)	
CRITERIA TO ADVANCE	- Muscular strength $\geq 80\%$ of unaffected side - Full functional ROM maintained - No pain or instability with plyometric loading	

PHASE 4 — RETURN TO SPORT		Weeks 16–28+
GOALS	- Return to full sport participation with objective clearance - Maintain strength, ROM, and neuromuscular control under sport-specific load	
INTERVENTIONS	- Sport-specific conditioning, agility, and contact-preparation progression - Continued throwing program progression for overhead athletes (return to competition ~9 months) - High-velocity strengthening and single-arm plyometrics with kinematic-chain (hip/core to shoulder) sequencing - Maintenance rotator cuff and periscapular program; transition to independent HEP	
CRITERIA TO ADVANCE	5/5 scapular and rotator cuff strength; strength symmetry $\geq 80\text{--}90\%$ - Full functional ROM with enhanced neuromuscular control - Non-contact sport 5–6 months; contact/collision sport and climbing minimum 6 months - Physician clearance; no subjective instability (outcome measures: DASH, KJOC)	

GUIDING PRINCIPLES

This protocol follows criterion-based progression over rigid time-based advancement; phased rehabilitation balancing tissue healing with controlled stress application; objective milestones (ROM, strength LSI, functional testing) to guide phase transitions; individualization based on surgical findings, tissue quality, and patient factors; and ongoing surgeon–therapist communication throughout recovery.

REFERENCES

1. Ohio State University Wexner Medical Center Sports Medicine. Open Latarjet for Anterior Stabilization Clinical Practice Guideline (Accelerated and Traditional). 2020. <https://medicine.osu.edu/-/media/files/medicine/departments/sports-medicine/medical-professionals/shoulder-and-elbow/accelerated-and-traditional-latarjet-2020.pdf>
2. Massachusetts General Hospital Sports Physical Therapy. Rehabilitation Protocol for Latarjet Repair. <https://www.massgeneral.org/assets/MGH/pdf/orthopaedics/sports-medicine/physical-therapy/rehabilitation-protocol-for-latarjet.pdf>
3. Brigham and Women's Hospital Department of Rehabilitation Services. Anterior Stabilization of the Shoulder: Latarjet Protocol. <https://www.brighamandwomens.org/assets/BWH/patients-and-families/rehabilitation-services/pdfs/shoulder-latarjet.pdf>

For clinical use by licensed physical therapists treating patients of Robert Pettit, MD. This document is a rehabilitation guideline, not a substitute for clinical judgment. Progression must be individualized based on intraoperative findings, tissue quality, and patient response. Scan the QR code for the current version of this protocol.