Chapter 3

SLAP LESIONS AND REHABILITATION

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INTRODUCTION

Superior Labrum Anterior Posterior (SLAP) lesions are important pathologies for physicians and physiotherapists. It should not be forgotten that all aspects of the pathology should be understood in order to comprehend the lesions and the necessary treatment. In this section general anatomy of the shoulder, SLAP lesions and types, clinical tests and appropriate treatment protocol will be explained.

ANATOMY

The shoulder girdle is composed of four joints: acromioclavicular, sternoclavicular, scapulothoracic and glenohumeral. The glenohumeral joint, which is crucial for the shoulder girdle, is also called the scapulohumeral joint. The joint, which has a wide range of motion, can be shown as an example of the ball-socket type joint (Ergun, 2015).

Glenohumeral joint contains some advantages and disadvantages. While the structural form has a wide range of motion, stabilization is limited. The stabilization of the joint is provided by static and dynamic stabilizers. Dynamic stabilizers can be shown as examples of rotator cuff muscles and the long head of biceps brachii, while the examples of static stabilizers can be ligaments, joint and joint capsule, negative intra-articular pressure and glenoid labrum. As a static stabilizer, it should not be overlooked that the fibrocartilaginous labrum is an important structure for the shoulder girdle (Wilk, Arrigo & Andrews, 1997). Glenohumeral joint articulation is composed of a shallow glenoid fossa and the humeral head. The incompatibility of the articular surface increases mobility and decreases stability. Labrum increases the depth of the glenoid fossa and contributes to stability (Demirhan & Göksan, 1993). It also provides an origin for the long head of biceps brachii. It should be noted that the glenohumeral ligament acts as an anterior

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are given. It should be noted that in standard protocols, range of motion are progressed more slowly than those of accelerated protocols. For 4-6 weeks covering phase 3, the previous phase applications are continuing and progressing to active assisted exercises. In the accelerated protocols, submaximal strengthening exercises might be started in this phase. In phase 4, which is between at 6-12 weeks, maximum isometric exercises are started. Posterior capsule stretching exercises could be performed beginning from tenth week. Towards the end of the phase, it is recommended to initiate to the preferred strengthening program (Throwers Ten, Body Blade exercises in neutral position, etc.). It was stated that Body Blade exercises not only strengthen the muscles according to the standard strengthening protocol, but also provide a serious proprioceptive input and affect non-contractile structures (Buteau, Eriksrud & Hasson, 2007). After 12 weeks, plyometric, perturbation and sport-specific exercises are performed in a controlled manner in phase 5. Accelerated protocols recommend 4-6 months for returning to sports, while standard protocols indicate 6 months and more (Kanatlı, Başar & Ataoğlu, 2014; Manske & Prohaska, 2010; Brotzman, 2011).

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