

PHYSICAL THERAPY PROTOCOL

Anterior Labral Repair (Bankart)

Arthroscopic Anterior Capsulolabral Repair for Traumatic Anterior Shoulder Instability

FOR THE PHYSICAL THERAPIST

Overview and Goals

This protocol governs rehabilitation following arthroscopic anterior capsulolabral repair (Bankart repair) for traumatic anterior shoulder instability. The repair restores the labral attachment to the antero-inferior glenoid rim and re-tensions the anterior-inferior glenohumeral ligament complex, which together resist anterior humeral head translation. Because the rotator cuff is intact, active-assistive ROM in safe planes can begin POD 1 within staged limits.¹

The framework is consistent with the 2010 ASSET Consensus Rehabilitation Guideline for Arthroscopic Anterior Capsulolabral Repair,¹ the 2025 BESS Critical Evidence Synthesis,² and contemporary sport-specific return-to-play surveys.^{3,4}

Three principles guide rehabilitation. First, protect the anterior capsulolabral repair from forces that drive anterior humeral head translation — most importantly, end-range external rotation at 90° abduction (the apprehension position), shoulder extension, and straight-plane abduction. These motions are restricted through Phase 2 (12 weeks). Second, permit early active-assistive ROM within safe planes from POD 1, since the cuff is not detached and stiffness is less of a concern in this population. Third, defer vigorous strengthening and high-load activities until 12 weeks minimum, consistent with capsulolabral healing rates.¹

Progression between phases is criterion-based. Time ranges represent typical windows, not gates. Patients who do not meet criteria should remain in the current phase regardless of elapsed time.

READ BEFORE STARTING — SCOPE OF THIS PROTOCOL

This protocol applies to arthroscopic anterior capsulolabral (Bankart) repair for anterior instability.

- If concomitant **remplissage** was performed, see the Remplissage note below — the protocol is largely unchanged, with only minor optional ER caveats.
- If the procedure was a **posterior labral repair**, use Dr. Roth’s Posterior Labral Repair protocol instead — the protected motions are mirror-image (IR, cross-body adduction, and forward flexion with the arm adducted).
- If **glenoid bone augmentation** (Latarjet, distal tibial allograft, iliac crest autograft) was performed for bone loss, use Dr. Roth’s Latarjet / Glenoid Bone Augmentation protocol instead, which has different early-phase restrictions and bone-healing considerations.

Rehabilitation Phases

PHASE	SLING	RESTRICTIONS	ROM GOALS	EXERCISES	CRITERIA TO ADVANCE
PHASE 1 Weeks 0–6 <i>Repair protection & early staged</i>	• Sling for 4 weeks, worn at all times including at night.^{1,2} • Remove only for	• No end-range ER at 90° abduction. • No shoulder extension. • No straight-plane	• Active-assistive ROM begins POD 1 within pain-free limits — staged in two sub-phases:^{1,3} Weeks 0–3: • Forward elevation in scapular plane to	Pain & edema control: • Cryotherapy, NSAIDs per Dr. Roth’s instructions, scar mobilization once incisions healed Active-assistive ROM (within phase limits): • Pendulum (Codman) — gentle,	• Pain controlled at rest and with prescribed AAROM • No effusion or inflammation around incision sites

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PHASE	SLING	RESTRICTIONS	ROM GOALS	EXERCISES	CRITERIA TO ADVANCE
<i>motion</i>	prescribed PT, hygiene, and elbow/wrist/hand exercises. At-home working zone (Weeks 0–3): - Operative arm may be used out of the sling for low-demand activities within a “belt-buckle to nose” zone — elbow at the side, hand within this vertical range (typing, eating, drinking, basic self-care). Keeps the arm out of repair-stressing positions (extension, abduction, end-range ER). - Sling must be worn for any standing or walking outside the home (fall risk). - After Week 4, sling weaning over 1–2 weeks.	abduction. - No lifting, pushing, pulling. - No supporting body weight through the operative arm. - No active ER stretching.	~90°. ER at side to ~30°. No ER at 90° abduction. Weeks 3–6: - Forward elevation to ~135°. ER at side to ~30–40°. Continue restriction on ER at 90° abduction. Begin gentle IR within comfort. Elbow / wrist / hand: - Full active ROM as tolerated	gravity-assisted - Supine AAROM forward elevation in scapular plane with wand or contralateral arm - Supine AAROM ER with wand at side (do not exceed phase limit) - Table slides (gentle, gravity-eliminated) - Wall-walks introduced cautiously after Week 3 Submaximal isometrics (arm at side, neutral): - Submaximal shoulder isometrics in all planes (ER, IR, flexion, extension, abduction) - Elbow isometrics - Scapular retraction isometrics with very light or no resistance Distal extremity: - Elbow, wrist, hand AROM; ball squeezes for grip preservation Avoid: - End-range ER at 90° abduction (the apprehension position) - Shoulder extension behind plane of body - Straight-plane abduction - Resisted exercises beyond submaximal isometrics - Forceful stretching at end ranges - Scapular protraction with horizontal abduction - Sling-off ambulation in public spaces (fall risk)	- Forward elevation ≥ 135° pain-free - ER at side ≥ 30–40° pain-free - Tolerates submaximal isometrics without anterior shoulder pain - Sling discontinued without arm guarding - Minimum 6 weeks elapsed
PHASE 2 Weeks 6–12 <i>Progressive ROM & neuromuscular control</i>	None.	No end-range ER at 90° abduction until Phase 3 (Week 12+) — the apprehension position; it stresses the repair throughout the	- Goal: full ROM in all planes by Week 12, except end-range ER at 90° abduction (end-state target is 90°, the “Statue of Liberty” position, reached gradually in Phase 3 — not Phase 2).¹³ Forward elevation: - Progress to full	Active ROM: - Continue Phase 1 AAROM with progressive range - Progressive AROM in all planes within phase limits - Pulleys, wand exercises - Aquatic AROM RTC & scapular neuromuscular control (within allowed ROM): - Theraband ER and IR at 0° abduction (yellow → red) - Side-lying dumbbell ER (1–2 lbs)	- Full or near-full pain-free ROM in all planes except end-range ER at 90° abduction - ER at 90° abduction approaching contralateral side, without apprehension - Pain ≤ 1/10 with all prescribed

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PHASE	SLING	RESTRICTIONS	ROM GOALS	EXERCISES	CRITERIA TO ADVANCE
		capsulolabral healing window.¹ - No vigorous or high-load activity. - No throwing, overhead sport, or contact activity.	ER at side: ~60° by Weeks 8–10, then symmetric by Week 12 ER at 90° abduction: - Introduce gradually starting Week 8 toward a 90° end-state in Phase 3; do not push toward 90° during Phase 2 Internal rotation: - Full progression including hand-behind-back Cross-body adduction: - Full Posterior tightness: - Address with cross-body stretching (preferred over sleeper stretch — see callout)	- Standing dumbbell ER in scapular plane - Forward punch with light band - Prone Y, T, W (gravity → light dumbbells) - Rows (low → moderate load) - Reverse flys, scapular pull-downs - Closed-chain (wall push-ups → quadruped → planks) Posterior shoulder tightness: - Cross-body stretching for IR gains (preferred) - Avoid sleeper stretch (see callout) Avoid: - End-range ER at 90° abduction - Aggressive ER stretching - Sleeper stretch - High-load or vigorous strengthening - Sport-specific drills, throwing, overhead activity	strengthening - Smooth scapulohumeral rhythm - Tolerates light isotonic RTC strengthening without anterior pain - Minimum 12 weeks elapsed before vigorous strengthening
PHASE 3 Weeks 12–24+ <i>Strengthening, dynamic stability & return to activity</i>	None.	- Resistance progresses gradually. - Sport-specific training initiated based on the patient's target activity. - Contact and collision activity deferred until Phase 3 criteria are met.	Full ROM in all planes. End-state target for ER at 90° abduction is 90° — the "Statue of Liberty" position (90° abduction, 90° ER).¹ This is the functional end-state goal; ER at 90° abduction beyond 90° is not pursued, even in overhead athletes. Introduced gradually starting Week 12.	Progressive strengthening (full intensity): - Theraband ER and IR progression (red → green → blue)^{1,2} - Combined IR/ER patterns at 90° abduction - Dumbbell progression for ER, IR, deltoid, periscapular muscles Compound movements: - Military press, lat pull-downs, push-up progressions, pull-ups (later phase) Dynamic stability & proprioception: - Plyometrics (medicine-ball wall throws, push-up plus) - Closed-chain perturbation training - Rhythmic stabilization at 90° flexion and 90° abduction - PNF patterns (D1, D2) Endurance training: - Progressive RTC and scapular endurance work - Sport-specific endurance demands Sport-specific progression: - Throwing program (interval throwing) for overhead athletes - Tennis serve, swimming stroke return - Contact sport: light contact drills → progressive contact → game readiness Residual deficits: - Address remaining ROM deficits early in Phase 3 with low-load prolonged stretching - Establish home maintenance program	<i>See Return-to-Activity Criteria section below.</i> Most patients return to non-contact sport at ~4 months; contact and collision sport at ~6 months.^{3,4}

Procedure-Specific Considerations

External Rotation at 90° Abduction Is the Protected Motion

The apprehension position — ER at 90° abduction — maximally stresses the anterior capsulolabral repair, because it drives the humeral head anteriorly into the repair. This is the central protected motion through Phase 2 (12 weeks). The end-state ROM target is 90° of ER at 90° abduction (the “Statue of Liberty” position) — not full or symmetric. ER at 90° abduction beyond 90° is not pursued, even in overhead athletes; the marginal ROM gain is not worth the recurrence risk. The 90°/90° target is reached gradually in Phase 3. Patients who report new-onset apprehension or anterior shoulder pain with ER progression in late Phase 2 or early Phase 3 should be re-evaluated to rule out capsulolabral compromise.^{1,2}

CONCOMITANT REMPLISSAGE — BRIEF NOTE

If concomitant remplissage was performed (suture anchors in the Hill-Sachs lesion with sutures passed through the infraspinatus tendon and posterior capsule to fill the humeral head defect), the rehabilitation protocol does not change. A 2021 survey of 317 shoulder surgeons found that 92.1% reported no change to return-to-play decision-making with the addition of remplissage.⁴ Meta-analyses (Tansey 2025, Villarreal-Espinosa 2024) show no significant difference in postoperative ROM — forward elevation, ER at side, ER at 90° abduction — between Bankart alone and Bankart + remplissage at final follow-up.^{5,6} Some cadaveric studies show increased construct stiffness with remplissage, but this has not translated into clinically meaningful ROM loss. Some surgeons elect to be slightly more conservative with early ER stretching given the infraspinatus capsulotenodesis, but no published evidence-based protocol modification exists. The standard Bankart protocol above is appropriate for both procedures.

Active-Assistive ROM Begins POD 1

The protected structures in this procedure are the labrum and anterior-inferior capsule, which are stressed by anterior translation forces (end-range ER at 90° abduction, shoulder extension behind the plane of the body, straight-plane abduction). Active-assistive ROM in safe planes — forward elevation in scapular plane, ER at side within phase limits — can begin POD 1 within the staged ROM limits.¹ Within these restrictions, smooth progressive AAROM through safe planes is the foundation of Phase 1.

Posterior Shoulder Tightness — Use Cross-Body, Not Sleeper Stretch

Patients with anterior instability frequently develop posterior shoulder tightness postoperatively, which limits internal rotation and can reproduce a GIRD-like pattern. The ASSET 2010 consensus specifically recommends cross-body adduction stretching to address this — and explicitly cautions against the sleeper stretch in this population.¹ The sleeper stretch positions the humerus in flexion + adduction + IR, which can drive the humeral head anteriorly against the still-healing repair. Cross-body adduction provides comparable IR gains without this anterior translation force. Use cross-body stretching from Phase 2 onward.

No Vigorous Strengthening Before Week 12 — Capsulolabral Healing Time

Capsulolabral healing requires approximately 12 weeks for sufficient construct integrity to support vigorous loading.^{1,2} Submaximal isometrics in Phase 1 and progressive neuromuscular control with light-to-moderate resistance in Phase 2 build foundational strength without compromising the maturing repair. Vigorous strengthening, plyometrics, and sport-specific high-load activity are deferred to Phase 3 (Week 12+) regardless of how strong or pain-free the patient feels at earlier time points.

Return-to-Activity Criteria

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Return to activity after anterior labral repair is criterion-based, with progression matched to the demands of the patient's target activity. The criteria below should be met before clearance to the corresponding activity tier. Per the 2010 ASSET consensus and a 2021 surgeon survey (Hurley et al., n = 317), most patients return to non-contact sport at ~4 months and contact/collision sport at ~6 months.^{1,4}

Activity Tier	Criteria & Timing
Activities of daily living (ADLs)	Full pain-free ROM in all planes (including end-range ER at 90° abduction). Typically by Week 12. Lifting up to 5 lbs at this point.
Light recreational (running, cycling, weight training without overhead loading)	Pain-free AROM, isotonic strength approaching the contralateral side, no apprehension. Typically ~3 months.
Non-contact sport (golf, tennis, swimming, rock climbing)	RTC strength symmetry approaching 90% on isokinetic or HHD testing, full pain-free overhead motion, no apprehension, sport-specific drill progression complete. Typically ~4 months.
Overhead athletes (throwing sports, volleyball)	Full strength symmetry (LSI ≥ 90%), pain-free overhead motion, ER at 90° abduction reaching 90° ("Statue of Liberty") without apprehension, interval throwing program complete. Typically ~5–6 months. Clearance by Dr. Roth required.
Contact / collision sport (football, rugby, hockey, lacrosse, wrestling, MMA)	Full strength symmetry, full ROM including end-range ER at 90° abduction without apprehension, completed sport-specific contact drill progression. Typically ~6 months; many surgeons add 2 months for collision athletes. Clearance by Dr. Roth required.
Strength & ROM benchmarks	RTC strength LSI ≥ 90% on isokinetic or HHD. Full pain-free ROM in all planes; ER at 90° abduction reaching 90°. No apprehension with apprehension-position testing. Sport-specific functional testing complete.

RECURRENCE RISK AND REALISTIC COUNSELING

Recurrence rates after arthroscopic anterior capsulolabral repair vary by population — pooled rates are approximately 5–15% in the general population but can exceed 20% in young, male contact athletes. Recurrence risk is highest in the first 12 months post-repair, particularly when patients return to contact sport before completing the full criteria-based progression. Patients should be counseled that criteria-based progression matters more than time-based gates, and that returning to contact sport at "the typical 6-month mark" without meeting strength and ROM benchmarks substantially increases recurrence risk.

References

1. Gaunt BW, Shaffer MA, Sauers EL, et al. The American Society of Shoulder and Elbow Therapists' Consensus Rehabilitation Guideline for Arthroscopic Anterior Capsulolabral Repair of the Shoulder. J Orthop Sports Phys Ther. 2010;40(3):155–168.
2. Wong C, Jaggi A, Willmore E, et al. Critical Evidence Synthesis on Rehabilitation Following Arthroscopic Shoulder Stabilisation Surgery for Traumatic Anterior Instability — Commissioned by the British Elbow & Shoulder Society. Br J Sports Med. 2025 (e-pub ahead of print).
3. Kelley TD, Clegg S, Rodenhouse P, Hinz J, Busconi BD. Functional Rehabilitation and Return to Play After Arthroscopic Surgical Stabilization for Anterior Shoulder Instability. Sports Health. 2022;14(5):733–739.
4. Hurley ET, Matache BA, Colasanti CA, et al. Return to Play Criteria Among Shoulder Surgeons Following Shoulder Stabilization. J Shoulder Elbow Surg. 2021;30(6):e317–e321.

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5. Tansey PJ, Clark DS, Ruelos VCB, Lindeman RW, Somerson JS. Arthroscopic Bankart Repair With Remplissage Results in Low Recurrent Instability Rates Without Reducing Shoulder Range of Motion at Midterm Follow-Up: A Systematic Review of Studies With Minimum 5-Year Outcomes. Am J Sports Med. 2025 (e-pub ahead of print).
6. Villarreal-Espinosa JB, Kay J, Ramappa AJ, et al. Arthroscopic Bankart With Remplissage Results in Lower Rates of Recurrent Instability With Similar Range of Motion Compared to Isolated Arthroscopic Bankart for Anterior Glenohumeral Instability: A Systematic Review and Meta-Analysis. Knee Surg Sports Traumatol Arthrosc. 2024;32(2):243–256.

Glossary

AAOS — American Academy of Orthopaedic Surgeons.

AAROM — Active-assisted range of motion; the patient initiates motion with assistance from gravity, pulley, wand, or therapist.

ADL — Activities of daily living.

AROM — Active range of motion; the patient moves the joint independently against gravity.

ASSET — American Society of Shoulder and Elbow Therapists; published the 2010 consensus rehabilitation guideline for arthroscopic anterior capsulolabral repair.

ER — External rotation.

GIRD — Glenohumeral internal rotation deficit; loss of internal rotation relative to the contralateral shoulder, often from posterior tightness.

HHD — Hand-held dynamometer; a portable device for objective strength measurement.

IR — Internal rotation.

LSI — Limb Symmetry Index; the operative limb's strength as a percentage of the contralateral limb ($\text{operative} \div \text{contralateral} \times 100$).

PNF — Proprioceptive neuromuscular facilitation; diagonal movement patterns (D1, D2) used in rehabilitation.

POD — Postoperative day.

PROM — Passive range of motion; the therapist or contralateral limb moves the joint while the patient stays relaxed.

ROM — Range of motion.

RTC — Rotator cuff.



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Dr. Roth completed his orthopaedic surgery residency at Harvard Medical School and his sports medicine fellowship at the Kerlan-Jobe Orthopaedic Clinic in Los Angeles. In practice since 2013, he specializes in advanced arthroscopic techniques and sports medicine procedures, and sees patients at Palo Alto Medical Foundation's Palo Alto and Dublin offices. He welcomes calls from physical therapists about his patients or this protocol.

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