CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

REHABILITATION PROTOCOL

AC Joint Stabilisation — Rehabilitation Protocol

This protocol covers the rehabilitation after acromioclavicular (AC) joint stabilisation with Dr Kieran Hirpara at Mater Private Hospital Rockhampton — surgery that restores the alignment of the joint between the collarbone and the shoulder blade after a dislocation, using a suspensory device, sometimes with a tendon graft. Bring this page or its PDF to your first physiotherapy visit so your rehabilitation stays coordinated. Your rehabilitation is progressed individually by your physiotherapist through the phases below, depending on how your shoulder progresses.

If you have any concerns about your wound after surgery, get in touch with the rooms. It is often helpful to take a photo of the wound and email it for review.

What to expect

AC joint stabilisation is different from most keyhole shoulder surgery: there is a repair that must be protected while it heals, and the thing that loads it most is simply the weight of your own arm. Gravity constantly pulls the arm — and with it the shoulder blade — downwards, away from the collarbone, which is exactly the direction the stabilisation has to resist. Early rehabilitation is therefore deliberately protective: the sling carries the weight of the arm, movement is kept within safe limits, and strengthening waits until the repair has matured.

The sling is protective. Wear it for **6 weeks**, and for the first **three weeks** keep it on while sleeping too — even lying down, the weight of the arm pulls on the repair. After three weeks it can come off in bed. When the sling is off for washing or exercises, keep the arm supported — rest the forearm on a pillow or table rather than letting the arm hang or carry anything. At night, most people are most comfortable on their back or on the non-operated side; if you lie on your back, a small pillow under the elbow and forearm stops the shoulder sagging backwards. Avoid lying on the operated shoulder while the repair heals.

You must not drive while you are wearing a sling. For this operation that usually means about six weeks.

Your exercise program uses three kinds of movement, and your team will mark which apply to you:

- **Active range of motion** — movement is allowed without aid or help.
- **Active-assisted range of motion** — using the other arm or an object to assist with moving the arm.
- **Passive range of motion** — completely relaxed, using the other arm or force to do 100% of the work.

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The journey at a glance:

- **Phase I – Protecting the repair** – weeks 0–6
- **Phase II – Restoring your movement** – weeks 6–12
- **Phase III – Strengthening** – weeks 12–18
- **Phase IV – Return to sport and heavy work** – week 18 onwards

The week ranges are typical rather than fixed – published protocols for this operation vary, and your physiotherapist will progress you on how the repair and your movement are going, not on the calendar. Most people are using the arm for normal daily activities by around three months. Return to contact and collision sport typically takes around four to six months, and for some sports and occupations the build-up runs longer.

Phase I – Protecting the repair (Weeks 0–6)

The first six weeks are about letting the repair heal while keeping the rest of the arm moving. The sling carries the weight of the arm whenever you are up and about. Your hand, wrist and elbow should keep moving from day one – use the hand for light tasks such as writing and eating while the arm is in the sling. The shoulder itself starts with gentle pendulum exercises and assisted movements within strict limits: nothing above shoulder height, no reaching across your body, and no reaching behind your back. Ice and regular pain relief make the exercises manageable – take your painkillers before your exercises and physiotherapy sessions. You can shower once your wound care advice allows; to wash under the operated arm, bend forward at the waist and let the arm fall gently away from the body, the same position as the pendulum exercise.

During this phase, do not lift anything heavier than about half a kilogram with the operated arm, do not carry bags on that side, do not lean on the arm or use it to push yourself up from a bed or chair, and do not let the arm hang unsupported – each of these pulls the shoulder blade down away from the collarbone and loads the repair.

For your physiotherapist:

Goals

- Protect the surgical stabilisation and allow soft-tissue healing
- Control pain and swelling; protect wound healing
- Prevent shoulder stiffness within the protected ranges
- Maintain hand, wrist, elbow and neck range of motion

Management

- Sling for 6 weeks whenever up and about; arm supported when the sling is off
- Pendulum exercises several times daily
- Passive and active-assisted elevation in the plane of the scapula, limited to 90 degrees
- Passive and active-assisted external rotation as comfort allows (initially to around 30 degrees)

- Hand, wrist, elbow and forearm active range of motion; ball squeeze
- Scapular setting — retraction and depression — and postural correction
- Sub-maximal, pain-free isometric internal and external rotation in neutral as tolerated
- Soft-tissue and scapulothoracic mobilisation as indicated; scar massage once the wound has healed
- Ice 15–20 minutes, several times daily, as needed; analgesia before exercises and sessions

Precautions

- Do not let the weight of the arm pull on the fixation — no hanging arm, no carrying, no downward traction
- No elevation above 90 degrees in any plane
- No active shoulder range of motion beyond the prescribed assisted program
- No cross-body (horizontal) adduction and no internal rotation behind the back
- No lifting heavier than about half a kilogram; no supporting body weight through the arm
- No driving while in the sling

Criteria to progress

- Around 90 degrees of passive flexion in the plane of the scapula
- Around 30 degrees of passive external rotation in the plane of the scapula
- Tolerating the range-of-motion and isometric program, with pain and swelling settling

Phase II — Restoring your movement (Weeks 6–12)

From about six weeks you wean out of the sling and the limits on movement are progressively lifted. Assisted movements become active ones, and range builds steadily — as a guide, published protocols progress range in roughly 15-degree steps each week, aiming for full movement by about week 12. Light elastic-band exercises for the rotator cuff and shoulder blade muscles begin during this phase. The repair still needs respect: keep lifting to about a kilogram, and avoid forceful pushing and pulling, push-ups, and lifting across the body or overhead. Reaching behind your back is usually the last movement to be freed up.

For your physiotherapist:

Goals

- Wean from the sling
- Progressively restore active range of motion in all planes (full, or near-full, by around week 12)
- Begin gentle strengthening; minimise muscle atrophy
- Re-establish scapulohumeral rhythm and neuromuscular control

Management

- Progress active-assisted to active elevation; wall slides and countertop slides into flexion

- Elevation in the scapular plane with attention to scapular mechanics — no hitching
- Behind-the-back internal rotation introduced gradually (to the beltline initially)
- Horizontal adduction as active reach only — no passive stretch yet
- Theraband internal and external rotation, biceps curl, row and serratus punch
- Dynamic scapular and cuff work: side-lying external rotation, prone row, prone extension, prone 'T's and 'Y's, standing scaption
- Proprioception and rhythmic-stabilisation drills
- Manual therapy and joint mobilisation as indicated

Precautions

- No lifting heavier than about a kilogram with the operated arm
- No forceful pushing or pulling; no push-ups
- No lifting of weighted objects overhead or across the body
- Avoid end-range stretching into cross-body adduction; behind-the-back movement progresses gradually

Criteria to progress

- At least around 140 degrees of passive flexion and 60 degrees of passive external rotation in the scapular plane
- Active flexion against gravity to at least around 100 degrees with good mechanics
- Tolerating the active range-of-motion and early strengthening program

Phase III — Strengthening (Weeks 12–18)

With the repair matured and movement largely restored, attention turns to rebuilding strength. The stretches that were off-limits earlier — across the body and up behind the back — are now used to win the final degrees of range. Resistance work progresses from elastic bands to light weights, and push-ups begin against a wall before progressing. Gym-based weight training is typically reintroduced from about week 16, with limited range and light loads at first. Heavy overhead lifting and forceful pushing and pulling are still avoided in this phase.

For your physiotherapist:

Goals

- Full active and passive range of motion in all planes
- Progressive strength, endurance and neuromuscular control of the cuff and scapular stabilisers
- Prepare for a graduated return to sport-specific loading

Management

- Multi-directional end-range stretching: cross-body stretch, behind-the-back internal rotation, hands-behind-head, sleeper stretch, external rotation at 90 degrees of abduction
- Progressive resistance (roughly 0.5–2.5 kg) added to the dynamic program: side-lying external rotation, prone row, prone extension, prone 'T's and 'Y's, standing scaption
- Theraband progressions: 'T's, 'W's, diagonals, internal and external rotation at 90 degrees
- Closed-chain work: wall push-ups from around week 12, progressing per tolerance
- Machine-based weight training from around week 16 — limited range, light load (rows, pull-downs, biceps and triceps; pressing reintroduced cautiously)
- Rhythmic stabilisation, proprioception and scapulohumeral-rhythm drills

Precautions

- Avoid heavy lifting, particularly overhead, and forceful pushing and pulling
- Strengthening stays pain-free and stops short of provocative end-range loading
- Maintain scapular control through range — regress the load if hitching or compensation appears

Criteria to progress

- Active and passive shoulder motion within functional limits in all directions
- Tolerating the progressive strengthening program without flare-up

Phase IV — Return to sport and heavy work (Week 18 onwards)

The final phase is a graduated return to strenuous work, overhead loading and sport. Plyometric and sport-specific drills are layered onto the strengthening program, and interval programs guide the return to throwing, swimming, golf and racquet sports. Return to contact and collision sport typically takes around four to six months from surgery — it depends on regaining full movement, strength and confidence in the arm, and published programs for collision athletes sometimes run longer, up to around nine months. Strength athletes typically rebuild towards their usual training over a similar timeframe. Your physiotherapist and surgeon will guide the final clearance, and some collision athletes choose to wear a shoulder brace for the first season back.

For your physiotherapist:

Goals

- Maintain full range of motion
- Progress strength, power and endurance to the demands of the patient's work and sport
- Graduated, criteria-based return to contact and overhead sport

Management

- Continue and progress the Phase III strengthening program
- Closed-chain progressions: push-up progression to unstable surfaces, ball-on-wall work
- Plyometrics for throwing and overhead athletes: rebounder throws, weighted-ball work, wall dribbles, deceleration drills
- Interval sport programs for throwing, golf, tennis and swimming
- Function- and occupation-specific kinetic-chain strength and endurance

Precautions

- Return to contact and collision sport only with full range, restored strength and surgical clearance
- Progression remains symptom-guided — if pain or a sense of instability appears, step back a stage

After your protocol

The phases above are drawn from published rehabilitation protocols for AC joint stabilisation and reconstruction — Massachusetts General Brigham Sports Medicine, the Massachusetts General Hospital sports medicine AC joint reconstruction program, the ACJ stabilisation guidelines of UK shoulder units, and a systematic review of publicly available AC joint reconstruction protocols. The week ranges are typical rather than fixed, and published programs vary — your ongoing rehabilitation is guided individually by your physiotherapist, working with the practice, based on how your repair and movement recover. This page works alongside the practice's general recovery advice — see managing post-operative pain and wound care. For the operation itself and the injury it treats, see AC joint stabilisation.

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