CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

REHABILITATION PROTOCOL

Distal Clavicle Excision — Rehabilitation Protocol

This protocol guides your recovery after arthroscopic distal clavicle excision (also called AC joint excision, or the Mumford procedure) with Dr Kieran Hirpara at Mater Private Hospital Rockhampton. Each phase below opens with a plain-English explanation of what matters most, followed by the structured protocol written **for your physiotherapist** — bring this page or its PDF to your first physiotherapy visit so your rehabilitation stays coordinated. Your physiotherapist will progress you through the phases based on how your shoulder is recovering, not on the calendar.

This protocol is for an **isolated** distal clavicle excision. If your operation also included a rotator cuff repair, follow the rotator cuff repair protocol instead — the repaired tendon sets a slower pace. (Distal clavicle excision is also commonly combined with a subacromial decompression; the protocol below applies equally in that case.)

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

Distal clavicle excision removes a few millimetres of bone from the end of the collarbone, so the worn surfaces of the AC joint — the small joint on top of your shoulder — no longer grind against each other. Nothing is repaired that needs protecting while it heals, so rehabilitation moves quickly: the sling is for comfort only and most people are out of it within the first week or two, movement starts straight away, and the published protocols for this operation all push towards early motion rather than rest.

Two things are specific to this operation and shape the protocol:

- **Reaching across your body is the slow mover.** Cross-body (horizontal adduction) movements compress the area where the bone was removed, so they are often the last movements to feel comfortable. Early on they are deliberately avoided, then reintroduced gradually.
- **Heavy pressing comes last.** Exercises that load the AC joint hard — bench press, dips and push-ups — are the final things to return, typically over three to four months. Most other activities come back well before that.

The journey at a glance:

- **Phase I — Early recovery and movement** — week 0–2

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- **Phase II – Restoring your range** – week 2–6
- **Phase III – Strengthening and return to activity** – week 6–12
- **Phase IV – Return to full activity** – week 12 onwards

Most people are using the arm for light everyday tasks within the first couple of weeks, back to most normal activities by four to six weeks, and back to sport and heavier work somewhere between eight and twelve weeks. Athletes in repetitive overhead sports – throwing, swimming, tennis – typically take a little longer, in the range of two to four months.

Phase I – Early recovery and movement (Week 0–2)

The first two weeks are about settling pain and swelling while getting the shoulder moving. Use ice regularly – three to four times a day is typical in the first week or two. The sling is for comfort only: wear it as much or as little as it helps, take the arm out often, and stop using it as soon as you are comfortable without it. Many people find it most useful when out of the house, to stop people bumping the arm. Do not drive while you are wearing the sling.

Start moving straight away: your elbow, wrist and hand should be moving from day one, along with gentle pendulum exercises and assisted shoulder movements – using your other arm, a stick or a pulley to help the operated arm upwards and outwards. Take your painkillers before your exercises and before physiotherapy appointments. The one movement to leave alone for now is reaching across your body towards the opposite shoulder.

For your physiotherapist:

Goals

- Settle pain and swelling
- Early range of motion – approximately 140° of forward flexion and 40° of external rotation at the side by the end of the phase
- Independence with the home exercise program

Management

- Sling for comfort only – wean and discontinue within the first 1–2 weeks, as comfort allows
- Cryotherapy 3–4 times daily, especially after exercise
- Immediate active range of motion of the neck, elbow, forearm, wrist and hand
- Pendulum exercises from day one
- Passive and active-assisted shoulder range of motion as tolerated – forward elevation, external rotation and behind-the-back internal rotation, using pulleys, a wand or cane, and supine gravity-assisted positions
- Scapular setting and periscapular range of motion; attention to scapulohumeral rhythm from the start
- Grip strengthening; gentle shoulder isometrics as pain allows

- Analgesia before exercises and physiotherapy sessions
- Home program performed 3–5 times daily

Precautions

- Avoid cross-body (horizontal) adduction
- No resisted shoulder exercise beyond gentle isometrics
- No lifting beyond light everyday items; no weight-bearing through the arm (pushing up from a chair or bed)
- No driving while wearing the sling

Criteria to progress

- Sling discarded and pain settling
- Comfortable assisted elevation to approximately 140° and external rotation to approximately 40°

Phase II — Restoring your range (Week 2–6)

With the sling gone, this phase works the shoulder towards full movement in all directions — assisted movements first, then under the arm's own power. Once your movement is close to full, gentle strengthening of the rotator cuff and shoulder blade muscles begins with elastic bands and light weights. Use the arm normally for daily activities, but keep lifting modest — no more than about 5 kg — and hold off on anything that presses or loads the arm hard. Reaching across your body is reintroduced gradually during this phase as comfort allows; some pinching awareness at the end of that movement is common and settles with time. Many people find heat before stretching and ice afterwards helpful, and lighter lower-body exercise such as walking, an exercise bike or jogging typically resumes from about week four.

For your physiotherapist:

Goals

- Full, or near-full, active range of motion in all planes by the end of the phase
- Normalised scapulohumeral kinematics
- Commence rotator cuff and periscapular strengthening once active range is near full

Management

- Progress passive and active-assisted range of motion to active range in all planes — flexion and scapular-plane elevation towards full, external rotation at the side and at 90° of abduction as tolerated, internal rotation behind the back with gentle posterior capsular stretching
- Reintroduce cross-body adduction range gradually, guided by symptoms
- Manual therapy and glenohumeral mobilisation as indicated
- Progress from isometrics to elastic-band rotator cuff and scapular stabiliser strengthening once active range of motion is near full — high repetitions, low load

- Heat before and ice after sessions as preferred; analgesia before exercises
- Graduated return to normal daily activities; light lower-body conditioning (walking, stationary bike, jogging) from approximately week 4

Precautions

- Keep lifting light — approximately 5 kg or less on the operated side
- Avoid loaded end-range horizontal adduction and positions of impingement
- No pressing exercises — bench press, dips, push-ups
- Defer combined abduction–rotation (90/90) stretching if the shoulder is irritable

Criteria to progress

- Full or near-full active range of motion without significant discomfort
- Band strengthening tolerated without flare-up of pain

Phase III — Strengthening and return to activity (Week 6–12)

With full movement back, attention turns to rebuilding strength and getting you back to what you do. Resistance work progresses from bands to dumbbells for the rotator cuff, deltoid and shoulder blade muscles, and exercise becomes more functional — gym work, swimming, a graduated throwing program for throwers, and a staged return to work duties and sport. Most people return to sport and heavier work during this phase, between roughly eight and twelve weeks, guided by comfort and strength rather than the calendar. The pressing exercises that load the AC joint most — bench press, dips and push-ups — are the last to be reintroduced, starting light and shallow.

For your physiotherapist:

Goals

- Restore strength, endurance and neuromuscular control of the shoulder girdle
- Graduated return to work duties, recreational activity and sport-specific training

Management

- Progressive resistance for the rotator cuff, deltoid and scapular stabilisers — bands to light dumbbells, typically 2–3 sets of 8–15 repetitions
- Add eccentric work, closed-chain exercise and, late in the phase, plyometric drills where relevant to the patient's sport
- Functional and sport-specific training — swimming, interval throwing program for throwers, sport drills under controlled conditions
- Graduated return to full work duties and sport, criteria-based

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Precautions

- Reintroduce AC-loading presses (bench press, dips, push-ups) last — begin light, with reduced range, and avoid the elbows dropping below or behind the line of the body
- Progression remains symptom-guided — an irritable AC joint settles with a short step back in load, not by pushing through

Criteria to progress

- Full, pain-free functional range of motion
- No pain or tenderness over the operated area with loading
- Strength approaching the other side on testing

Phase IV — Return to full activity (Week 12 onwards)

The final phase is the return to unrestricted activity. Day-to-day life and most sport are usually back well before this point; what remains is the heaviest end of loading. Pressing strength in the gym is rebuilt progressively, and returning to previous bench press performance can take up to about four months. Athletes in repetitive overhead sports are progressed back over roughly two to four months from surgery. Full return to sport and heavy work is confirmed at your follow-up review, based on full movement, comfortable loading and a satisfactory examination.

For your physiotherapist:

Goals

- Unrestricted return to work, gym and sport
- Maintain shoulder girdle strength and mechanics in the long term

Management

- Advance gym- and sport-specific conditioning as tolerated, including progressive heavy pressing with attention to technique that limits AC joint strain (controlled depth, elbows not travelling behind the body line)
- Complete interval throwing and overhead-sport progressions where relevant

Precautions

- Progression remains symptom-guided — recurrent aching over the AC area with a particular lift is a signal to adjust load or technique before progressing

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After your protocol

The phases above are adapted from published rehabilitation protocols for distal clavicle excision — Saint Louis University Department of Orthopaedic Surgery, University of Utah Sports Medicine, Sports Surgery New York, Palm Beach Orthopaedic Institute, OrthoVirginia and Specialty Physicians of Illinois — with the week ranges expressed as typical rather than fixed. Your rehabilitation is guided individually by your physiotherapist, working with the practice, based on how your shoulder recovers. This page works alongside the practice's general recovery advice — see managing post-operative pain and wound care. For the operation itself, see distal clavicle excision.

REFERENCES

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