

THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

REHABILITATION GUIDE FOLLOWING ACROMIOCLAVICULAR JOINT STABILISATION

(This is not an exhaustive list of all rehabilitative techniques or therapies and this should not over rule any clinical judgement)

Indication

Stabilisation of the acromioclavicular joint

Case profile

Patients with pain from a disrupted and unstable acromioclavicular joint
Failure of non-operative treatment with minimum of 3/12 from injury

Procedures

Modified weaver-Dunn procedure
LARS ligament procedure
Surgilig procedure

Post Operative Protocol Summary

Sling 6/52

Active assisted flexion to 90° 6/52

Active assisted abduction to 60° for 2/52, then progress abduction to 90° for 2-6/52

NO resistance 6/52 (other than 30% submaximal cuff in neutral)

**** NO PENDULAR EXERCISES**

TIMESCALE	REHABILITATION EXERCISES	GOALS
Day 1 – 2 weeks	<ul style="list-style-type: none"> Elbow, wrist and hand exercises Postural awareness and scapula setting AAROM, as comfortable-flexion only to 90° abduction to 60° Core stability exercises as appropriate 	<ul style="list-style-type: none"> Check if specific post-operative instructions have been given and amend the guide accordingly Good understanding of post- operative rehabilitation No complications following surgery Control of pain with adequate pain relief Normal sensation returned to limb Use of hand for light functional activity

		<ul style="list-style-type: none"> • In the first phase of rehabilitation the protocol is based on maintaining integrity of repair and scapula stabilisation NOT ROM or Strengthening • Education and advice on self-monitoring /management of sensation, skin colour, circulation, temperature • Commence scar management at 10 days • Maintain low level cardiovascular fitness
<u>2 – 6 weeks</u>	<ul style="list-style-type: none"> • Increase AAROM abduction to 90° • Continue with all above exercises • Isometric cuff exercises less than 30% Maximal Voluntary Contraction 	<ul style="list-style-type: none"> • Control of swelling and pain • Active elevation to 90° by 6/52 • Return to sedentary work as tolerated
<u>6 – 8 weeks</u>	<ul style="list-style-type: none"> • Regain scapula and gleno humeral stability for shoulder joint control rather than range • Gradually increase ROM above 90° active assisted then active • Commence Level 1 exercises • Progress dynamic scapula control • Increase proprioception through open and closed chain exercises • Progress core stability 	<ul style="list-style-type: none"> • Correction of abnormal movement patterns • Return to driving 6/52 safe from surgical perspective but competency to drive is the responsibility of the individual patient
<u>8 – 12 weeks</u>	<ul style="list-style-type: none"> • Progress active ROM through full range • Progress rotator cuff rehabilitation (appropriate Level 2 exercises) 	<ul style="list-style-type: none"> • Full ER at the side by 12/52 • Normal movement pattern through range by 12/52 • Breast stroke swimming 8/52 • Freestyle swimming 12/52 • Lifting after 8/52

		<ul style="list-style-type: none"> • Heavy lifting after 12/52 • JAMAR grip strength measure correlates with global UL strength • Y balance test • Posterior shoulder endurance test (1-2kg wt repeated prone lying abd to fatigue then compare to contralateral side) • Global joint mobility and stability assessment using functional movement screen
<u>12 weeks onwards</u>	<ul style="list-style-type: none"> • Progress scapula stabilisation programme • Level 3 exercises 	<ul style="list-style-type: none"> • Ensure scapula dynamic control through full ROM • Return to manual work after 12/52 • Return to contact sports 6/12 • Cycling after 3/12 • Golf 3/12 • CKQUEST (plank touch test) >21 touches in 15 seconds • Single arm hop test • Psychological readiness to return to sport scale

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