Rehabilitation Guideline for Acromioclavicular Joint Reconstruction (including Coracoclavicular Ligament Reconstruction)

This guideline is intended to guide clinicians through the post-operative course for acromioclavicular joint reconstruction (with or without coracoclavicular ligament reconstruction). This guideline is time based (dependent on tissue healing) as well as criterion based. Specific intervention should be based on the needs of the individual and should consider exam findings and clinical decision making. The timeframes for expected outcomes contained within this guideline may vary based on surgeon's preference, additional procedures performed, and/or complications. If a clinician requires assistance in the progression of a post-operative patient, they should consult with the referring surgeon.

The interventions included within this guideline are not intended to be an inclusive list. Therapeutic interventions should be included and modified based on the progress of the patient and under the discretion of the clinician.

Considerations for the Post-operative Care in Acromioclavicular Joint Reconstruction
Many different factors influence the post-operative acromioclavicular joint reconstruction rehabilitation outcomes, including possible coracoclavicular ligament reconstruction. It is recommended that clinicians collaborate closely with the referring physician regarding modifications in the rehabilitation course.

Post-operative considerations
If you develop a fever, unresolving numbness/tingling, excessive drainage from the incision, uncontrolled pain or any other symptoms you have concerns with, please contact referring physician.

PHASE I: IMMEDIATE POST-OP (0-6 WEEKS AFTER SURGERY)

Rehabilitation Goals	• Protect the surgical repair • Control pain and swelling • Protect wound healing • Prevent shoulder stiffness

Sling/precautions (adjust this section as appropriate)	• Sling
	  ○ Wear it most of the time for the first 2 weeks.
	  ○ Sleep with the sling on.
	  ○ More instructions will be given at the first post-op appt.
	  ○ Remove the sling to shower and for PT exercises.
	  ○ For washing under the affected arm, bend forward at the waist and let the arm hang passively, same position at the pendulum exercise.
	• Avoid active shoulder range of motion
	• Avoid reaching behind the back
	• Avoid reaching across the body
	• Avoid passive shoulder range of motion >90 degrees in any direction
	• Avoid lifting of objects
	• Avoid supporting of body weight
	• Ice as needed for pain control

Intervention	*Manual Therapy* • Soft tissue mobilization as indicated • GH, ST joint mobilization as indicated • Scar mobilization once incision healed

	Mobility/ROM • Pendulum • Supine assisted shoulder flexion to 90 degrees • Supine assisted shoulder external rotation • Isometric shoulder internal rotation • Isometric shoulder external rotation • Elbow and forearm AROM • Scapular retraction
Criteria to Progress	• Has achieved 90 degrees of passive shoulder flexion in the plane of the scapula. • Has achieved 30 degrees of passive shoulder ER in the plane of the scapula. • Tolerating range of motion and isometrics exercises.

PHASE II: INTERMEDIATE POST-OP (7-12 WEEKS AFTER SURGERY)

Rehabilitation Goals	• Protect the surgical repair • Improve shoulder range of motion • Minimize muscle atrophy • Improve neuromuscular control
Sling/precautions	• Sling: wean out of the sling unless otherwise instructed • No lifting objects heavier than 1lb • Avoid forceful pulling/pushing • Avoid reaching behind your back
Additional Interventions **Continue with Phase I interventions*	*Mobility/ROM* • Counter top slides into flexion • Wall walks/slides • Sidelying internal rotation stretch *Strengthening* • Sidelying external rotation • Prone row • Prone shoulder extension • Prone 'T' • Prone 'Y' • Standing scaption ○ *Theraband Strengthening* • Internal rotation • External rotation • Biceps curls • Serratus punch
Criteria to Progress	• Tolerates P/AAROM/AROM program progression. • Has achieved at least 140 degrees PROM flexion in the scapular plane. • Has achieved at least 60 degrees PROM into ER in the scapular plane. • Can actively flex shoulder in the scapular plane against gravity to at least 100 degrees with good mechanics.

PHASE III: LATE POST-OP (13-18 WEEKS AFTER SURGERY)

Rehabilitation Goals	• Protect the surgical repair • Regain full range of motion • Improve strength and stability
Precautions	• Avoid lifting objects heavier than 2-3 pounds

	• Avoid any weighted lifting overhead • Avoid forceful pushing/pulling
Additional Interventions **Continue with Phase I-II Interventions*	*Manual Therapy* • Rhythmic stabilization, proprioception, and scapulohumeral rhythm exercises performed in clinic *Mobility/ROM* • Hands-behind-head stretch • Behind the back internal rotation • Cross-body stretch *Strengthening Progression* • Add progressive resistance 1-5 pounds to sidelying external rotation, prone row, prone shoulder extension, prone T, prone Y, standing scaption • W's • External rotation and internal rotation at 90 degrees scaption *Closed Kinetic Chain Strengthening* • Wall pushups
Criteria to Progress	• Tolerates progression of stretching/ROM/strengthening • Active and passive shoulder motion within functional limits in all directions

PHASE IV: ADVANCED STRENGTHENING (19+ WEEKS AFTER SURGERY)

Rehabilitation Goals	• Maintain full range of motion • Continue strengthening • Improve tolerance for functional activities • Advance sports and recreational activity (when recommended)
Additional Interventions **Continue with Phase II-III interventions*	*Closed Kinetic Chain Strengthening/Plyometrics* • Pushup progression: progress to traditional, then to unstable surface • Ball on wall • Rebounder throws at side, progress to weighted ball • Wall dribbles – overhead, circles
Criteria to Progress	• Independent self-management of symptoms. • Demonstrate appropriate understanding of condition and maintenance to prevent risk of recurrence.

Revised October 2021

Contact	Please email MGHSportsPhysicalTherapy@partners.org with questions specific to this guideline

References:

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2. Millet PJ, Braun S, Gobezie R et al. Acromioclavicular joint reconstruction with coracoacromial ligament transfer using the docking technique. BMC Musculoskeletal Disorders 2009-01-14; 10:6.
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