

## Arthroscopic Rotator Cuff Repair (Medium to Large Tears) Rehabilitation Guideline

This rehabilitation protocol serves only as a general information guideline for patients and may be individually modified by the surgeon depending on the preoperative chronicity of the tear, health of the patient and their tissues as well as the presence of postoperative risk factors. The rehabilitation program is designed in a stepwise fashion to progressively allow more activity because in the current world, the healing of the rotator cuff takes time and cannot be accelerated. If you develop a fever, excessive drainage from the incision or new and excessive pain then contact the surgeon.

### Phase I: (Week 1 through Week 8)

- Protect the repair. Reduce swelling and minimize pain
- Maintain Active range of motion (AROM) of the involved fingers, wrist and elbow but keep the upper arm next to your side (adducted).
- Can be out of the sling as long as you don't actively reach with the upper arm away from the side.
- Ice frequently (at least 20 minutes on 5x/day for the first 5 days and then as needed.) Keep a towel between your skin and the ice to protect the skin.
- No lifting. (Nothing more than a "pen or a teacup" in the operative arm until the strengthening phase is started.
- No weight-bearing or pushing off (e.g. To get out of bed) with the operative arm.
- At week 1, begin supine passive forward elevation in the plane of the scapula (using the nonoperative arm to hold the operative arm in support. The nonoperative arm does all the work, passively flexing the operated shoulder up in forward elevation and back down. Perform these 5 minutes 5x/day or 1 minute every hour while awake.
- Also Begin Supine Passive External rotation with the upper arm next to the side and using a cane or stick for this. The surgeon may restrict the amount of External Rotation allowed in degrees past neutral (forearm pointing straight ahead) depending on the intraoperative status and health of the Subscapularis rotator cuff tendon. Please see the pictures of these exercises in the "EXERCISES" Section.
- 2 weeks after the sutures are removed, you could start scar massage with any moisturizer (CeraVe, Vaseline Intensive Care, Vitamin E ointment) as long as there is no drainage from the incisions and incisions look to be healing well.

## Phase 2: (Week 8 through Week 12)

- Continue to emphasize the PROM (supine passive range of motion) stretching routine but now add AROM (active range of motion) which means actively reaching above in the plane of the scapula (see EXERCISES section for pictures) with the upper arm away from the side for full Forward elevation and External Rotation.
- Can start Wall walks (sliding the hand up the wall while facing the wall, stretching, and then actively lifting hand away from the wall, if possible, when fully elevated. Can always use the wall or your other arm to support the operative arm while coming down.
- Still maintain Non-Weight-bearing/No pushing off with the operative arm.

## Phase 3: (week 12 through 24)

- Continue all the above PROM supine stretching, AAROM (wall walks) and AROM exercises for the operative shoulder. (1 minute every hour while awake)
- Add cuff and parascapular strengthening exercises (see Exercise Sheet) with therapy bands 3 days per week
- No lifting of heavy objects greater than 10 lbs. until directed by Surgeon.

## Phase 4: (6 months postoperatively and Onward)

- Continue the ROM (range of motion) exercises and strengthening program as above.
- Could progress to using dumbbells (lying on your side) for the specific cuff and parascapular exercises but gauge the amount of weight so that you can perform 15 repetitions every time in a slow and controlled fashion without breaking a sweat.
- Avoid sudden uncontrolled jerky lifting movements indefinitely (e.g. You and a buddy are lifting a piano and he drops his side, causing your arm to be yanked unexpectedly downward) Can return to Swimming, golf and most recreational activities.
- For the recreational or competitive athlete, return-to-sport is individualized based on factors such as contact vs. noncontact sport and level of demand on the upper extremity.