

Rehabilitation Protocol: Arthroscopic Rotator Cuff Repair



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Name: _____

Date: _____

Diagnosis: _____

Date of Surgery: _____

Phase I (Weeks 0-4)

- Sling immobilization with supporting abduction pillow to be worn at all times except for showering and rehab under guidance of PT
- Range of Motion – True Passive Range of Motion Only to Patient Tolerance
 - Goals: 140° Forward Flexion, 40° External Rotation with elbow at side, 60-80° Abduction without rotation, Limit Internal Rotation to 40° with the shoulder in the 60-80° abducted position
 - Maintain elbow at or anterior to mid-axillary line when patient is supine
- Therapeutic Exercise – No canes or pulleys during this phase
 - Codman Exercises/Pendulums
 - Elbow/Wrist/Hand Range of Motion and Grip Strengthening
 - Isometric Scapular Stabilization
- Heat/Ice before and after PT sessions

Phase II (Weeks 4-8)

- Discontinue sling immobilization
- Range of Motion
 - **4-6 weeks:** Gentle passive stretch to reach ROM goals from Phase I
 - **6-8 weeks:** Begin AAROM → AROM as tolerated
- Therapeutic Exercise
 - **4-6 weeks:** Being gentle AAROM exercises (supine position), gentle joint mobilizations (grades I and II), continue with Phase I exercises
 - **6-8 weeks:** Progress to active exercises with resistance, shoulder flexion with trunk flexed to 45° in upright position, begin deltoid and biceps strengthening**
- Modalities per PT discretion

Phase III (Weeks 8-12)

- Range of Motion – Progress to full AROM without discomfort
- Therapeutic Exercise
 - Continue with scapular strengthening
 - Continue and progress with Phase II exercises
 - Begin Internal/External Rotation Isometrics
 - Stretch posterior capsule when arm is warmed-up
- Modalities per PT discretion

Phase IV (Months 3-6)

- Range of Motion – Full without discomfort
- Therapeutic Exercise – Advance strengthening as tolerated: isometrics → therabands → light weights (1-5 lbs),
 - 8-12 repetitions/2-3 sets for Rotator Cuff, Deltoid and Scapular Stabilizers
 - Return to sports at 6 months if approved
- Modalities per PT discretion

Comments:

****IF BICEPS TENODESIS WAS PERFORMED - NO BICEPS STRENGTHENING UNTIL 8 WEEKS POST-OP**

Frequency: _____ times per week

Duration: _____ weeks

Signature: _____

Date: _____