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Arthroscopic Rotator Cuff Repair Protocol

This is a concise, practical rehabilitation protocol for patients and physiotherapists after Arthroscopic Rotator Cuff Repair. The structure is designed for blog or patient education. The basic pattern is protection first, passive motion next, active motion after tendon healing has started, and strengthening only after motion is improving and pain is controlled.
Please do not deviate from this protocol without discussing with Dr Rishabh Hegde (the treating doctor / primary surgeon) prior.

General principles

- Protect the repair in the first 4–6 weeks.
- Use the sling as advised, usually nearly full-time early on.
- Prioritize pain control, edema control, hand-elbow motion, and scapular posture in the first phase.
- Passive motion comes before active motion.
- Strengthening should not start too early, especially after larger repairs.
- Progression depends on pain, quality of motion, and repair size, not just time.

Phase	Time	Main goals	Main restrictions
Phase 1	0–4 weeks	Protect repair, pain control, distal mobility	Sling, no active shoulder motion, no lifting
Phase 2	4–6 weeks	Begin protected passive motion progression	No resisted shoulder activity, no active elevation
Phase 3	6–12 weeks	Restore AAROM/AROM, begin gentle muscle activation	No heavy strengthening, avoid painful substitution
Phase 4	12–16 weeks	Progressive strengthening and scapular control	No sudden high-load overhead activity
Phase 5	4–6 months	Functional strengthening and return to activity	Return only when strength and motion are adequate
Phase 6	6+ months	Sport/work progression if indicated	Overhead sport only after functional clearance

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Phase 1: 0 to 4 weeks

Goals

- Protect the repair.
- Reduce pain and swelling.
- Maintain hand, wrist, and elbow mobility.
- Prevent stiffness in surrounding regions.
- Maintain scapular awareness and posture.

Immobilization

Use the sling full-time except for hygiene, therapy, and prescribed exercises. Sleep in the sling

Exercises

- Hand gripping.
- Wrist flexion-extension.
- Forearm pronation-supination.
- Elbow flexion-extension.
- Cervical ROM.
- Gentle scapular setting and postural correction.
- Pendulum exercises
- Cryotherapy as needed.

Range of motion

- No active shoulder ROM.
- Passive forward elevation may begin in a protected range if allowed.
- Passive external rotation is limited and gentle.
- Avoid extension behind the body and sudden reaching.

Avoid

- Active shoulder elevation.
- Lifting objects with the operated arm.
- Supporting body weight through the arm.
- Sudden jerking motion.
- Aggressive stretching.

Phase 2: 4 to 6 weeks

Goals

- Continue protection while improving passive mobility.
- Reduce guarding.
- Prepare for assisted motion.

Range of motion

- Progress passive forward flexion gradually.
- Progress passive external rotation within comfort and repair limits.
- Internal rotation remains protected, especially behind the back.
- Motion should stay smooth and non-painful.

Exercises

- Continue all distal limb exercises.
- Continue scapular setting.
- Therapist-guided PROM.
- Wand-assisted or table-assisted motion only if permitted.
- Gentle Codman exercises if possible

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Avoid

- Active shoulder lifting against gravity.
- Resisted cuff or deltoid work.
- Forcing end range.

Phase 3: 6 to 12 weeks

Goals

- Restore active-assisted and then active ROM.
- Improve scapulohumeral rhythm.
- Begin low-level cuff and deltoid activation.
- Reduce compensatory shrugging.

Range of motion

- Begin AAROM, then AROM as tolerated.
- Start in supine or gravity-minimized positions before upright motion.
- Progress flexion, abduction in scapular plane, and ER gradually.
- Do not force painful motion or allow major substitutions.

Exercises

- Supine assisted flexion.
- Wand exercises for flexion and ER.
- Pulley work if approved.
- Side-lying or supported active motion.
- Submaximal isometrics for ER, IR, and deltoid with arm at side.
- Scapular stabilization drills.
- Rhythmic stabilization and basic proprioception.

Avoid

- Heavy resistance.
- Fast repetitive overhead activity.
- Painful active arc with compensatory shrug.

Phase 4: 12 to 16 weeks

Goals

- Achieve near-full ROM.
- Restore cuff strength and scapular strength.
- Improve endurance and control.

Exercises

- Theraband ER and IR.
- Side-lying ER.
- Scaption raises.
- Prone rows and prone horizontal work as tolerated.
- Serratus and lower trapezius strengthening.
- Closed-chain control drills.
- Light dumbbell strengthening.
- Eccentric strengthening as tolerated.

Progression focus

Movement quality is more important than load. Strengthening should still be progressive and controlled, with careful attention to scapular mechanics.

Phase 5: 4 to 6 months

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Goals

- Build functional strength.
- Improve endurance and dynamic stability.
- Return to daily activities without pain.
- Prepare for occupational or sporting demand.

Exercises

- Progressive resistance strengthening.
- Functional reaching drills.
- Advanced scapular control drills.
- Wall push-up progression.
- Light overhead strengthening if pain-free.
- Task-specific strengthening for work or sport.

Avoid

- Sudden heavy lifting overhead.
- Repetitive painful overhead activity.
- Returning to manual labor or sports before adequate control is achieved.

Phase 6: 6 months and beyond

Goals

- Return to unrestricted activity when strength, ROM, and control are restored.
- Resume sport-specific or work-specific activities safely.

Return-to-activity criteria

- Full or near-full ROM.
- No significant pain at rest or with exercise.
- Good cuff and scapular strength.
- No major substitution patterns.
- Able to perform functional tasks confidently.

Sports or heavy work

- Heavy labor and racquet or throwing sports should return only after full functional recovery.
- Large or massive tear repairs may require a slower timeline.

Home program outline

Daily in the early phase

- Sling compliance.
- Hand, wrist, elbow, and neck motion.
- Passive motion only within allowed limits.
- Ice and swelling control.

Three to five days per week after active motion begins

- AAROM and AROM drills.
- Scapular control work.
- Rotator cuff strengthening.
- Flexibility and endurance drills.
- Functional progression.

Dr Rishabh Hegde