

Arthroscopic Shoulder Surgery (Debridement / Decompression / Distal Clavicle Excision)



Physical Therapy Protocol · Accelerated, Symptom-Guided Progression (No Repair Performed)

Synthesized from the Saint Louis University subacromial decompression / distal clavicle excision protocol and the University of Virginia general shoulder arthroscopy protocol. Because no structural repair was performed, there are no protective ROM restrictions — progression is accelerated and guided by pain, swelling, and quality of motion.

AT A GLANCE

TIMELINE	6–12 weeks total; symptom-guided rather than tissue-protection based
IMMOBILIZATION	Sling for comfort only — typically discontinued between POD 1 and 2 weeks
KEY MILESTONES	Immediate PROM/AAROM without restriction · full AROM by ~6 weeks · cuff and periscapular strengthening from weeks 2–3
RETURN TO ACTIVITY	Gradual return to sport/work from 6 weeks to 3 months once ROM is full and pain-free with satisfactory strength and physician clearance

KEY PRECAUTIONS

- Progression is symptom-guided: reactive pain or swelling lasting >24 hours after a session indicates the load or volume should be reduced.
- If distal clavicle excision was performed, avoid aggressive horizontal (cross-body) adduction stretching for ~6 weeks.
- Delay provocative overhead loading until scapulohumeral mechanics are normalized and impingement signs (Neer/Hawkins) are negative.

PHASED REHABILITATION

PHASE 1 — EARLY MOTION		Weeks 0–2
GOALS	- Control postoperative pain and swelling - Restore motion early and prevent stiffness - Normalize scapulohumeral kinematics	
INTERVENTIONS	- Sling for comfort only; discontinue as early as POD 1 (most patients out by 1–2 weeks); may remove for sleep and exercises - Passive pendulums started immediately; PROM/AAROM without restriction (pulleys, wand, table slides) - Early ROM benchmarks: flexion/abduction toward 90°+, ER ~45°, progressing as tolerated - Submaximal rotator cuff isometrics in all planes; scapular exercises with manual resistance - AROM neck, elbow, wrist, and hand 5x daily; cryotherapy - Home program 5 days/week; supervised PT 2–3 visits/week as needed	
CRITERIA TO ADVANCE	- Pain and swelling controlled - Near-full PROM/AAROM without guarding - Sling discontinued	

PHASE 2 — FULL MOTION & PROGRESSIVE STRENGTHENING		Weeks 2–6
GOALS	- Achieve full AROM in all planes by end of week 6 - Restore rotator cuff and periscapular strength - Re-establish normal rhythm with elevation	
INTERVENTIONS	- Progress AROM in all planes; gentle end-range stretching as symptoms allow (defer cross-body stretching if DCE) - Rotator cuff isotonics with bands/light dumbbells: high repetition, low load (ER/IR at 20–30° abduction, scaption, prone series) - Periscapular isotonics: rows, shrugs, serratus punches, press-ups - Advance cuff isotonics toward 6–8 lb as tolerated late in phase - Proprioception and rhythmic stabilization drills; PNF patterns - Aerobic conditioning: bike, elliptical without arm resistance	
CRITERIA TO ADVANCE	- Full pain-free AROM by end of week 6 - Negative or improving impingement signs - Strength progressing without reactive soreness >24 hours	

PHASE 3 — FUNCTIONAL RETURN		Weeks 6–12
GOALS	- Return to full occupational, recreational, and sport demands - Restore strength, power, and endurance to baseline	
INTERVENTIONS	- Advanced strengthening: conventional machine and free-weight training; full-arc isokinetics at higher speeds as available - Sport-specific progression: swimming, tennis drills, interval throwing program as applicable - Work-conditioning tasks for manual laborers (lifting, carrying, overhead tolerance) - Independent HEP 3–5x/week with tapering supervised visits	
CRITERIA TO ADVANCE	- Full pain-free ROM with negative Neer and Hawkins tests - Satisfactory strength testing for demand level - Physician clearance for unrestricted activity - Completion of interval sport program where applicable	

GUIDING PRINCIPLES

This protocol follows criterion-based progression over rigid time-based advancement; phased rehabilitation balancing tissue healing with controlled stress application; objective milestones (ROM, strength LSI, functional testing) to guide phase transitions; individualization based on surgical findings, tissue quality, and patient factors; and ongoing surgeon–therapist communication throughout recovery.

REFERENCES

1. Saint Louis University Department of Orthopaedic Surgery, Sports Medicine. Shoulder Subacromial Decompression and Distal Clavicle Excision Rehabilitation Protocol.
<https://www.slu.edu/medicine/orthopaedic-surgery/sports-medicine/-pdf/shoulder-subacromial-decompression-and-distal-clavicle-excision.pdf>
2. University of Virginia Department of Orthopaedic Surgery. Post-operative Rehabilitation Protocol: General Shoulder Arthroscopy.
<https://med.virginia.edu/orthopaedic-surgery/wp-content/uploads/sites/242/2023/01/Shoulder-arthroscopy-General.pdf>
3. Corban J, Shah S, Ramappa AJ. Current Evidence Based Recommendations on Rehabilitation Following Arthroscopic Shoulder Surgery. Curr Rev Musculoskelet Med. 2024;17(7):247-257.

For clinical use by licensed physical therapists treating patients of Robert Pettit, MD. This document is a rehabilitation guideline, not a substitute for clinical judgment. Progression must be individualized based on intraoperative findings, tissue quality, and patient response. Scan the QR code for the current version of this protocol.