

AC Joint / Coracoclavicular Ligament Reconstruction Rehabilitation Protocol

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Patient: _____ **DOS:** _____

Surgeon Parameters

Other Precautions:

Precautions above are patient-specific and supersede the general timeframes below. **The coracoclavicular reconstruction is the rate-limiting factor: the weight of the arm pulls directly on the construct, so the arm stays supported and early motion is passive, supine, and supported.** Progression is milestone-based (pain, ROM, scapular control). Therapist to use clinical judgment to individualize exercise selection and pace within each phase.

Phase	Goals	Precautions	Treatment Focus
Phase 1 Weeks 0–6	Goals - Protect the CC/AC reconstruction; control pain/swelling - Maintain elbow/wrist/hand mobility - Gentle passive shoulder motion	Precautions - Abduction/immobilizer sling full-time for 6 wks; off only for hygiene and exercises - No downward tension on the construct — keep the arm supported; never let it hang unsupported outside of exercises - No active elevation; no lifting - Avoid cross-body adduction and hand-behind-back	Treatment Focus - Immediate elbow/wrist/hand motion and grip - Supine passive ROM only, gentle and pain-free - Avoid unsupported gravity dependent exercises which may stress repair axially for 2-3 wks - Scapular setting in sling - Ice/modalities PRN pain-swelling
► Advance to Phase 2 when: wound healed, pain controlled, supine PROM progressing, sling discontinued at 6 wks.			
Phase 2 Weeks 6–8	Goals - Discontinue sling - Restore full passive, then active ROM - Activate scapular stabilizers	Precautions - Avoid resisted overhead loading; graft integration still maturing - No lifting or carrying with the operative arm - Introduce cross-body adduction and hand-behind-back gradually - Progress by milestone, not calendar	Treatment Focus - AAROM → AROM (cane, pulley, wall slides), supine → upright - Gentle PROM/stretching toward full motion - Scapular stabilizer activation (retraction, depression, serratus) - Submaximal pain-free cuff isometrics
► Advance to Phase 3 when: full or near-full PROM, AROM progressing without shrug, good scapular control. Full AROM may take until ≈12 wks.			
Phase 3 Weeks 8–12	Goals - Full AROM by ≈12 wks - Progressive rotator cuff and scapular strengthening - Normal scapulohumeral rhythm	Precautions - No heavy pressing or deadlift-type loads until strength is restored - Start light and below shoulder level; no resisted overhead loading until full AROM with good control If chronic or revision reconstruction: strengthening and unsupported ROM may be delayed per Other Precautions above	Treatment Focus - Band/light dumbbell cuff and scapular strengthening (IR/ER at side, rows, prone series, serratus), 2–3 sets x 10–15 - Closed-chain progression (wall → incline) - Continue ROM/stretching to full
► Advance to Phase 4 when: full pain-free AROM, strengthening pain-free, normal scapular control.			

Phase	Goals	Precautions	Treatment Focus
Phase 4 <i>Weeks 12–24+ (≈ Month 3–6+)</i>	Goals • Restore symmetric strength • Sport-/work-specific training • Return to full duty and sport by individual progression	Precautions • Weight training from ≈3–4.5 months; heavy pressing and deadlift-type loads last • Contact/collision and overhead sport typically deferred to ≈6 months • Clearance by criteria (ROM, strength, scapular control), not time alone	Treatment Focus • Progressive weight training (machines → free weights) • Plyometrics and sport-specific drills • Interval throwing program if applicable • Strength testing vs. contralateral
► Full Release (typically 3–6+ months / 12–24+ wks): full pain-free ROM, symmetric strength, normal scapular control, sport-specific progression completed, cleared by physician. Contact/collision and overhead athletes generally ≈6 months.			

Special Considerations

- Timelines vary with construct, graft use, and chronicity; chronic or high-grade (type V) reconstructions progress more slowly
- New prominence of the distal clavicle, a pop, or sudden pain — stop and contact the surgeon

Thank you for taking care of our patient.

This protocol serves as a general guideline and outline only. Our team defers to the clinical judgment and expertise of the treating physical therapist to make appropriate adjustments and modifications based on the individual patient's presentation, progress, and response to treatment. For any questions regarding this protocol, please contact Dr. Wollenman directly at (561) 215 – 0184.