ACJ Stabilisation / Reconstruction

Overview

- Surgical stabilisation for high-grade ACJ dislocation (Rockwood Type III–V)
- Techniques include coracoclavicular ligament reconstruction, synthetic augmentation (e.g. LARS, TightRope, LockDown), and anatomic ACJ capsular repair
- Sling for 4–6 weeks post-operatively
- No elevation above 70° and no cross-body adduction for 6 weeks
- Full return to contact sport typically 4–6 months; overhead athletes may require longer

Rehabilitation Phases

Phase 1 — Protection	Weeks 0–6
Goals: • Protect repair and allow ligament/construct healing • Minimise pain, swelling, and muscle guarding • Maintain hand, wrist, and elbow mobility	**Exercises & Interventions:** • Sling at all times except exercises and hygiene • No pendulum exercises until 6 weeks • Elbow, wrist, and hand ROM • Scapular retraction — gentle, pain-free • Passive shoulder flexion to 70° in scapular plane only • Ice and elevation for oedema management • Posture correction and cervical spine mobility
Precautions: ■ No active shoulder elevation > 70° in any plane for 6 weeks ■ No cross-body adduction for 6 weeks ■ No active IR/ER against resistance ■ No pushing, pulling, or weight-bearing through the arm ■ Sling when sleeping for first 4–6 weeks	
Phase 2 — Active Motion	**Weeks 6–12**
Goals: • Restore full active range of motion • Initiate rotator cuff and periscapular muscle activation • Normalise scapular kinematics and posture	**Exercises & Interventions:** • Active-assisted progressing to active shoulder flexion and abduction • External and internal rotation — theraband, light resistance • Scapular stabilisation — retraction, depression, upward rotation • Closed-chain upper limb exercises (wall press-up, table lean) • Proprioceptive neuromuscular facilitation patterns • Hydrotherapy if available • Postural re-education and thoracic mobility exercises
Precautions: ■ Avoid aggressive end-range elevation stretching until 12 weeks ■ No contact sport or heavy lifting until cleared ■ Avoid cross-body loading until 10–12 weeks	

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Rehabilitation Phases (continued)

Phase 3 — Strengthening	Weeks 12–20
Goals: • Progressive rotator cuff and periscapular strengthening • Restore neuromuscular control and dynamic ACJ stability • Sport- and occupation-specific conditioning	**Exercises & Interventions:** • Progressive resistance training — rotator cuff, deltoid, periscapular • Closed- and open-chain upper limb strengthening • Plyometric upper limb exercises (late Phase 3) • Sport-specific drills — throwing, overhead, contact (graduated) • Dynamic ACJ stabilisation and proprioception exercises • Return-to-sport functional testing
Precautions: ■ Avoid heavy axial load through shoulder (e.g. heavy bench press) until 16 weeks ■ Contact and collision drills introduced only after functional testing criteria met	
Phase 4 — Return to Sport	**Months 4–6+**
Goals: • Full return to contact sport, overhead activity, and manual work • Confident ACJ stability under load and stress • Prevent recurrence with ongoing maintenance programme	**Exercises & Interventions:** • Progressive contact and collision exposure — graduated return-to-play protocol • Full sport-specific training at match intensity • Overhead sport-specific interval programme (throwing, swimming) • Maintenance periscapular and rotator cuff strengthening 2–3× per week
Precautions: ■ Overhead athletes (swimmers, throwers, gymnasts) may require 6–9 months ■ Ongoing maintenance programme to preserve long-term ACJ stability	

Clinical Notes

- Rockwood Type III injuries: management individualised — Type IIIB (unstable, symptomatic) favours surgical stabilisation
- Synthetic loop devices (TightRope, LockDown, LARS) may allow earlier active motion than biological reconstructions — confirm timeline with surgeon
- Concurrent distal clavicle excision typically does not alter rehabilitation timeline
- Scapular dyskinesis common post-ACJ injury — address periscapular retraining throughout all phases
- Hook plate removal — separate timeline applies; typically 8–12 weeks post-removal before strengthening resumes

References

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2. Perry NPJ, Omonullaeva NK, Bacevich BM, et al. Acromioclavicular joint anatomy and biomechanics. Clin Sports Med. 2023;42(4):557–571.
3. Behrens A, Behrendt P, Heintzen MJ, et al. Mid-term clinical and sonographic outcomes of minimally invasive acromioclavicular joint reconstruction. Arch Orthop Trauma Surg. 2023;144:879–888.
4. Frank RM, Cotter EJ, Leroux TS, Romeo AA. Acromioclavicular joint injuries: evidence-based treatment. J Am Acad Orthop Surg. 2019;27(17):775–788.
5. Warth RJ, Martetschläger F, Gaskill TR, Millett PJ. Acromioclavicular joint separations. Curr Rev Musculoskelet Med. 2013;6(1):71–78.

This rehabilitation protocol is intended as a general guide for qualified physiotherapists and healthcare professionals. It should be adapted to individual patient presentation, surgical findings, tissue quality, and progress. All progression decisions should be made in consultation with the treating surgeon.