



- Active movement of the arm overhead is introduced based on the physician's recommendations.
- Swimming is allowed at 5 months after surgery.

**Advanced Rehabilitation Phase (5 months–1 year)**

- Submaximal sport-specific training is progressed to maximal training by the end of 1 year after surgery.

**General Precautions and Contraindications**

- Flexion should precede abduction when restoring active motion.
- The patient should avoid leaning on the arm or carrying more than 5 lb of weight in the early and intermediate phases of rehabilitation.
- Patients with complete tears of the supraspinatus should avoid lifting more than 15 lb in the first year postoperatively.
- Skiing, skating, roller-blading, and other such activities are forbidden in the first year after surgery to avoid reinjury from a fall.

(A) Assisted lateral rotation in supine. A towel is placed under the elbow to keep the humerus in neutral and prevent excessive anterior displacement. The patient pushes the involved arm into lateral rotation, using the uninvolved arm to supply the power. (B) Assisted extension. The patient pushes backward into extension, using the uninvolved arm to supply the power. Caution should be used to prevent excessive glenohumeral (GH) extension and anterior displacement of the GH joint. (C) Pulley-assisted elevation. The uninvolved arm supplies the power to raise the involved arm. Caution should be used to prevent excessive scapular elevation as compensation for lack of GH mobility. The motion should be stopped as soon as a deviation in the path of instant center of rotation of the GH or scapulothoracic joint is noted. This exercise can be progressed to active assisted elevation when directed by the physician. (D) Assisted medial rotation. The patient is instructed to medially rotate the arm by pushing the arm backward, followed by pulling the hand upward toward the scapula. Cautions should be used to prevent excessive scapular anterior tilt and GH anterior displacement. (E) Assisted abduction. The patient is instructed to (1) lie on the back, (2) lock the fingers together and stretch the arms overhead (the uninvolved arm powers the involved arm), (3) bring the hands behind the neck, and (4) flatten the elbows (reverse by sliding the hands overhead and down). Caution should be taken while abducting to ensure the scapulae are in a neutral position and adduct as the arm abducts. (F) Assisted lateral rotation in a doorway. The patient is instructed to stand in a doorway facing the door frame. The elbow is flexed to 90 degrees. The palm is on wall. The elbow is held in adduction. The body turns gradually until the patient faces into the room. Caution should be taken to ensure proper scapular alignment during the lateral rotation process. (G) Isometric medial and lateral rotation. (H) Isometric extension. (I) Isometric abduction. (J) Isometric flexion. (K) Resistive exercise for shoulder extensors. Caution should be taken to prevent thoracic flexion or scapular anterior tilt. The range should be limited to extension to the midaxillary line to prevent contractions of the rhomboid in the short range. (L) Resistive exercise for shoulder flexion. The motion is upward into flexion as if throwing an "upper cut" punch. Caution should be taken to monitor the ST PICR.