

Shoulder Arthroscopy

Shoulder Arthroscopy (Diagnostic / Debridement / Washout) – Post-operative Rehabilitation

Topic scope: Post-operative rehabilitation after a **generic keyhole shoulder arthroscopy in which nothing was repaired** – diagnostic assessment, washout (lavage), debridement of degenerate tissue, removal of loose bodies, and isolated subacromial decompression or distal clavicle excision. **Specific repair or reconstruction procedures have their own protocols that take priority** – rotator-cuff repair, labral/instability stabilisation (anterior-Bankart, posterior-stabilisation, Latarjet), capsular release, biceps tenodesis and AC-joint stabilisation each convert to a slower, construct-protecting pathway. This page is the *default* keyhole pathway used **only when the operation note confirms no repair was performed**.

Defining principle of the rehab here: when nothing is repaired there is no construct to protect, so the rehab is an early-motion pathway – a sling for comfort only (days, not weeks), unrestricted use below shoulder height from day one, motion progressed on comfort rather than the calendar, and strengthening as soon as range and pain allow. The single branch point is whether anything was actually repaired or stabilised; if it was, recovery converts to that procedure's protected protocol. Unlike a cuff repair or a labral repair, there is no healing tissue that early movement can disrupt, so the usual risks of early motion (re-tear, construct failure) do not apply – the main thing early motion prevents here is post-operative stiffness.

The operation and why the rehab is fast

A keyhole (arthroscopic) shoulder operation in this scope involves looking inside the joint and subacromial space through small portals and doing one or more of: confirming a diagnosis, washing out the joint, trimming (debriding) frayed labrum, degenerate cuff or inflamed bursa, removing loose bodies, or shaving bone in a subacromial decompression or distal clavicle excision. **None of these creates a repair that must heal under protection.** That is the central fact that separates this pathway from cuff repair, stabilisation and the other

audited protocols: the tissue is either removed or simply inspected, so the post-operative soreness – not a healing construct – is what paces recovery.

Because of this, recovery is among the quickest of any shoulder operation. Most people are back to desk-based work within days to a week, out of the sling within the first week, driving within one to three weeks once the sling is off and they can control the car confidently, and back to heavier manual work and sport somewhere between six and twelve weeks depending on the demands placed on the shoulder.

Evidence by theme

1. EARLY MOTION IS THE GOAL – THERE IS NO CONSTRUCT TO PROTECT

The case for early movement here is largely a **mechanistic** one rather than one settled by a dedicated trial: with no repair to disrupt, the only thing prolonged immobilisation achieves is avoidable stiffness, discomfort and delayed return to activity. The closest high-quality evidence comes by analogy from the cuff-repair literature, where – even with a *real* construct to protect – randomised trials and meta-analyses show early controlled motion **does not** increase re-tear and tends to reduce stiffness (number-needed-to-harm for re-tear in the order of several hundred). If early motion is safe when a repair *is* present, it is plainly safe when there is **nothing** to protect. *Mechanistic + analogous moderate evidence; no debridement-specific RCT.*

2. THE PROCEDURES THEMSELVES: A CANDID NOTE ON EFFICACY

Two landmark **placebo-controlled** surgical trials bear directly on the commonest reason a no-repair arthroscopy is done – subacromial pain:

- **FIMPACT (BMJ 2018)** – a double-blind trial of 210 patients randomised to arthroscopic subacromial **decompression, diagnostic arthroscopy** (placebo surgery), or **exercise therapy**. At 24 months decompression gave **no benefit over diagnostic arthroscopy**; both surgical arms improved, but no more than each other. *Strong (placebo-controlled RCT).*
- **CSAW (Lancet 2018)** – a three-arm placebo-controlled UK trial reaching the same conclusion: decompression was **no better than investigational (diagnostic) arthroscopy**, and the small edge of either over no-treatment was not clinically important. *Strong (placebo-controlled RCT).*

The honest reading is that for subacromial pain the *surgical* element adds little over diagnostic arthroscopy or structured exercise – which reinforces why, when this operation is done, the **rehabilitation** (early motion, restoring strength and confidence) carries much of the recovery. A longer-term single RCT (Magnussen-class, 10-year follow-up, in the corpus) did favour decompression over therapy alone, so practice remains individualised – but the placebo-controlled data are the higher tier.

3. DEBRIDEMENT OF DEGENERATE TISSUE – LIMITED, OLD EVIDENCE

Arthroscopic **debridement of irreparable degenerative cuff lesions** (Burkhart, *J Bone Joint Surg* 1995, in the corpus) can relieve pain and restore functional “force-couple” mechanics in selected patients, but the evidence

base is small, old and uncontrolled. Debridement and washout are best understood as **symptom-directed** measures, not structural repairs – which again places the weight of recovery on rehabilitation rather than on a healing construct. *Weak (historical case series).*

4. THE PHASED PROTOCOL IS CONSENSUS, DRAWN FROM PUBLISHED SURGEON PROTOCOLS

The phase structure below is **expert/consensus**, compiled from published patient-guidance protocols for general/diagnostic shoulder arthroscopy and debridement (Chahla – Rush; Nwachukwu – HSS; Obrock; Royal National Orthopaedic Hospital). There is **no rehabilitation RCT** defining the optimal regimen for a no-repair arthroscopy; the week ranges are typical, not trial-derived. *Weak/consensus.*

Phased post-op timeline (no repair performed)

Phase	Window	Sling	ROM / use	Strengthening	Notes
I – Early movement & settling	Week 0–2	Comfort only, days (rarely > 1–2 wk), off ASAP; no sleeping in it	Free hand/wrist/ elbow + light ADLs from day 1; pendulums and assisted ROM progressing to active ROM as comfort allows	Scapular setting; gentle cuff/deltoid isometrics as comfort allows	Settle the post-op flare. No driving while in the sling. Dressings off ~10–12 days
II – Restore movement, start strength	Week 2–6	Off	Progress active ROM in all planes toward full (interim targets ~140–160° flexion, 40–60° ER)	Isometric → elastic-band cuff + scapular work; light isotonic from ~wk 4	Desk work + driving once sling off, pain settled, confident to control the car (typically wk 1–3)
III – Return to full activity	Week 6 onward	Off	Maintain full, pain-free ROM	Conventional resistance training from ~wk 6; eccentric/closed-chain; sport-specific conditioning. Cap heavy cuff loading at ~3×/week	Heavier manual work & sport return ~6–12 wk by demand; most back to everything by ~3 months

Branch point – if anything was repaired or stabilised: recovery converts to that procedure’s protected protocol (e.g. **rotator-cuff repair** – sling ~6 weeks, restricted ROM, deferred strengthening, ~5 months total; or the relevant **stabilisation/capsular-release** pathway). The operation note and the rooms confirm which pathway applies.

CQ HAND + UPPER LIMB

Key controversies / evidence quality

1. **Does the surgery help at all (for subacromial pain)?** Two placebo-controlled RCTs (FIMPACT, CSAW) found decompression **no better than diagnostic arthroscopy**, and arthroscopy little better than exercise. This is the strongest evidence in the topic – and it argues that, where a no-repair arthroscopy is performed, **good rehabilitation is doing much of the work**. *Strong*.
2. **Debridement evidence is thin and dated.** The supportive data (e.g. Burkhart 1995) are small, uncontrolled case series; debridement is symptom-directed, not curative. *Weak*.
3. **The rehab protocol itself is consensus, not trial-derived.** No RCT defines the optimal regimen after a no-repair arthroscopy; phase timings are typical surgeon-protocol values, and recovery is individualised by the treating physiotherapist. *Weak/consensus*.
4. **Safety of early motion is inferred, not directly tested here.** It rests on a sound mechanism (nothing to protect) reinforced by analogy to the cuff-repair early-motion trials, rather than a debridement-specific RCT. *Mechanistic + analogous moderate*.

The evidence base for this generic pathway is genuinely limited. The high-quality data (placebo-controlled trials) speak to whether the operation helps, not to how best to rehabilitate it; the rehabilitation guidance is consensus-level. This is stated plainly because it is the honest position.

Evidence-strength flags (summary)

- **STRONG (placebo-controlled RCT):** subacromial decompression gives no benefit over diagnostic arthroscopy – FIMPACT (BMJ 2018), CSAW (Lancet 2018).
- **MODERATE (analogous RCT/MA):** safety of early controlled motion (extrapolated from cuff-repair early-motion trials – early motion does not raise re-tear and reduces stiffness even when a construct is present).
- **WEAK (historical case series):** arthroscopic debridement of irreparable degenerative cuff lesions (Burkhart 1995).
- **WEAK / CONSENSUS:** the post-operative **rehabilitation protocol itself** (published surgeon patient-guidance documents; no defining rehab RCT).
- **SAFETY NOTE (rare complication):** glenohumeral **chondrolysis** has been linked to post-arthroscopic intra-articular continuous **bupivacaine** infusion and to thermal capsulorrhaphy – a reason such adjuncts are avoided, not a reflection on standard debridement.

CITATIONS

RAG CORPUS (180,000+ ORTHOPAEDIC ARTICLES)

- Burkhart SS. Débridement of degenerative, irreparable lesions of the rotator cuff. *J Bone Joint Surg Am.* 1995. DOI: 10.2106/00004623-199506000-00006
- Magnussen R, et al. Subacromial decompression yields a better clinical outcome than therapy alone: a prospective randomized study with minimum 10-year follow-up. *Am J Sports Med.* 2018. DOI: 10.1177/0363546518755759
- Bailie DS, Ellenbecker TS. Severe chondrolysis after shoulder arthroscopy associated with continuous bupivacaine infusion. *Arthroscopy.* 2009. DOI: 10.1016/j.arthro.2009.08.024
- (The corpus is thin on no-repair / diagnostic-arthroscopy rehabilitation specifically; the higher-tier evidence below comes from the placebo-controlled surgical trials and published surgeon protocols.)

LITERATURE (URLS)

- FIMPACT – Paavola M, et al. Subacromial decompression versus diagnostic arthroscopy for shoulder impingement: randomised, placebo surgery controlled clinical trial. *BMJ.* 2018. <https://pmc.ncbi.nlm.nih.gov/articles/PMC6052435/>
- CSAW – Beard DJ, et al. Arthroscopic subacromial decompression for subacromial shoulder pain: a multicentre, pragmatic, placebo-controlled, three-group, randomised surgical trial. *Lancet.* 2018. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)32457-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32457-1/fulltext)

PUBLISHED REHAB PROTOCOLS (PATIENT-GUIDANCE – BASIS FOR THE PHASE STRUCTURE)

- Chahla J. Shoulder Arthroscopy Debridement – Rehab Protocol. Rush University Medical Center. <https://www.jorgechahlamd.com/wp-content/uploads/2021/08/Shoulder-Arthroscopy-Debridement.pdf>
- Nwachukwu BU. Post-Operative Shoulder Arthroscopy Debridement Rehab Protocol. Hospital for Special Surgery. <https://manhattansportsdoc.com/post-operative-shoulder-arthroscopy-debridement-rehab-protocol/>
- Obrock B. Post-operative Rehabilitation Protocol – General Shoulder Arthroscopy (Debridement, Subacromial Decompression, and/or Distal Clavicle Resection). <https://www.drblakeobrock.com/pdf/obrock-shoulder-arthroscopy-general.pdf>
- Royal National Orthopaedic Hospital. A Patient's Guide to Diagnostic Shoulder Arthroscopy. <https://www.rnoh.nhs.uk/patients-and-visitors/patient-information-guides/diagnostic-shoulder-arthroscopy-patients-guide>

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