Figure 4. Assisted active flexion with a stick in front of a mirror. Pushing strongly downwards, both elbows straight. (4A). Second step, pushing strongly forward and maintaining the shoulder down at the horizontal (4B). Pushing strongly to zenith (4C). Stick on the head (4D).

tion, with traction-decoaptation downwards (Figure 2F). External rotation in abduction, called "the nap position" (Figure 2G) is essential because it opens the antero-inferior capsular pouch.

- Passive internal rotation in a standing position with the physiotherapist who must ensure to correct a compensatory vicious attitude of the patient, but leaning forward and ascension of the shoulder stump. The rise of the hand must be progressive, gentle and firm (Figure 3A). This exercise is prohibited during the first 3 weeks after a repair of the supraspinatus tendon which would then be put under tension. Passive mobilization in internal rotation can be done either with a stick (Figure 3B), or with the contralateral hand (Figure 3C). The torso should be straight, with a slight adduction of the shoulder blades.

Assisted active mobilization exercises

Assisted active mobilization exercises are initiated only after full recovery of the passive range of motion. They should