



Figure 5. Active elevation and external rotation with abduction (5A); Complete active elevation (5B); Complete active external rotation and abduction (5C).

1 systematically be preceded, within the same session, by passive
2 mobilization exercises.

3 The timing of initiation depends on the surgical procedure.
4 On average, these exercises are introduced 3 weeks after sub-
5 acromial decompression, 6 weeks after arthroscopic rotator cuff
6 repair [8], and may begin earlier following shoulder arthro-
7 plasty, in parallel with passive mobilization [4–6].

8 The organization of rehabilitation remains consistent:
9 patients perform self-rehabilitation 3–4 times daily, comple-
10 mented by two to three supervised sessions per week with a
11 physiotherapist trained in the protocol.

Active-assisted forward elevation with a stick is a key exer- 12
cise, though it is often difficult for patients to perform correctly. 13
Initially, the patient depresses the shoulder girdle by pushing the 14
stick downward with both elbows extended and the trunk upright. 15
Elevation to the horizontal plane is then achieved with 16
assistance from the contralateral arm. This position is main- 17
tained while the physiotherapist ensures that the shoulder does 18
not elevate – a common compensatory mechanism associated 19
with subacromial impingement and pain (Figures 4A–4C). 20

It is advisable to perform this exercise in front of a mirror, 21
with the physical therapist and alone at home, to correct the 22