

REHABILITATION AFTER ACL RECONSTRUCTION WITH MENISCAL REPAIR

ACL reconstruction with meniscal repair: hinged brace and 0–90° bend for 4–6 weeks, running from about 4 months, sport 9–12 months.

PATIENT NAME

DATE OF SURGERY

WHAT IS INSIDE

- What was done, and what to expect week by week
- Weight bearing, walking aids and precautions
- Your exercises, with a diagram and a dosage for each
- Warning signs, and exactly who to call
- Getting back to driving, work and sport
- A progress chart to fill in and bring to appointments

26 minutes to read. Reviews: Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks. Then reviews at 3, 6, 9 and 12 months, with the 9-month visit carrying return-to-sport testing.

Harbour Orthopaedics & Sports Medicine

(02) 9052 1883 · drmatthewbroadhead.com.au

This is a general guide. Your operation record and the instructions you are given always take precedence over anything written here. Last reviewed 5 August 2026.

This guide is for an ACL reconstruction WITH meniscal repair: an ACL graft plus stitches in the meniscus. Your operation record says which operation you had. If your ACL was reconstructed without a meniscal repair, you follow a different, faster programme: see the guide "ACL reconstruction" instead. The two programmes are different, and following the wrong one matters. This one protects a stitched meniscus that the other programme would overload. If you are not sure which applies to you, call the rooms before you start.

Why the extra caution? Only the outer quarter or so of the meniscus has a blood supply, so stitched meniscus heals slowly: three months and more. Early deep bending and twisting shear the repair. Protecting it now buys you a meniscus for life; a failed repair means another operation and a higher long-term risk of arthritis. The brace, the crutches and the 90-degree limit are not padding. They are the treatment.

Everything else about ACL rehabilitation still applies: full extension early, swelling control, quadriceps activation, and a nine-to-twelve-month road back to pivoting sport. Every timeframe in this guide is typical, not a rule, and Dr Broadhead's instructions for you, especially the weight-bearing and range limits in your operation record: always override the general figures here. If you are reading this before surgery, prehabilitation still matters: a straight, quiet, strong knee going in predicts a better knee coming out.

AT A GLANCE

WEIGHT BEARING

Protected weight bearing with crutches, in the brace: your operation record sets the exact limits

BRACE

Hinged knee brace, movement limited to 0–90° for the first 4–6 weeks

DRIVING

Not while braced or on crutches: later than an isolated ACL reconstruction; individually assessed at review

PHYSICAL WORK

Usually 3 months or more, depending on the duties: planned at your reviews

REVIEWS

Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks. Then reviews at 3, 6, 9 and 12 months, with the 9-month visit carrying return-to-sport testing

WALKING AIDS

Crutches for 4–6 weeks alongside the brace

PRECAUTIONS

No loaded deep bending or twisting for 3–4 months; root and radial repairs are the most protected

DESK WORK

Typically around 2 weeks, with the brace on and the leg elevated

SPORT & ACTIVITY

Running from about 4 months; pivoting sport 9–12 months, and only after passing testing

WHAT WAS DONE IN YOUR OPERATION

Two things were fixed at one operation. First, the torn anterior cruciate ligament (ACL) was replaced with a graft, from the hamstrings, the patellar tendon (BTB) or the quadriceps tendon; your operation record says which. The graft is fixed strongly from day one and remodels into a living ligament over many months.

Second, the torn meniscus. One of the two C-shaped shock absorbers between the thigh and shin bones, was repaired with stitches rather than trimmed away. A repair is chosen when the tear can heal, because keeping the meniscus protects the joint surface for decades. But only the outer quarter or so of the meniscus has a blood supply, so the stitched tissue heals slowly, and for the first months it must be shielded from the deep bending and twisting that would shear the stitches apart.

Some repairs need more protection than others. Root repairs (where the meniscus anchors to bone) and radial repairs (tears across the full width) carry the highest load and are the most protected, if that is you, your operation record will set stricter weight-bearing and range limits than the typical figures in this guide. Your operation record wins every time.

THE IDEAS THAT MAKE EVERYTHING ELSE MAKE SENSE

1. The brace and the limits are the treatment

Routine braces are not used after an isolated ACL reconstruction, but yours is not an isolated reconstruction. The hinged brace, the 0–90° limit and the protected weight bearing exist to shield the meniscal stitches while they heal. Wearing the brace loosely, unlocking it early or "just squatting once" undoes work that cannot be re-done without another operation.

2. Dates are guides; tests are gates

Best practice is criteria-based progression. Time sets the earliest possible date for each step; objective criteria decide whether you actually move. Each phase in this guide lists both. With a meniscal repair, time carries extra weight in the early months, because the stitches heal on biology's schedule, not on effort.

3. Get it straight, keep it dry, switch the quads on

The first fortnight still has four jobs: full extension, minimal swelling, quadriceps activation without a lag, and a safe walking pattern with the crutches and brace. Full extension does not threaten the repair. It is allowed, expected and worked on from day one. It is deep bending under load that is off the menu.

4. Swelling is the brake

Increasing swelling after a session means the load was too high. A knee that is bigger the next morning means you did too much yesterday. With a repair on board, respect the brake even more, swelling is the knee's only way of telling you the load reached tissue that is trying to heal.

5. Time protects the graft in a way tests cannot

Returning to pivoting sport before nine months substantially increases ACL re-injury risk. Each additional month of delay up to nine months meaningfully reduces that risk, and passing a full discharge test battery reduces it further. The two together are far stronger than either alone. With a meniscal repair, the window is nine to twelve months.

6. Which graft you had changes the details

Hamstring graft: avoid heavy resisted hamstring curls and end-range hamstring stretching for about 4–6 weeks; posterior thigh ache and a numb patch below the incision are common. Patellar tendon (BTB): expect more front-of-knee and kneeling discomfort; kneecap mobilisation matters more, and kneeling tolerance is a late milestone. Quadriceps tendon: a slower start to quadriceps activation, be patient with early strength numbers; front-of-knee tenderness settles. Your operation record says which you had.

WEIGHT BEARING AND WALKING AIDS

WEIGHT BEARING

PROTECTED WEIGHT BEARING WITH CRUTCHES, IN THE HINGED BRACE: EXACT LIMITS SET BY YOUR OPERATION RECORD

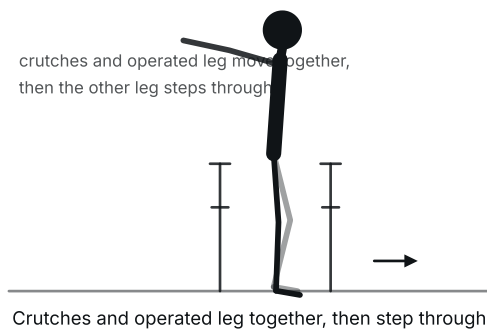
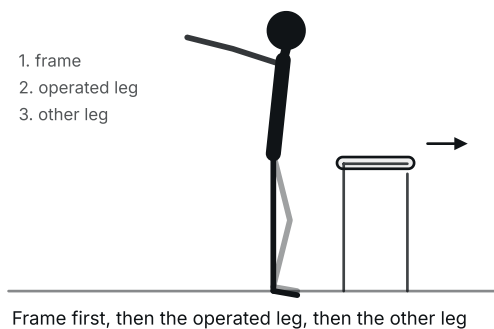
Unlike an isolated ACL reconstruction, you do not simply put full weight through the leg from day one. Load squeezes and shears the stitched meniscus, so weight bearing is protected, typically touch or partial weight with two crutches, in the brace, for the early weeks. Your operation record sets your exact limit; root and radial repairs are usually the most restricted.

This is the single biggest practical difference from the isolated pathway, and the reason the two guides must not be mixed. A friend who was off crutches at

ten days after their ACL reconstruction had a different operation from you.

Weight bearing is progressed at your reviews as the repair heals, not by feel, and not by the calendar alone.

STAGE	TYPICAL TIMING	MOVE ON WHEN
Two crutches, protected weight bearing, brace on	Weeks 0 to 4–6	As set in your operation record: confirmed at the 2-week review
Weaning to full weight bearing	From the 4–6 week review	Cleared at review; brace range opened; quadriceps control returning
One crutch, then none	About weeks 6–8	Walking without a limp; swelling not increasing with walking



PROTECTING THE MENISCAL REPAIR

STRICTEST FOR THE FIRST 4–6 WEEKS; NO LOADED DEEP BENDING OR TWISTING FOR 3–4 MONTHS

Only the outer quarter or so of the meniscus has a blood supply, so stitched meniscus heals slowly: three months and more. Early deep bending and twisting shear the repair. Protecting it now buys you a meniscus for life; a failed repair means another operation and a higher long-term risk of arthritis.

RULE	WHY	HOW TO MANAGE
Wear the hinged brace, set 0–90°, whenever you are up, for the first 4–6 weeks	Bending past 90 degrees rolls the thigh bone back over the repaired part of the meniscus and stresses the stitches.	Check the dial settings daily; do not change them yourself. The range is opened at your review, not at home.
Keep to your protected weight-bearing limit with two crutches for the first 4–6 weeks	Body weight compresses and shears the healing meniscus long before it can take the load.	Follow the limit in your operation record. If you have forgotten what it is, call the rooms rather than guessing.
No loaded deep bending: deep squats, lunges, kneeling back on your heels, for 3–4 months	Deep flexion under body weight puts the highest compressive and shear load on exactly the part of the meniscus that was stitched.	Squat-type strength work stays above 90 degrees until cleared. Use a raised chair, a shower stool and a long-handled reacher early on.
No twisting or pivoting on the planted foot for 3–4 months	Rotation grinds the tibia against the healing meniscus. It is the classic mechanism that tears a repair.	Turn by stepping around in small steps, not by swivelling. This also protects the ACL graft, which shares the same enemy.
Root and radial repairs: expect stricter limits than the figures above	These repairs carry the highest mechanical load and have the most to lose. They are the most protected of all.	Your operation record overrides this guide. When the record and the guide disagree, the record wins.

EVERYDAY SITUATIONS

Sitting down and standing up. Choose higher chairs, keep the operated foot slightly forward, and push up through the arms and the other leg. Avoid low couches for the first 4–6 weeks.

Showering. The brace comes off for showering once the wound allows, sit on a shower stool, keep the knee within its range, and put the brace back on before you walk anywhere.

Stairs. Up with the good leg first, down with the crutches and operated leg first: "up with the good, down with the bad". Take them one at a time with the rail until cleared.

Getting into a car (as a passenger). Seat back and reclined slightly, back in first, then swing both legs around together. Keep the knee inside its brace range.

Picking things up off the floor. Do not squat for it. Use a long-handled reacher, or go down on the non-operated knee keeping the operated knee within range.

Sleeping. Follow your operation record on night-time brace wear. Never a pillow under the knee: support the whole lower leg from calf to heel so the knee rests straight.

YOUR BRACE: HINGED KNEE BRACE WITH ADJUSTABLE RANGE-OF-MOVEMENT DIALS

PERIOD	INSTRUCTION
--------	-------------

Weeks 0 to 4–6	Worn whenever you are up on your feet and while doing your exercises, with the dials set to your prescribed range. It may come off for showering (seated) and for icing, once the wound allows.
----------------	---

At night	Follow your operation record: some repairs are braced at night in the early weeks and others are not. If the record does not say and you are unsure, call the rooms.
----------	--

From the 4–6 week review	The range is opened and the brace is weaned as quadriceps control returns, on Dr Broadhead's instruction, not by feel.
--------------------------	--

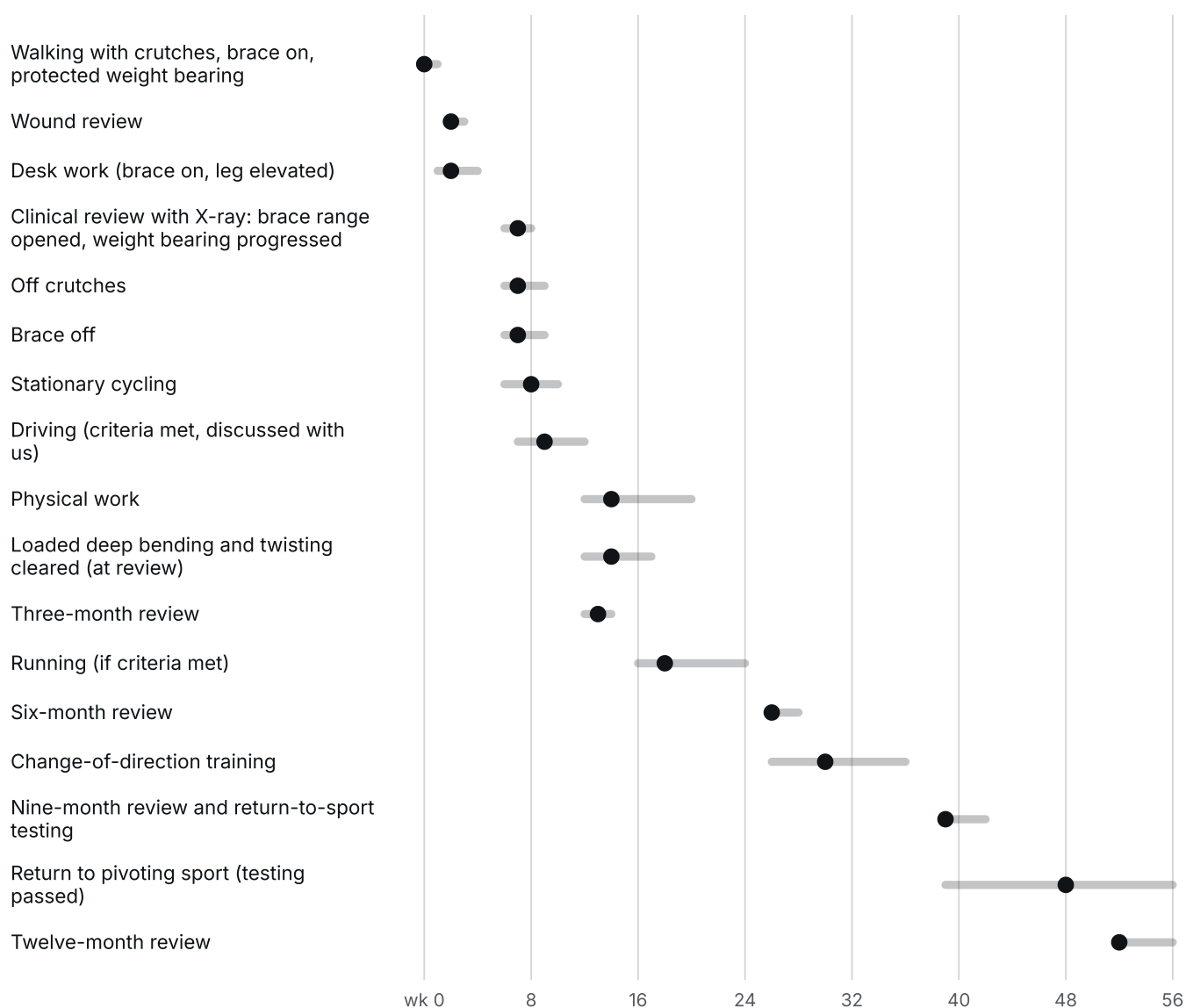
PERIOD	PERMITTED RANGE
--------	-----------------

Weeks 0 to 4–6	0–90°: full straightening allowed, bend limited to a right angle, set on the brace dials
----------------	--

From the 4–6 week review	Opened progressively as advised at review; unrestricted range only when cleared
--------------------------	---

- Check the dial settings every day, dials can be knocked. Do not change them yourself; the range is opened at your review.
- Check the skin under the straps daily. The brace should be snug but not biting; numbness, blistering or pressure marks mean the fit needs adjusting, call the rooms.
- Straps loosen as swelling settles: re-tension them so the hinges stay lined up with the knee crease.
- If the brace is removed for showering or icing, put it back on before you stand up and walk.

YOUR RECOVERY TIMELINE



Bars show the earliest-to-latest normal window; the dot is typical. Your own dates are set with us, not by this chart.

THE PHASES, ONE BY ONE

You move to the next phase by meeting its exit criteria, not by the calendar. The week numbers are typical, nothing more.

PHASE 1: PROTECT AND ACTIVATE

WEEKS 0-2

Shield the repair: brace on, range 0-90°, protected weight bearing, while doing the same four early jobs as every ACL knee: extension, swelling, quadriceps, safe walking.

GOALS: TICK THEM OFF

- ☐ Extension (straightness) equal to the other side. The repair does not restrict this
- ☐ Flexion to 90 degrees, within the brace limit, and no further
- ☐ Straight leg raise with no lag
- ☐ Swelling settling rather than building
- ☐ Safe, consistent crutch walking within your weight-bearing limit
- ☐ Wound healed

DO THIS

- Heel props and prone hangs several times daily, full extension is still the number one priority, and it is fully allowed.
- Quadriceps sets, straight leg raises and ankle pumps every day.
- Kneecap (patellar) mobilisation in all four directions once the dressing allows.
- Heel slides to 90 degrees only: respect the limit even though the knee could go further.
- Ice 15-20 minutes several times a day, and elevate properly: lying down, foot above heart.

AVOID THIS

- Bending past 90 degrees, even unloaded, even "just to see".
- Taking more weight than your operation record allows, or walking without the brace.
- A pillow under the knee, and prolonged sitting with the leg hanging down.
- Hamstring stretching if you had a hamstring graft: leave the donor site alone for 4-6 weeks.

READY FOR THE NEXT PHASE WHEN...

- Full extension, matching the other side
- Comfortable flexion to the 90-degree brace limit
- Straight leg raise with no lag
- Effusion (fluid in the knee) settling; wound healed
- Confident, safe crutch-and-brace walking

PHASE 2: RANGE WITHIN LIMITS AND BASE STRENGTH

WEEKS 2–6

Consolidate extension and quadriceps control inside the 0–90° window, keep the repair quiet, and prepare for the review where the limits come off.

GOALS: TICK THEM OFF

- ☐ Full extension maintained every single day
- ☐ Easy, comfortable flexion to 90 degrees
- ☐ Quadriceps and hip strength work within the permitted range
- ☐ Single-leg stance control (within your weight-bearing limit, or once cleared)
- ☐ Brace and crutch discipline holding: the repair protected every hour of every day

DO THIS

- Keep the daily extension work: it still leads.
- Inner-range quadriceps work, straight leg raises with progression, and hip and calf strengthening that does not bend the knee past 90 degrees.
- Seated assisted knee bends up to, not past: 90 degrees.
- Start scar massage once the wounds are fully healed and dry.
- At the 4–6 week review: the brace range is opened, weight bearing progresses and the crutches begin to go, on instruction, not by feel.

AVOID THIS

- Bending past 90 degrees before the review clears it.
- Squats, lunges, cycling and swimming kicks. They all take the knee past the limit or load it; they wait.
- Heavy resisted hamstring curls and end-range hamstring stretching until about 4–6 weeks if you had a hamstring graft.

READY FOR THE NEXT PHASE WHEN...

- Cleared at the 4–6 week review: brace range opened, weight bearing progressing
- Full extension held
- Effusion 1+ or less
- Straight leg raise strong, with no lag

PHASE 3: RESTORE RANGE AND BUILD STRENGTH

WEEKS 6–12

Out of the brace and off the crutches: regain the full bend gradually, walk normally, and build strength, still without loaded deep bending or twisting.

GOALS: TICK THEM OFF

- ☐ Flexion recovered progressively towards the other side
- ☐ Walking without crutches, brace or a limp
- ☐ Stationary cycling once the bend allows a full revolution
- ☐ Double-leg and then single-leg strength work above 90 degrees of bend
- ☐ Quadriceps strength building towards 70–80% of the other leg

DO THIS

- Regain the bend with heel slides, seated bends and the bike, gradually; the repair is healing, not healed.
- Sit-to-stands, mini squats (shallow), step-ups and controlled step-downs.
- Hamstring strengthening from 6 weeks, whichever graft you had.
- Balance work: progress single-leg stance to unstable surfaces and head turns.

AVOID THIS

- Loaded deep bending: deep squats, lunges, kneeling back on your heels, until 3–4 months.
- Twisting or pivoting on the planted foot until 3–4 months.
- Running: it starts around 4 months on this pathway, later than after an isolated reconstruction.
- Breaststroke kick when you return to the pool.

READY FOR THE NEXT PHASE WHEN...

- Full extension; flexion approaching the other side
- No effusion after exercise sessions
- Controlled single-leg squat to 45 degrees
- Quadriceps limb symmetry approaching 70–80%

PHASE 4: RUNNING AND LOADING

MONTHS 4–6

Return to running, about a month later than the isolated pathway, then build volume, heavier strength and pre-planned agility.

GOALS: TICK THEM OFF

- ☐ Running from about 4 months, once the running gates are passed
- ☐ Progressive running volume from straight lines
- ☐ Bilateral then unilateral plyometrics (two-leg, then one-leg jumping work)
- ☐ Heavy strength work through full range, deep loaded bending returns here, gradually, once cleared at 3–4 months

DO THIS

- Pass the running gates first: pain 2/10 or less, no effusion, full range, quadriceps symmetry at least 70–80%, good single-leg squat, pain-free double- then single-leg hopping.
- Follow a graded return-to-running programme rather than "seeing how it feels".
- Reintroduce deeper squatting and lunging progressively once cleared: the 3–4 month restriction ends by instruction, not by default.
- Keep two to three strength sessions a week.

AVOID THIS

- Reactive, unplanned change of direction. That is next phase's work.
- Competitive sport of any kind, including "just training".
- A sudden festival of deep squats in week one of being cleared, graded means graded.

READY FOR THE NEXT PHASE WHEN...

- Strength symmetry at least 80–90%
- Hop-test battery commenced
- Sound landing mechanics
- Full, comfortable range including loaded flexion

PHASE 5: CHANGE OF DIRECTION AND SPORT-SPECIFIC WORK

MONTHS 6-9

Cutting, pivoting and reactive agility, then non-contact and finally contact team training: the same territory as every ACL knee, entered a little later.

GOALS: TICK THEM OFF

- ☐ Cutting and pivoting drills, progressing from pre-planned to reactive
- ☐ Sport-specific skills reintroduced
- ☐ Non-contact team training, then contact training
- ☐ Strength and hop symmetry closing on 90%

DO THIS

- Train movement quality under fatigue. The graft is most at risk when you are tired.
- Rehearse your sport's specific demands: marking, landing, side-stepping, tackling technique.
- Start a structured neuromuscular warm-up programme now and keep it permanently.
- Track psychological readiness honestly. It is measured, not assumed.

AVOID THIS

- Match play, including "friendly" games and social sport.
- Skipping the strength work because the fun drills are back.

READY FOR THE NEXT PHASE WHEN...

- Strength and hop symmetry at least 90%
- Movement quality holding up under fatigue
- Psychological readiness (ACL-RSI) improving

PHASE 6: RETURN TO SPORT AND SECONDARY PREVENTION

FROM 9–12 MONTHS

Full training, then match play, with a repaired meniscus, the return window is nine to twelve months, and the prevention habits are permanent.

GOALS: TICK THEM OFF

- ☐ Pass the full return-to-sport test battery
- ☐ Full training without reaction from the knee
- ☐ Graduated return to match play, typically in the 9–12 month window
- ☐ Structured prevention warm-up embedded: permanently

DO THIS

- Complete formal return-to-sport testing before match play: strength, hop battery, movement quality and the ACL-RSI questionnaire.
- Return through full training first: weeks of it, before your first game.
- Keep the neuromuscular warm-up: twenty minutes, three times a week, forever.
- Continue periodic strength testing out to 24 months.

AVOID THIS

- Returning on a date instead of a test result.
- Dropping the prevention warm-up once the season starts.

READY FOR THE NEXT PHASE WHEN...

- Return-to-sport testing passed and reviewed with Dr Broadhead and your physiotherapist
- Playing full matches with no swelling, no giving way and growing confidence

YOUR EXERCISES

Little and often beats one heroic session. Each exercise lists what you should feel, sharp pain that lingers afterwards means ease off and, if it persists, call.



ANKLE PUMPS

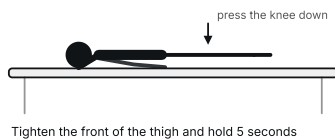
PHASE 1

Keep blood moving in the calf: your main clot-prevention exercise, doubly important while weight bearing is restricted.

10 firm pumps, every waking hour, for the first 2 weeks

1. Lie or sit with the leg supported.
2. Pull your foot up towards you as far as it goes.
3. Point it away as far as it goes.
4. Repeat briskly.

Feel: You should feel the calf muscles working. The brace does not get in the way of this one, no excuses.



STATIC QUADRICEPS SETS

PHASE 1

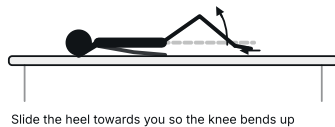
Switch the thigh muscle back on: swelling turns it off, and everything else depends on it.

10 holds of 5 seconds, 3–4 times daily

1. Lie with the leg straight.
2. Push the back of the knee down into the bed by tightening the front of the thigh.
3. Watch the kneecap draw upward slightly.
4. Hold, then fully relax.

Feel: You should feel this in the front of the thigh. A quadriceps tendon graft makes this harder at first, persist; a slow start here is expected.

Harder: Your physiotherapist may add muscle stimulation (NMES) over the quadriceps if activation is slow.



HEEL SLIDES, TO 90 DEGREES ONLY

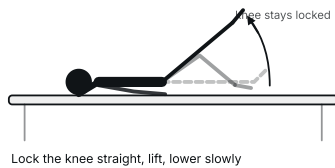
PHASE 1

Keep the bend easy within the permitted range, without stressing the meniscal repair.

10 slow slides to 90 degrees, 3–4 times daily

1. Lie on your back.
2. Slide the heel towards your bottom until the knee reaches a right angle, no further.
3. Hold 5 seconds.
4. Slide slowly back to straight.

Feel: 90 degrees is a right angle: shin vertical when lying down. If in doubt, stop short. The limit applies even though the knee could bend further. That is the point.



STRAIGHT LEG RAISE

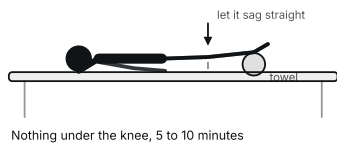
PHASE 1

Quadriceps strength with the knee locked straight. The milestone is lifting without a lag.

10 lifts, hold 3 seconds, 3 times daily

1. Lie on your back, other knee bent, operated leg straight.
2. Tighten the thigh first, locking the knee straight.
3. Lift the whole leg about 30 cm.
4. Lower slowly with the knee still locked.

Feel: If the knee sags as you lift (a "lag"), keep working the static quads. The lag going is the sign of progress.



HEEL PROP (EXTENSION STRETCH)

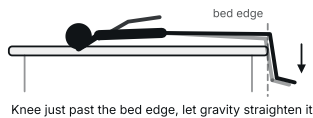
PHASE 1

Full straightening: fully allowed, fully expected, and still the highest-priority exercise in this guide.

5–10 minutes, 2–3 times daily

1. Lie or sit with the heel propped on a rolled towel or the arm of a couch, nothing under the knee.
2. Let the knee sag towards straight under its own weight.
3. For extra effect, rest a small weight (a bag of rice) above the kneecap.

Feel: A firm stretch behind the knee is exactly right. The meniscal repair does not restrict straightening, do not let the brace make the knee lazy about extension.



PRONE HANG

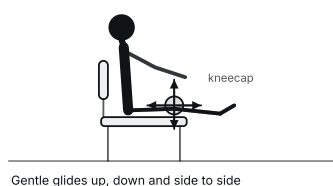
PHASE 1

Gravity-assisted full extension: the partner exercise to the heel prop.

3–5 minutes, 2–3 times daily

1. Lie face down on a bed with both legs from the kneecap down hanging off the end.
2. Let the operated knee sag towards straight under the weight of the lower leg.
3. Stay relaxed and let gravity do the work.

Feel: A firm stretch behind the knee is the goal. If you had a hamstring graft and feel a pull in the back of the thigh rather than the knee, shorten the time and build up.



KNEECAP MOBILISATION

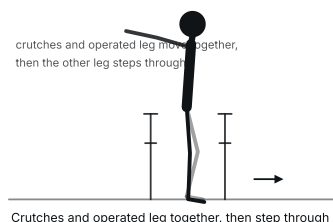
PHASE 1

Keep the kneecap gliding freely so the bend and the scar do not tether: extra important after a patellar tendon (BTB) graft.

1–2 minutes in each direction, twice daily, once the dressing allows

1. Sit with the leg straight and thigh relaxed.
2. With thumbs and fingers, glide the kneecap gently up, down, left and right.
3. Small movements: this is a glide, not a push.

Feel: It should feel odd, not painful.



WALKING WITH CRUTCHES, BRACE ON

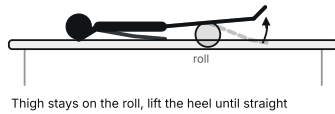
PHASE 1

A safe, consistent walking pattern inside your weight-bearing limit. The pattern you will keep for 4–6 weeks, so make it a good one.

Short walks every waking hour, within your weight-bearing limit

1. Brace on and checked before you stand.
2. Crutches and the operated leg move forward together.
3. Take only the weight your operation record allows through the operated leg.
4. Step the other leg past, not just up to, the operated one.

Feel: Slow and tidy beats fast and ragged. If you cannot remember your weight-bearing limit, call the rooms, do not guess upward.



INNER-RANGE QUADRICEPS OVER A ROLL

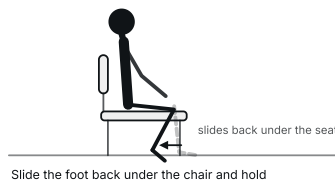
PHASE 2

Strengthen the last few degrees of straightening, safe, repair-friendly quadriceps work in the range that matters most.

2–3 sets of 10, hold 3 seconds, once or twice daily

1. Lie with a firm roll (a rolled towel) under the knee.
2. Keeping the thigh on the roll, lift the heel until the knee is fully straight.
3. Hold, then lower slowly.

Feel: All the movement happens below the knee, well inside the 0–90° window. Push through to completely straight every repetition.



SEATED ASSISTED KNEE BEND, TO 90 DEGREES ONLY

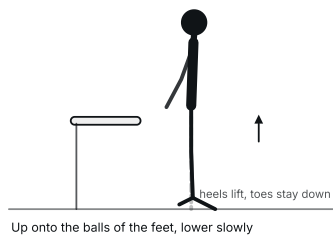
PHASE 2

Keep the bend easy and comfortable up to the brace limit.

10 bends, hold 5 seconds, 2–3 times daily

1. Sit on a chair, feet on the floor.
2. Slide the operated foot back until the knee reaches a right angle, no further.
3. Hold, release, repeat.

Feel: Foot directly under the knee is roughly 90 degrees; behind that line is past the limit. After the 4–6 week review, this exercise progresses past 90, not before.



HEEL RAISES

PHASE 2

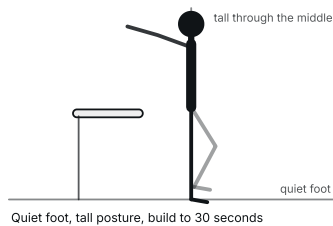
Calf strength: one of the few standing strength exercises fully open to you early, within your weight-bearing limit.

2–3 sets of 10, once or twice daily, within your weight-bearing limit

1. Stand tall holding the bench or rail, brace on.
2. Rise up onto the balls of the feet, loading within your permitted limit.
3. Lower slowly.

Feel: Once cleared for full weight bearing, share the load evenly, then progress to single-leg raises.

Harder: Single-leg raises on the operated side after clearance at the 4–6 week review.



SINGLE-LEG BALANCE

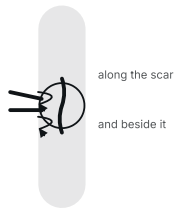
PHASE 2

The knee's position sense (proprioception), started once weight bearing is cleared, then progressed steadily.

Build to 3 holds of 30 seconds each leg, daily, once cleared for full weight bearing

1. Stand near the bench, fingertips hovering.
2. Lift the other foot and balance on the operated leg.
3. Progress: eyes tracking side to side, then a gentle head turn, then no hands, then an unstable surface.

Feel: Quiet foot, soft knee, tall posture. Balance work, not twisting work. The foot stays planted and the body stays square.



SCAR MASSAGE

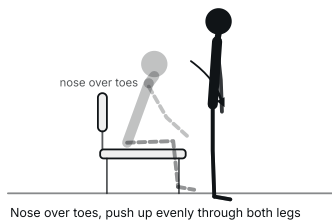
PHASE 2

Soften and desensitise the scars, including the graft donor site: once fully healed.

2–3 minutes, twice daily, from about 3 weeks once healed and dry

1. Use a bland moisturiser.
2. Firm, small circles along and beside each scar.
3. Include the skin around them, which is often more sensitive than the scars themselves.

Feel: Firm enough to blanch the skin slightly; it should not be painful. A numb patch near the incision is common: massage the edges of it; it usually shrinks with time.



SIT-TO-STAND

PHASE 3

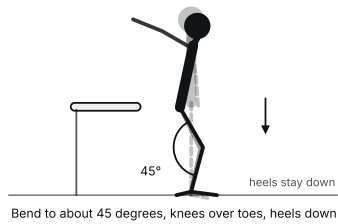
Real-world double-leg strength, reintroduced once the brace and crutches are gone.

2–3 sets of 8–10, once or twice daily, from Phase 3

1. Sit on a firm, raised chair.
2. Feet back, lean forward, push up through both legs evenly.
3. Lower back down slowly with control.

Feel: Start from a higher chair than usual. A low chair takes the knee deeper than the repair wants this early. Share the load evenly, no cheating onto the good leg.

Harder: Lower the chair height gradually as the deep-bending restriction lifts at 3–4 months.



MINI SQUAT: SHALLOW

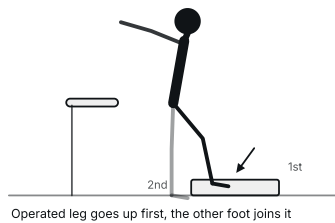
PHASE 3

Thigh and hip strength through a small, repair-safe range.

2–3 sets of 10 to about 45 degrees, once or twice daily, from Phase 3

1. Stand holding the bench, feet hip-width.
2. Bend both knees to about 45 degrees: well short of deep.
3. Keep the heels down and knees over the toes.
4. Push back up.

Feel: Shallow is the point: deep loaded bending waits until 3–4 months and clearance. Knees track over the toes, no diving inward.



STEP-UPS

PHASE 3

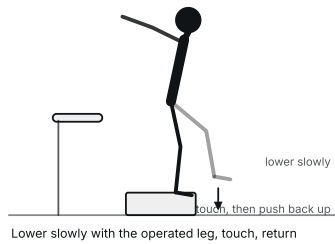
Single-leg strength for stairs, slopes and: eventually: running.

2–3 sets of 8 each leg, once daily, from Phase 3

1. Stand facing a low step, hand on the rail.
2. Step up with the operated leg, bringing the other foot up to join it.
3. Step down leading with the non-operated leg.

Feel: A low step keeps the knee bend modest: right for a healing repair. Push through the whole foot; knee over the toes.

Harder: Raise the step height only as the deep-bending restriction lifts.



STEP-DOWNS (CONTROLLED LOWERING)

PHASE 3

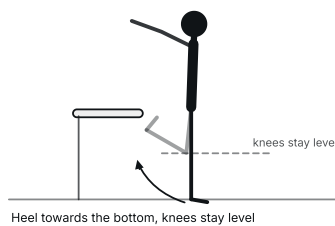
The controlled lowering strength that landing, decelerating and cutting are built on.

2–3 sets of 8 each leg, alternate days, from later in Phase 3

1. Stand on a low step on the operated leg, hand on the rail.
2. Slowly lower the other heel towards the floor by bending the operated knee.
3. Touch, then push back up.

Feel: Slow and controlled beats deep; keep the pelvis level and the knee over the toes.

Harder: Raise the step, slow the lowering, remove hand support.



STANDING KNEE BEND (HAMSTRING WORK)

PHASE 3

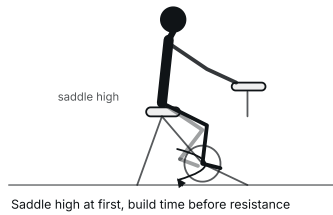
Rebuild hamstring strength: the muscle group that actively protects the ACL graft.

2–3 sets of 10, once daily, from 6 weeks

1. Stand holding the bench.
2. Bend the operated knee, bringing the heel towards your bottom.
3. Lower with control.

Feel: If you had a hamstring graft, this is deliberately delayed until about 6 weeks, donor-site ache when you start is normal and settles.

Harder: Add an ankle weight, then progress to gym-based hamstring work with your physiotherapist.



STATIONARY CYCLING

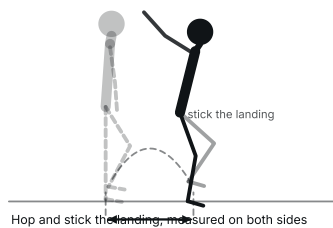
PHASE 3

Range, circulation and endurance, reintroduced once the brace limit is lifted and the bend allows a full revolution.

10–20 minutes, most days, from about 6–8 weeks once cleared and the bend allows

1. Saddle high at first: a higher seat needs less bend.
2. Start with gentle half-revolutions back and forth if a full turn is not there yet.
3. Progress time before resistance.

Feel: Cycling waits until after the 4–6 week review on this pathway. A full pedal stroke needs more bend than the brace allows.



HOP-TEST BATTERY

PHASE 5

The measuring stick for return to sport: performed and scored with your physiotherapist, not alone.

Testing sessions with your physiotherapist from Phase 4 onward, not a daily exercise

1. Single hop for distance on each leg.
2. Triple hop for distance.
3. Crossover hop for distance.
4. Timed 6-metre hop.
5. Each score on the operated leg is compared with the other side.

Feel: The target is at least 90% of the other leg on every test. How you land is scored as well as how far you hop. A long, ugly hop does not pass.

SWELLING, ICE AND ELEVATION

WHAT IS NORMAL

- Swelling is the single biggest brake on progress. It peaks about 6–8 days after surgery, then settles gradually.

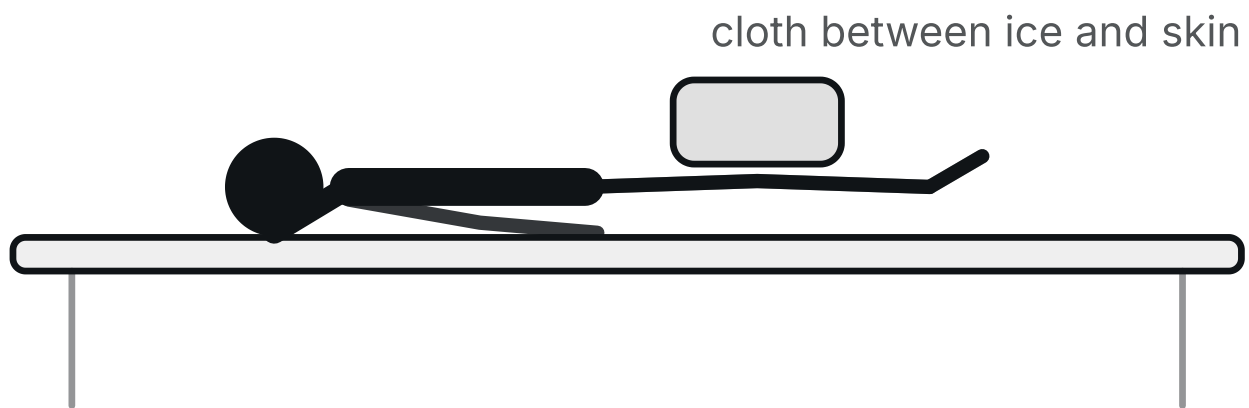
- Most of the swelling resolves over the first two to three months, but it is normal for the limb to puff up after a long day or a burst of activity for some months after that, measurable swelling is still present at 7 weeks in most knee replacement patients.
- A limb that is bigger the morning after activity means you did too much the day before, not that something is wrong.
- Warmth and mild redness around the wound settle over weeks.

ICE

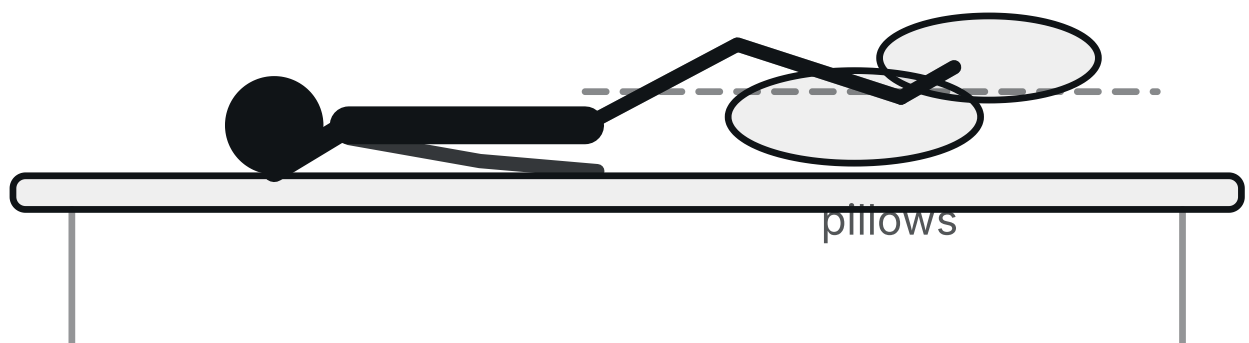
- Ice is safe, cheap and comfortable, and probably gives a small benefit for pain and swelling in the first few days.
- Use it for 15–20 minutes at a time, 4–6 times a day for the first 2 weeks, then as needed after activity and physiotherapy. It is particularly useful in the hour after exercise.
- Always place a thin cloth between the ice and your skin. Never sleep with ice on. Never ice over numb skin or a fresh wound dressing without checking with the rooms first.
- Stop and call the rooms if the skin becomes white, mottled or numb.
- An honest note about the evidence: the 2025 Cochrane review of icing after knee replacement (22 trials, 1,839 patients) found small improvements: pain at 48 hours better by 1.6 points out of 10, about 8 degrees more bend at discharge, and less blood loss: all on low-certainty evidence. The reviewers concluded the benefits may be too small to justify routine use. Use ice because it is harmless and makes you more comfortable, not because it changes the final result.
- There is no good evidence that expensive cold-compression machines work better than a bag of ice or a gel pack. The trials have never been analysed in a way that answers that question. Please do not spend money on one on our recommendation.

ELEVATION & COMPRESSION

- Elevate the limb above heart level for 20–30 minutes several times a day: foot higher than the knee, knee higher than the hip, hip higher than the heart.
- Lie down to do this: a recliner does not raise the leg above your heart.
- Avoid sitting with the leg hanging down for long periods.
- A graduated compression stocking or sleeve helps control swelling, wear it as advised.



15 to 20 minutes, 4 to 6 times daily



Foot above knee, knee above hip, lying flat

WOUND AND SCAR CARE

- Keep the dressing dry and intact until it is reviewed. Most modern waterproof dressings allow showering, but do not soak, scrub, or put soap directly on the wound.
- No baths, spas, pools or ocean swimming until the wound is fully healed and has been reviewed, usually 2–3 weeks at a minimum.
- Do not apply creams, powders or antiseptics unless you have been told to.
- Clips or stitches are removed or checked at your first appointment.
- Tell the rooms about any dressing that becomes soaked, loose or soiled.
- From about 3 weeks, once the wound is fully healed and dry: massage the scar with a bland moisturiser for 2–3 minutes, twice a day, using firm circular pressure. This softens the scar and desensitises the skin around it.
- Silicone gel or sheeting can improve the appearance of prominent scars.
- Protect the scar from the sun for 12 months. It burns easily and can darken permanently.
- Scars take a full 12–18 months to fade and flatten.
- Numbness in the skin around and below the scar is normal and often permanent, small skin nerves are unavoidably divided during surgery.

SLEEP AND POSITIONING

Follow your operation record on whether the brace is worn at night in the early weeks: practice varies with the repair. If the record does not say and you are unsure, call the rooms.

Never sleep with a pillow under the knee. If you want support, place a pillow under the whole lower leg from calf to heel, so the knee rests straight.

On your back with the leg elevated is usually the most comfortable position for the first weeks, and it helps the morning swelling. Side sleeping works with a pillow between the knees once comfortable.

PAIN, MEDICATION AND WHAT TO EXPECT

Expect real pain for the first week or two, needing regular pain relief. A two-part operation (graft plus repair) is often sorer early on than an isolated reconstruction. Take medication as prescribed and ahead of exercise sessions rather than chasing pain afterwards.

Wean the strongest medications first as things settle.

Donor-site pain is its own story: hamstring grafts commonly ache in the back of the thigh for some weeks, patellar tendon (BTB) grafts at the front of the knee, especially with kneeling, and quadriceps tendon grafts above the kneecap. All of it settles; none of it means something is wrong with the graft.

Joint-line ache on the side of the repair with the first deeper bends and the first weeks of walking is common. Sharp joint-line pain with a click or catch, or a knee that locks, is different, call the rooms.

PREVENTING BLOOD CLOTS

- Get up and move at least hourly while you are awake.
- Do ankle pumps: 10 firm up-and-down pumps of the ankles: every waking hour for the first 2 weeks.
- Stay well hydrated.
- Take any prescribed blood thinner exactly as directed, and wear stockings as advised.
- Avoid long-haul flights for 6 weeks after joint replacement: discuss any earlier travel with the rooms.

DRIVING: THE CRITERIA THAT ACTUALLY MATTER

You may drive when **all** of the following are true:

- You are off opioid painkillers and any other sedating medication.
- You can sit comfortably in the driver's seat.
- You can perform an emergency stop at full force, without hesitation and without pain.

- You are not using a walking aid in the car, and not wearing a brace that limits the movement needed to work the pedals.
- You have practised the movements in a stationary car first.

What the driving research does and doesn't show

What the research actually measures is braking reaction time on a simulator. Those studies show braking performance returns to its pre-operative level at about 2 weeks after a right hip replacement and about 4 weeks after a right knee replacement, with movement time back to normal by 6 weeks. After knee arthroscopy the simulator evidence is more conservative than common practice: in the one study that measured it directly, braking was still slower one week after surgery than before it, and had recovered by four weeks, and a 2021 review of eight studies put the average return at about six weeks. Most people having a simple arthroscopy are driving well before that, which is why the criteria above matter more than the date. But these are averages, in one study, about one in three right-hip patients still could not meet an emergency-stop benchmark at six weeks. Treat the timeframes in this guide as targets for discussion with us, not as permissions.

No published study has compared automatic and manual cars. The logical point is simply that a manual needs the left leg for the clutch, so left-sided surgery is the relevant caution in a manual. Advice about driving earlier with a left-leg operation in an automatic is clinical judgement, not trial evidence.

In Australia, your treating doctor's advice governs: under the Austroads "Assessing Fitness to Drive" standards, temporary post-operative impairment is a matter of clinical judgement, and commercial drivers are held to a higher standard. Driving while impaired may invalidate your

insurance, check your insurer's position. Do not drive for at least 24 hours after any general anaesthetic or sedation.

GETTING BACK TO WHAT YOU DO

ACTIVITY	TYPICAL	WHEN IT'S RIGHT	NOTES
Walking for exercise	From about 6–8 weeks (unaided)	Cleared for full weight bearing; no limp	Before that, walking is crutch-and-brace walking within your limit
Desk work	About 2 weeks	Comfortable sitting with the brace on and the leg elevated; travel sorted	You cannot drive yourself yet: plan transport
Swimming (straight-line, no breaststroke kick)	After the brace is off, about 6–8 weeks	Wound healed; cleared at review	Flutter kick only; breaststroke kick loads the repair in exactly the wrong way. It waits until cleared
Stationary cycling	About 6–8 weeks	Brace limit lifted; enough bend for a full revolution	Saddle high at first
Driving	After the brace and crutches are gone: later than the isolated pathway	All the driving criteria below, discussed with us	A brace that limits knee movement rules out driving on its own
Physical work	Usually 3 months or more	Strength and endurance for the actual duties; squatting and twisting duties wait for the 3–4 month clearance	Modified duties in between where available: raise it at the 2-week review
Loaded deep bending and twisting (deep squats, lunges, pivoting drills)	Cleared from 3–4 months	Cleared at review: root and radial repairs may be later	The single most important restriction in this guide

ACTIVITY	TYPICAL	WHEN IT'S RIGHT	NOTES
Running (straight line)	From about 4 months: if criteria are met	Pain $\leq 2/10$, no effusion, full range, quadriceps symmetry $\geq 70-80\%$, good single-leg squat, pain-free hopping	About a month later than the isolated pathway
Change of direction and sport-specific training	Months 6–9	Strength and hop symmetry approaching 90%	Pre-planned first, reactive later; non-contact before contact
Pivoting sport (netball, football, soccer, basketball, skiing)	9–12 months	Full return-to-sport test battery passed: strength $\geq 90\%$, hop battery $\geq 90\%$, movement quality under fatigue, psychological readiness	Time plus testing together protect the graft and the repair far better than either alone
Kneeling and squatting to the floor	From 3–4 months, built gradually	Deep-bending clearance given	Later and more gradually after a BTB graft, kneeling tolerance is a late milestone

Flying after joint replacement: an honest note

You will often hear "no flying for six weeks" after joint replacement. Be aware that this is a convention, not a proven rule: a 2025 review found limited data and no demonstrated difference in clot risk between people who did and did not fly after hip or knee replacement: mostly within the first week.

The six-week convention reflects practical realities rather than trial evidence: managing airports and cramped seating, being past the highest-risk clot window while still on prevention, the higher baseline clot risk of long-haul flights over four hours, and individual airline and travel-insurance rules, check both, as some airlines impose their own restrictions.

If you need to travel long-haul in the first six weeks, talk to the rooms first so clot prevention, an aisle seat, stockings and on-board movement can be planned.

WARNING SIGNS: ACT, DON'T WATCH

None of these should be watched overnight to see how they go. Early treatment of a problem is simple; late treatment is not.

EMERGENCY: 000 Emergency department / call 000

- Sudden shortness of breath
- Chest pain
- Coughing blood, or feeling faint

GP TODAY See your GP today

- New, one-sided calf pain, tenderness or firmness
- Calf or whole-leg swelling out of proportion to the rest of your recovery

CALL THE ROOMS Call the rooms: same day

- Pain that is increasing rather than decreasing after the first week
- New redness spreading out from the wound
- Wound discharge, particularly cloudy, thick or offensive fluid, or wound edges opening
- Fever of 38°C or higher, or shaking chills, or feeling generally unwell
- The knee locks: gets stuck and will not fully straighten
- A new, sharp joint-line pain with a click, catch or giving way, especially after a bend or twist past your limits
- The knee gives way, or a sudden "pop" with new swelling at any stage of rehabilitation
- Brace problems you cannot fix: dials moved and you do not know the setting, broken hinge, skin damage under the straps

For joint replacement patients, a wound problem is never something to "wait and see". Early treatment of an infected joint replacement is vastly more successful than late treatment, call the rooms the same day.

ARRANGING PHYSIOTHERAPY IN AUSTRALIA

- Most privately insured patients self-fund private physiotherapy or use extras cover. A GP Chronic Disease Management plan subsidises only five allied-health visits per calendar year, not enough for a major reconstruction, so plan for this.
- Compensable patients (workers compensation, CTP) follow an insurer-approved plan.
- Tele-rehabilitation and app-supported home programmes are reasonable additions, but a sports knee reconstruction still needs periodic in-person objective strength testing.

COMMON QUESTIONS

How do I know if this is the right guide for me?

This guide is for an ACL reconstruction with a meniscal repair: stitches in the meniscus as well as a new ACL graft. Your operation record says which operation you had. If your ACL was reconstructed without a meniscal repair, follow the guide "ACL reconstruction" instead: it has no brace, no 90-degree limit and a faster start. The two programmes are genuinely different. If you are unsure which applies, call the rooms before starting.

Why can't I bend my knee past 90 degrees for six weeks after a meniscal repair?

Because bending deeply rolls the thigh bone back over exactly the part of the meniscus that was stitched, and shears the repair. Only the outer quarter or so of the meniscus has a blood supply, so the stitches hold slowly-healing tissue for three months and more. The 0–90° limit protects it through the most fragile weeks. Protecting it now buys you a meniscus for life; a failed repair means another operation and a higher long-term risk of arthritis.

Why do I have a brace when other ACL patients don't?

Routine bracing after an isolated ACL reconstruction does not improve laxity, range, pain, graft survival or function, so those patients go without. Braces are used where the meniscus was repaired. That is you, and where other ligaments were involved or quadriceps control is poor. Your hinged brace holds the knee to 0–90° for the first 4–6 weeks to shield the stitches. It is not a precaution; it is part of the operation working.

How much weight can I put on my leg?

Less than an isolated ACL patient, weight bearing is protected, with two crutches and the brace on, typically for the first 4–6 weeks. Load squeezes and shears the healing meniscus. Your exact limit is in your operation record, and root and radial repairs are usually the most restricted. If you cannot remember your limit, call the rooms rather than guessing upward. Weight bearing is progressed at your reviews, not by feel.

How long will I be on crutches?

Typically 4–6 weeks: much longer than the one to two weeks after an isolated ACL reconstruction, because the crutches are protecting the meniscal repair, not just helping your balance. They start to go after the 4–6 week review, once your weight bearing is progressed and the brace range is opened, and they are fully gone when you can walk without a limp, usually around weeks 6–8.

When can I drive after ACL reconstruction with meniscal repair?

Later than the isolated pathway. A brace that limits knee movement rules out driving by itself, and so do crutches, so driving waits until both are gone, typically some weeks after the 4–6 week review. Then the usual criteria apply: off strong painkillers, comfortable in the seat, and able to perform an emergency stop at full force without hesitation, practised in a stationary car first. Confirm your timing with us at review.

When can I go back to work?

Desk work typically around two weeks, with the brace on, the leg elevated under the desk and transport organised. You cannot drive yourself yet. Physical work usually takes three months or more, because squatting, kneeling and twisting duties wait for the 3–4 month

deep-bending clearance. Raise your job's actual demands at the two-week review so modified duties can be planned early.

When can I run after this operation?

From about four months, roughly a month later than after an isolated ACL reconstruction, to give the meniscal repair its healing time. The criteria still rule the date: pain no more than 2 out of 10, no fluid in the knee, full range of movement, quadriceps strength at least 70–80% of the other leg, a good single-leg squat, and pain-free double- then single-leg hopping. The date does not open the gate.

When can I play netball or football again?

Nine to twelve months, and only after passing formal return-to-sport testing: strength and hop symmetry at 90% or better, sound movement under fatigue, and psychological readiness. Returning to pivoting sport before nine months substantially increases re-injury risk, and each extra month up to nine lowers it; with a repaired meniscus the window sits at the later end. Netball, football, soccer and basketball are exactly the sports this rule exists for.

What is a root or radial repair, and why is mine more protected?

A root repair re-anchors the meniscus where it attaches to bone; a radial repair stitches a tear running across the meniscus's full width. Both interrupt the hoop of tissue that spreads your body weight, so the stitches carry the highest loads of any repair, and have the most to lose. If your operation record names one of these, expect stricter weight-bearing and range limits than the typical figures here. The record overrides the guide, every time.

What happens if the repair fails?

Usually a return of joint-line pain, clicking, catching or locking, sometimes after a bend or twist the knee was not ready for. A failed repair generally means another operation, often removal of the torn part, which raises the long-term risk of arthritis in that part of the

knee. That is what the brace, the crutches and the 3–4 months of restrictions are buying you: a meniscus for life. Call the rooms if those symptoms appear at any stage.

Do I sleep and shower in the brace?

Showering: the brace can come off once the wound allows, sit on a shower stool, keep the knee within its range, and put the brace back on before you walk anywhere. Sleeping: practice varies with the repair, so follow your operation record; some repairs are braced at night in the early weeks and others are not. If the record does not say and you are unsure, call the rooms rather than deciding at midnight.

When can I squat, lunge or kneel again?

Loaded deep bending and twisting: deep squats, lunges, kneeling back on your heels, pivoting on the planted foot, waits 3–4 months, until the repair is cleared at review. It is the single most important restriction in this guide. After clearance it comes back gradually, not all at once, and later again after a patellar tendon (BTB) graft, where kneeling tolerance is a late milestone in its own right.

How do I stop this happening again?

Structured neuromuscular warm-up programmes roughly halve the risk of ACL injury, with the largest effect in female athletes. Ready-made versions exist for the sports that matter here: Prep-to-Play for AFL and AFLW, the Netball Australia KNEE Program, and FIFA 11+ for football. The dose is simple: twenty minutes, three times a week, forever. Among returning athletes under 25, roughly one in four re-injures an ACL, with the other knee at least as vulnerable as the graft. In those operated under 20, graft rupture alone reached 18% by five years. The warm-up is permanent.

THE EVIDENCE BEHIND THIS GUIDE 15 sourced statements

CLAIM	SOURCE
Only the peripheral 10 to 25% of the meniscus is vascular, so repaired meniscus heals slowly	Arnoczky & Warren, Am J Sports Med 1982, microvasculature of the human meniscus (PMID 7081532)
Meniscal repair preserves function compared with meniscectomy but carries a higher reoperation rate; failed repair usually means resection	Paxton, Stock & Brophy, Arthroscopy 2011, meniscal repair versus partial meniscectomy systematic review (PMID 21820843)
Meniscal loss raises the long-term risk of knee osteoarthritis: the rationale for repairing and protecting the meniscus	Papalia et al., Br Med Bull 2011, meniscectomy as a risk factor for knee osteoarthritis, systematic review (PMID 21247936)
Root repairs are protected with restricted weight bearing and range because root tears defunction the meniscus (equivalent to meniscectomy if untreated)	LaPrade et al., Am J Sports Med 2017, posterior meniscal root repair outcomes (PMID 27919916)
Restricted rehabilitation (limited range and weight bearing) is standard for complex, root and radial repairs; freer rehabilitation may be acceptable only for simple peripheral vertical tears: evidence limited	O'Donnell et al., Am J Sports Med 2017, systematic review of rehabilitation protocols after isolated meniscal repair (PMID 28256906)
Return to pivoting sport before 9 months increases ACL re-injury; each month of delay up to 9 months reduces it, and passing discharge criteria reduces it further	Grindem et al., Br J Sports Med 2016, Delaware-Oslo cohort (PMID 27162233)
Roughly 1 in 4 athletes under 25 who return to sport sustain a further ACL injury to either knee	Wiggins et al., Am J Sports Med 2016, systematic review and meta-analysis (PMID 26772611)
In patients reconstructed under 20, graft rupture alone was 18% at a mean 5 years, highest at 28.3% in males under 18; 47% of ruptures occurred in the first postoperative year	Webster & Feller, Am J Sports Med 2016 (PMID 27390346)
The other knee is at least as vulnerable as the graft: contralateral injury 8% against ipsilateral	Wiggins et al., Am J Sports Med 2016, systematic review and meta-analysis

CLAIM	SOURCE
7%	(PMID 26772611)
Routine bracing does not improve outcomes after isolated ACL reconstruction, bracing here is for the meniscal repair, not the graft	Wright & Fetzer, Clin Orthop Relat Res 2007, systematic review of bracing after ACL reconstruction (PMID 17279043)
Criteria-based (not purely time-based) progression is best practice after ACL reconstruction	van Melick et al., Br J Sports Med 2016, evidence-based clinical practice update (PMID 27539507)
Athletes not meeting discharge criteria before return had about four times the graft rupture rate	Kyritsis et al., Br J Sports Med 2016, discharge criteria and graft rupture risk (PMID 27215935)
ACL-RSI scale measures psychological readiness; fear of re-injury is the most common reason athletes do not return	Webster, Feller & Lambros, Phys Ther Sport 2008, ACL-RSI development (PMID 19083699); Ardern et al., Br J Sports Med 2014, psychological readiness (PMID 25293342)
Structured neuromuscular warm-up programmes roughly halve ACL injury risk, with the largest effect in female athletes	Webster & Hewett, J Orthop Res 2018, meta-analysis of meta-analyses of ACL injury-reduction programmes (PMID 29737024)
FIFA 11+ structured warm-up reduces lower-limb injuries in football	Thorborg et al., Br J Sports Med 2017, FIFA 11 and 11+ systematic review and meta-analysis (PMID 28087568)

This guide is general information for patients of Dr Matthew Broadhead (Harbour Orthopaedics & Sports Medicine) and is not a substitute for the specific advice given to you by Dr Broadhead, your physiotherapist or your hospital team.

Surgical findings vary, and your protocol may differ from what is written here: your operation record and your surgeon's instructions always take precedence.

If in doubt, call the rooms on (02) 9052 1883. In an emergency, call 000.

Last reviewed: 2026-08-05 by Dr Matthew Broadhead, FRACS (Orth).

YOUR PROGRESS TRACKER

Fill this in once a week: it shows your trend at a glance and makes reviews far more useful.
Bring it to every appointment.

Week	1	2	3	4	5	6	7	8	9	10	11	12
Exercises done (sessions)												
Walking distance / time												
Pain score (0–10)												
Knee bend (degrees)												
Swelling (less / same / more)												

QUESTIONS FOR DR BROADHEAD
