

REHABILITATION AFTER CURETTAGE AND GRAFTING OF A BONE TUMOUR

Curettage and bone graft recovery: protected weight bearing on crutches for roughly 6–12 weeks while the bone fills in.

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

18 minutes to read. Reviews: Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks, then a further X-ray review at about 3 months. These reviews govern each advance in weight bearing.

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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 covers recovery after curettage and grafting of a benign or locally aggressive bone lesion, such as a giant cell tumour or a bone cyst. It is written for you and for your physiotherapist, including a physiotherapist working with you a long way from Sydney, so everyone follows the same plan.

The central idea is different from most orthopaedic recoveries. The soft tissues here usually heal quickly. The hazard is FRACTURE through the cavity left in the bone. So this guide is built around one thing: a graduated, criteria-based weight-bearing plan, protected with crutches over roughly 6–12 weeks while the bone fills in.

These protocols are individualised, more so than joint replacement. How big the cavity is, where it sits, and whether it was filled with cement or graft all change the timeline. Every timeframe here is typical, not a rule: your operation record and your team's instructions always govern, and each advance in weight bearing is your team's call, not the calendar's.

AT A GLANCE

WEIGHT BEARING

Protected, with crutches, graduated over roughly 6–12 weeks: your operation record sets the starting level and your team advances it

BRACE

Not usually: the crutches and the weight-bearing plan do the protecting; a splint is used only if your team fits one

DRIVING

When the standard criteria are met, you are off crutches for driving purposes, and your team agrees, no fixed week

PHYSICAL WORK

After your team clears full weight bearing and the X-rays show the defect consolidating: individualised

REVIEWS

Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks, then a further X-ray review at about 3 months. These reviews govern each advance in weight bearing

WALKING AIDS

Two crutches from the start; weaned in steps as pain settles and X-rays show the defect filling in

PRECAUTIONS

Protect the bone: stick to your permitted weight, no running, jumping or twisting until cleared

DESK WORK

Often within a few weeks, once comfortable and travel is sorted

SPORT & ACTIVITY

Low-impact first; impact and pivoting sports last, on your team's clearance

WHAT WAS DONE IN YOUR OPERATION

A curettage removes the lesion from inside the bone: a window is made in the bone's wall and the abnormal tissue is carefully scraped out, leaving a clean cavity.

The cavity is then filled: either with bone graft (your own bone, donor bone or a bone substitute) or with bone cement. Which one was used matters for your

timeline: cement is mechanically solid almost immediately, while graft is a scaffold that your body must slowly convert into living bone.

Until the cavity has filled in: biologically, or with cement plus the healing of the bone around it. The wall of the bone is thinner and weaker than normal at that spot. That temporary weakness, not the wound, is what the whole rehabilitation plan is protecting.

THE IDEAS THAT MAKE EVERYTHING ELSE MAKE SENSE

1. The hazard is fracture, not the wound

The skin and muscle usually heal within weeks. The bone is the slow part: the cavity left after curettage weakens it temporarily, and a fracture through that spot is the complication the whole plan is designed to prevent. Feeling good is not the same as being healed. The bone does not report its strength as pain.

2. Crutches are the treatment, not a sign of weakness

Protected weight bearing with crutches, graduated over roughly 6–12 weeks, is what lets the bone fill in safely. You advance as pain settles AND X-rays show the defect filling: criteria, not dates. Ditching the crutches early is the one way to sabotage an otherwise excellent operation.

3. Cement and graft run on different clocks

Cemented defects gain mechanical support almost immediately, so weight bearing usually advances earlier. Grafted defects need biological healing, living bone growing through the graft, and are protected longer. Larger defects, defects near a joint surface, and lower-limb weight-bearing bones are protected longest of all. Your team will tell you which clock you are on.

4. The rest of you keeps moving

Protecting the bone does not mean resting the limb. The joints next to the operated bone start range-of-motion work early, the muscles are kept switched on from the first week, and the rest of your body trains normally. Protect one thing well; move everything else.

5. X-rays govern the advances

Each step up in weight bearing follows an X-ray showing the defect filling in, together with settling pain. That is why the review appointments matter so much. They are not just check-ins, they are the gates through which your rehabilitation advances.

6. Follow-up continues after the bone heals

Some of these lesions: giant cell tumour in particular: come back in a meaningful minority of patients, so surveillance imaging continues after you are back to full activity. It is routine, it is how everyone with these lesions is followed, and it is the reason recurrences are caught small.

WEIGHT BEARING AND WALKING AIDS

WEIGHT BEARING

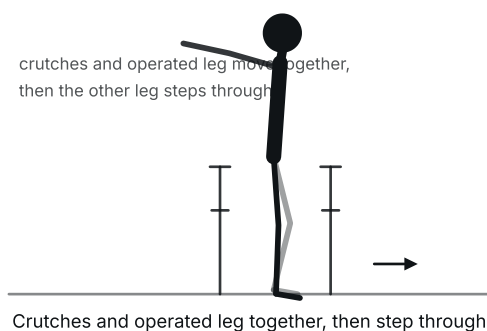
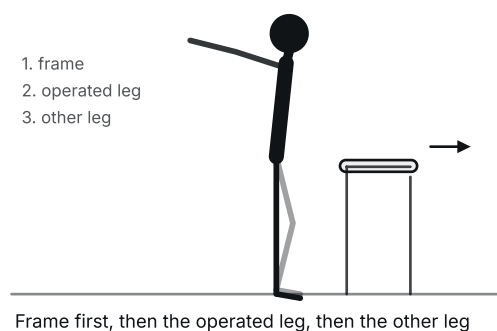
PROTECTED WEIGHT BEARING WITH CRUTCHES, GRADUATED OVER ROUGHLY 6–12 WEEKS: CRITERIA-BASED, AND SET BY YOUR TEAM

Your operation record sets your starting level. It may be touch weight, partial weight or another specific instruction. If you are not sure what yours is, ask before you leave hospital, or call the rooms.

You advance through the stages below when the criteria are met: settling pain plus X-rays showing the defect filling in plus your team's go-ahead, not when a set number of weeks has passed.

Cemented defects usually advance earlier, because cement supports load almost immediately. Grafted defects are protected longer while living bone grows through the graft. Larger defects, defects near a joint surface, and lower-limb weight-bearing bones are protected longest.

STAGE	TYPICAL TIMING	MOVE ON WHEN
Two crutches, at the weight set in your operation record	From day one	The operation record governs: touch, partial or another set level; your physiotherapist checks your technique
Weight increases in steps	Typically from around 6 weeks: cemented defects often earlier, grafted defects later	Pain settling at the current level AND X-rays showing the defect filling in AND your team's go-ahead
One crutch, then a stick	As your permitted weight approaches full	No limp at the permitted load; confident on level ground and stairs
No aid	Typically somewhere in the 6–12 week window: large, grafted, juxta-articular and lower-limb defects take longest	Full weight bearing cleared by your team; walking without a limp



PROTECTING THE BONE WHILE IT FILLS IN

ROUGHLY 6–12 WEEKS: EACH STEP IS SET, AND LIFTED, BY YOUR TEAM ON X-RAY AND SYMPTOMS

The wall of the bone is temporarily thinner and weaker where the cavity was. Until it fills in, loads it would normally shrug off can crack it. These rules exist only for that window. They are lifted in stages as the X-rays improve.

RULE	WHY	HOW TO MANAGE
Stick to your permitted weight: every step, every day	The bone cannot feel "almost healed". Overloading a defect that is still filling in is how fractures happen, and it usually happens on a good day, not a bad one.	Use the crutches exactly as taught, have your physiotherapist re-check your technique at each stage, and treat the permitted level as a ceiling, not a target to beat.
No running, jumping, or twisting on the operated limb until cleared	Impact and rotation concentrate force through the weakened section far beyond what walking does.	Low-impact work: cycling, pool work once the wound is healed, upper-body training, keeps you fit in the meantime.
Make your home and habits fall-proof	A stumble that a normal bone would tolerate can fracture a healing one.	Clear loose rugs and cords, light the path to the bathroom at night, take stairs with the crutch technique you were taught, and avoid wet or icy surfaces early on.
If the operation was in your arm, the same rules apply to lifting and leaning	An upper-limb defect is loaded by carrying, pushing up from chairs and catching yourself, not by walking.	Your team will set a lifting limit and show you how to get out of chairs without pushing through the operated arm.

EVERYDAY SITUATIONS

Stairs at home. Use the crutch-stairs technique you were taught: the good leg leads going up, the crutches and operated leg lead going down. A rail plus one crutch is a safe alternative once your physiotherapist approves it.

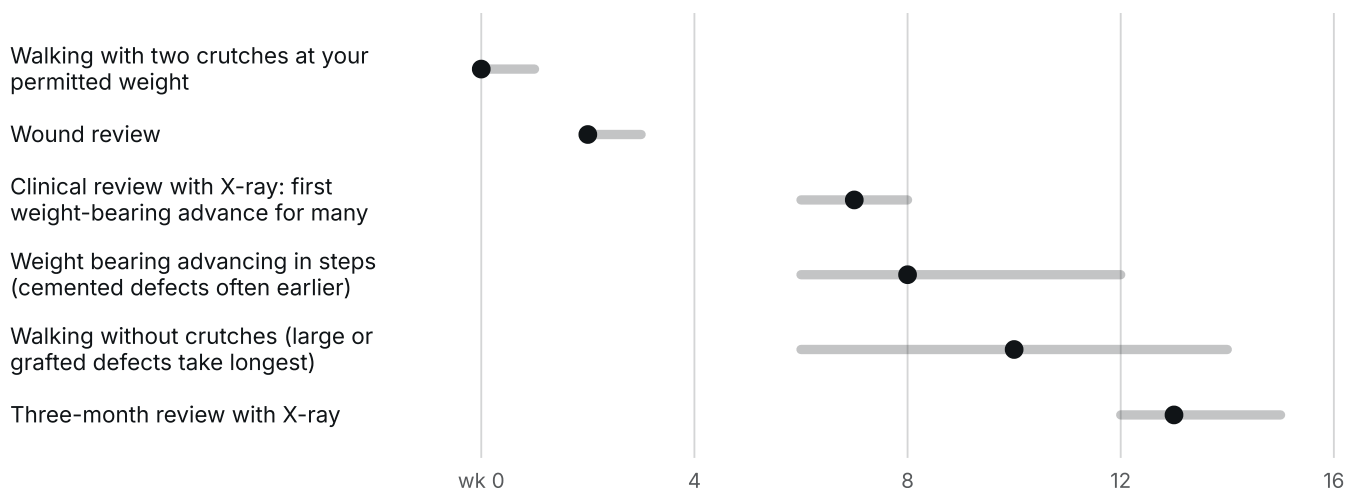
Getting into a car. As a passenger: seat back, back in first, then swing the legs in together. Keep the permitted-weight rule in mind when pivoting.

Supermarkets and long outings. A trolley is not a walking aid. Early on, shop with someone else or online, and save your crutch-walking capacity for the walking itself.

Uneven ground, sand and gravel. Leave these until you are confidently off crutches. They demand exactly the twisting, catching steps the healing bone dislikes.

Standing to cook or work. Perch on a high stool so the operated limb is not quietly taking more weight than permitted while your attention is elsewhere.

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 SETTLE

WEEKS 0-2

Let the wound settle, master crutch walking at your permitted weight, and start moving the joints next to the operated bone straight away.

GOALS: TICK THEM OFF

- ☐ Crutch technique safe and correct at your permitted weight: checked by a physiotherapist
- ☐ Wound clean, dry and settled
- ☐ Gentle range of motion of the adjacent joints under way
- ☐ Muscles around the operated bone switched on daily
- ☐ Ankle pumps every waking hour
- ☐ Swelling controlled with elevation and ice

DO THIS

- Learn the crutch technique properly, including stairs, before you leave hospital, and stick to the weight written in your operation record.
- Start gentle range-of-motion work for the joints above and below the operated bone from early on, protecting the bone is not resting the limb.
- Do static muscle work (such as quadriceps sets for a leg) and ankle pumps from the first days.
- Ice and elevate to keep swelling down.

AVOID THIS

- Taking more weight than permitted "just to test it": the bone cannot feel almost-healed, and testing it is how fractures happen.
- Walking without the crutches, even for two steps to the bathroom at night.
- Soaking the wound, no baths, spas or pools yet.

READY FOR THE NEXT PHASE WHEN...

- Wound reviewed and settled
- Safe, confident crutch walking at the permitted weight, including stairs
- Adjacent joints moving comfortably through the permitted range

PHASE 2: PROTECTED LOADING

WEEKS 2-6

Hold the line on protected weight bearing while building range and gentle strength around the operated bone.

GOALS: TICK THEM OFF

- ☐ Permitted weight bearing maintained without lapses
- ☐ Full or near-full range of motion of the adjacent joints
- ☐ Straight leg raise (for a lower limb) without sag
- ☐ Scar care under way once the wound is fully healed
- ☐ General fitness maintained: upper body, trunk and the other limb

DO THIS

- Keep the range-of-motion work going daily. The adjacent joints should be moving well before the bone is ready for load.
- Progress gentle strength work that does not overload the defect: straight leg raises and controlled mat work for a lower limb, as your physiotherapist directs.
- Start stationary cycling only if and when your team approves it: light resistance, as a range and fitness tool, not a strength test.
- Begin scar massage once the wound is fully healed and dry.
- Train everything that is not protected. This is the phase where general fitness is easiest to lose and easiest to keep.

AVOID THIS

- Creeping load: a little more weight each day without anyone deciding it. Advances happen at reviews, on X-rays, not by drift.
- Impact of any kind on the operated limb.

READY FOR THE NEXT PHASE WHEN...

- Around the 6 to 8 week review: pain settled at the current level, and X-rays showing the defect filling in
- Your team gives the go-ahead to advance weight bearing

PHASE 3: GRADUATED WEIGHT BEARING

TYPICALLY WEEKS 6–12: CRITERIA-BASED, AND SET BY YOUR TEAM

Step the load up as the X-rays and your symptoms allow, and wean off the crutches in stages.

GOALS: TICK THEM OFF

- ☐ Weight bearing advancing through the steps your team sets
- ☐ Weaning from two crutches to one, then to a stick, then to nothing
- ☐ Walking without a limp at each new level before advancing again
- ☐ Strength work building as load is cleared: sit-to-stands and heel raises for a lower limb

DO THIS

- Advance exactly as instructed after each review: cemented defects often move faster here, grafted, large, near-joint and lower-limb defects more slowly. Both are normal; you are on your own clock.
- Add functional strength work as each load level is cleared: sit-to-stands, heel raises, and progressive walking.
- Keep cycling for fitness and range.
- Report any of the warning signs below immediately. This is the phase where the bone is doing its final filling-in.

AVOID THIS

- Skipping a stage of the wean because a good week felt like proof. The X-ray, not the week, is the proof.
- Running, jumping or sport of any kind until specifically cleared.

READY FOR THE NEXT PHASE WHEN...

- Full weight bearing cleared by your team
- Walking unaided without a limp
- X-rays showing the defect consolidating

PHASE 4: FULL LOADING AND RETURN

FROM ABOUT 3 MONTHS: TEAM-GUIDED

Rebuild full strength, balance and confidence, return to work and activity in the right order, and settle into surveillance.

GOALS: TICK THEM OFF

- ☐ Strength approaching the other side on everyday tests: sit-to-stand, single-leg balance, stairs
- ☐ Return-to-activity list progressing, low-impact first
- ☐ Physical work resumed when strength and your team's clearance align
- ☐ Surveillance imaging appointments in the diary and attended

DO THIS

- Progress strength and balance work: single-leg balance, heel raises, sit-to-stands with less hand support.
- Return to low-impact activity first; add impact and pivoting sports last, and only on your team's clearance.
- Keep the review appointments even when you feel completely normal, follow-up imaging is how a recurrence, if one ever happens, is caught small. A meaningful minority of giant cell tumours do recur, which is exactly why the surveillance exists.

AVOID THIS

- Treating feeling normal as being finished: the last X-ray clearances and the surveillance visits still matter.
- A sudden leap to high-impact sport in a single week, build the runway.

READY FOR THE NEXT PHASE WHEN...

- Cleared for full activity by your team
- Surveillance rhythm established: the only ongoing commitment

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

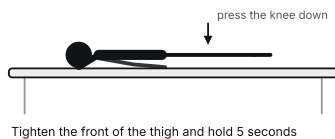
PHASE 1

Keep blood moving in the calf: your main clot-prevention exercise while walking 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. Move through the full range each time.



STATIC QUADRICEPS SETS

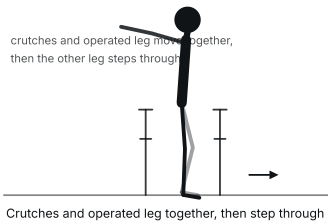
PHASE 1

Keep the thigh muscle switched on while the bone is protected, strength is far easier to keep than to rebuild.

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. Hold, then fully relax.

Feel: You should feel this in the front of the thigh. This loads the muscle, not the healing bone. It is safe from the first days.



CRUTCH WALKING AT YOUR PERMITTED WEIGHT PHASE 1

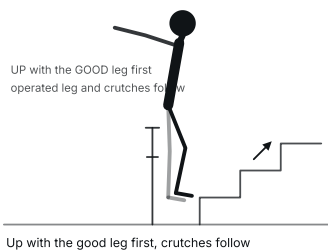
Safe, correct walking that protects the healing bone: the single most important skill of the first six weeks.

Short, frequent walks through the day, building distance gradually

1. Move both crutches forward.
2. Step the operated leg forward level with the crutches, taking only the weight your team has permitted.
3. Push down through the handgrips and step the other leg through.
4. Keep an even, unhurried rhythm.

Feel: Weight goes through your hands, not your armpits. If you cannot feel how much weight you are taking, ask your physiotherapist to re-train it with scales: most people take more than they think.

Harder: Your team advances the permitted weight in steps; your physiotherapist re-checks technique at each step.



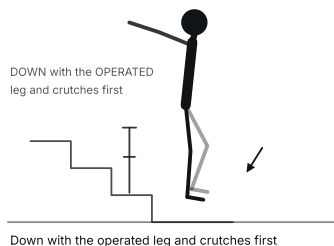
STAIRS WITH CRUTCHES: GOING UP PHASE 1

Manage stairs safely without overloading the operated limb.

Practise with supervision until confident; then as your home requires

1. Stand close to the step, crutches beside you.
2. Step UP with the good leg first.
3. Bring the operated leg and the crutches up to the same step, keeping to your permitted weight.
4. Re-balance before the next step.

Feel: "Good leg leads up." Use the rail plus one crutch if there is one: hand the second crutch to a helper.



STAIRS WITH CRUTCHES: GOING DOWN

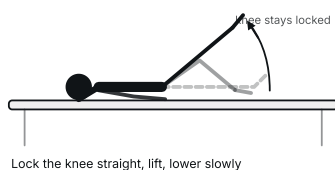
PHASE 1

The higher-risk direction on stairs, done slowly and in the right order, it is safe.

Practise with supervision until confident; then as your home requires

1. Stand close to the edge, balanced.
2. Lower the crutches to the step below.
3. Step DOWN with the operated leg to the crutches, keeping to your permitted weight.
4. Bring the good leg down to the same step.

Feel: "Crutches and operated leg lead down." Slow is safe, never carry things downstairs in your hands early on.



STRAIGHT LEG RAISE

PHASE 2

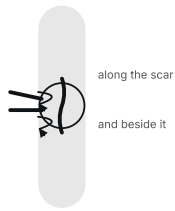
Thigh strength without loading the healing bone through the foot.

10 lifts, hold 3 seconds, 2–3 times daily

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

Feel: If your team has restricted this movement for your particular lesion, their instruction wins: ask if unsure.

Easier: Static quadriceps sets until the lift is comfortable.



Firm small circles, 2 to 3 minutes twice daily

SCAR MASSAGE

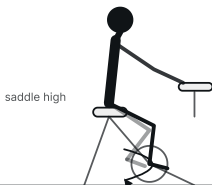
PHASE 2

Soften and desensitise the scar once the wound is 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 the scar.
3. Include the skin around it.

Feel: Firm enough to blanch the skin slightly; it should not be painful.



Saddle high at first, build time before resistance

STATIONARY CYCLING

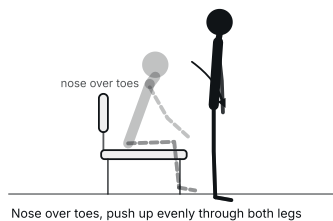
PHASE 2

Fitness and joint range with the bone protected, only once your team approves it.

10–20 minutes, light resistance, most days: once cleared by your team

1. Confirm with your team first: the go-ahead depends on where your defect is.
2. Saddle high, resistance light.
3. Build time before effort; this is a fitness tool, not a strength test for the bone.

Feel: Smooth and easy: if you are mashing the pedals, the resistance is too high for this stage.



SIT-TO-STAND

PHASE 3

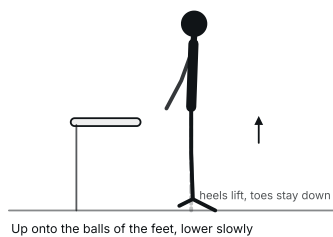
Real-world leg strength, added as your permitted weight advances.

2–3 sets of 8–10, once or twice daily, once your team has cleared the load

1. Sit on a firm chair with arms.
2. Feet back, lean forward, push up, using the arms to keep the operated leg within its permitted share.
3. Lower back down slowly with control.

Feel: Early on, the arms and the good leg do the extra work; share the load evenly only once full weight bearing is cleared.

Harder: Less hand support, then a lower chair, as clearance advances.



HEEL RAISES

PHASE 3

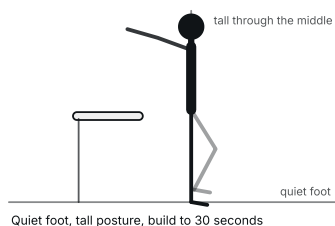
Calf strength for a normal push-off: added in the graduated-loading phase.

2–3 sets of 10, once or twice daily: once cleared

1. Stand tall holding the bench or rail.
2. Rise up onto the balls of both feet.
3. Lower slowly.

Feel: Keep within your permitted weight on the operated side until full weight bearing is cleared.

Harder: Gradually even weight, then more onto the operated side.



SINGLE-LEG BALANCE

PHASE 4

Steadiness and confidence for the return to full activity: the final rebuilding block.

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

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 no hands.

Feel: Quiet foot, tall posture. This one waits for full weight-bearing clearance. It loads the whole limb through one leg.

SWELLING, ICE AND ELEVATION

WHAT IS NORMAL

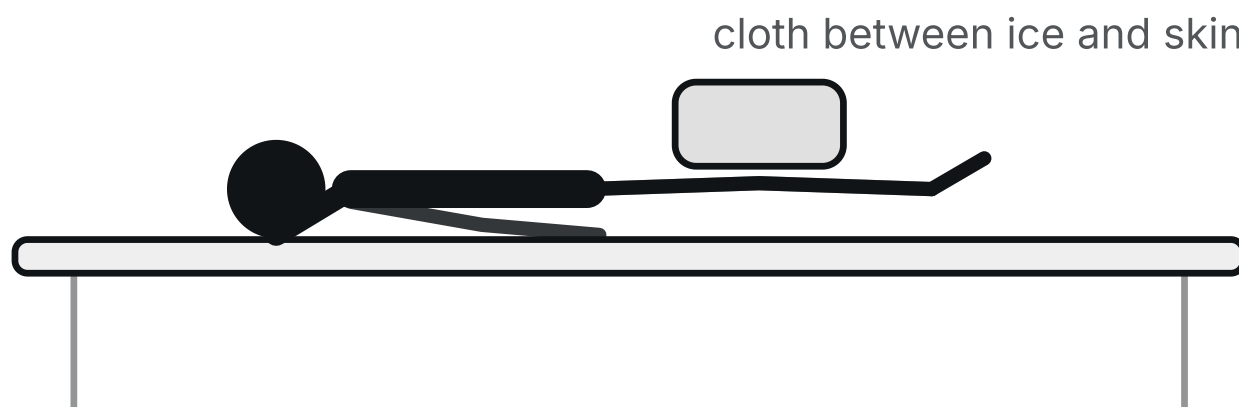
- Swelling and bruising around the operated area are normal in the early weeks and settle gradually.
- A limb that is puffier after a longer day on the crutches means you did more than usual: pace it back a little.
- A deep, dull ache in the bone that comes with activity and settles with rest is a normal part of bone healing.
- What is NOT normal: sudden new pain, pain that is clearly increasing, or swelling with fever or spreading redness, see the warning signs section and call.

ICE

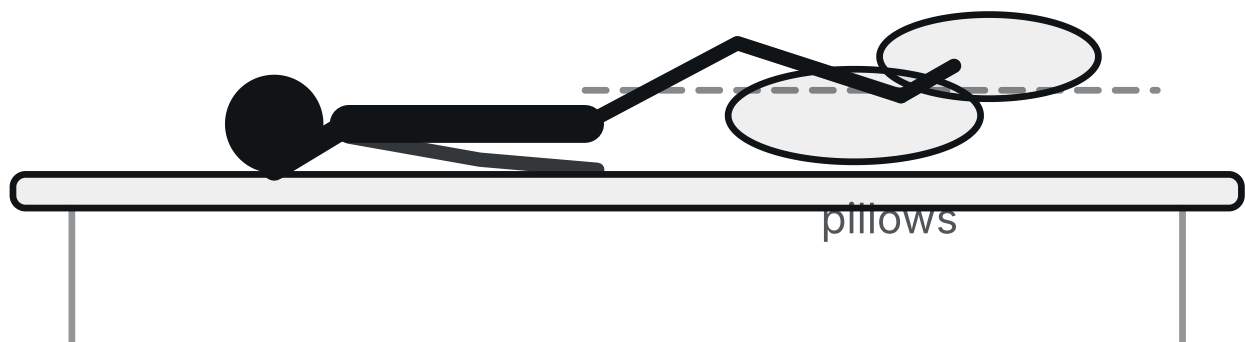
- Ice is safe, cheap and comfortable, and probably gives a small benefit for pain and swelling in the first few days.
- Use it for 15–20 minutes at a time, 4–6 times a day for the first 2 weeks, then as needed after activity and physiotherapy. It is particularly useful in the hour after exercise.
- Always 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.

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.
- The wound after curettage is usually the easy part of this recovery. It typically heals within a few weeks while the bone takes months. Do not let a nicely healed wound talk you out of the crutches.
- 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

Sleep in whatever position is comfortable. There are usually no positional restrictions after curettage and grafting. If your team has given you a specific instruction for your lesion, theirs wins.

A pillow supporting the operated limb often helps in the first weeks.

Getting up at night is the riskiest walk of the day: keep the crutches within reach of the bed, light the path, and never do the trip without them. A half-asleep shortcut is exactly how a protected bone gets overloaded.

PAIN, MEDICATION AND WHAT TO EXPECT

Expect surgical pain for the first one to two weeks, needing regular pain relief, then a steady settling. Take medication as prescribed and ahead of physiotherapy rather than chasing pain afterwards.

A deep ache in the bone with activity, easing with rest, is normal for some months. It is the sound of bone healing, not of trouble.

The pattern that matters is the trend: pain should be settling week on week at each weight-bearing level. Pain that is suddenly worse, or clearly increasing, is a warning sign, stop weight bearing and call (see the warning signs section).

Take any prescribed blood thinner exactly as directed while your walking is restricted.

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 the outset, with crutches, at your permitted weight	Safe technique; wound settled	Distance builds within the permitted level; the level itself advances only at reviews
Desk work	Often within a few weeks	Comfortable sitting; safe travel sorted; pain controlled	Crutch commuting is the usual limiting factor: talk to your employer early
Swimming and pool walking	Once the wound is fully healed and reviewed	Wound closed and team-cleared	A good early fitness option: the water carries the weight the bone cannot yet take
Stationary cycling	When your team approves, often in the protected phase	Team go-ahead for your particular defect	Light resistance; fitness tool, not a strength test

ACTIVITY	TYPICAL	WHEN IT'S RIGHT	NOTES
Driving	Individualised, usually once off crutches for the operated side	The standard driving criteria in this guide, plus your team's agreement	A right-leg defect and a manual car are the cautious combinations: discuss at a review
Physical work	After full weight bearing is cleared and X-rays show consolidation	Strength and endurance for the actual duties; team clearance	Modified duties are often the bridge back
Low-impact sport and gym work	After full weight-bearing clearance	No limp; strength rebuilt; team agreement	The first rung of the return-to-sport ladder
Running, jumping and pivoting sports	Last, on specific clearance	X-ray consolidation, full strength, and your team's explicit go-ahead	Impact is the load the healing defect tolerates worst, so it returns last

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

- Sudden increase in pain at the operated site: STOP weight bearing, go back to the crutches, and contact the rooms for urgent review and imaging
- A crack or snap: felt or heard, in the operated limb: STOP weight bearing and contact the rooms for urgent review and imaging
- New inability to take weight you could take yesterday: STOP weight bearing and contact the rooms for urgent review and imaging
- A new deformity: a change in the shape or line of the limb: STOP weight bearing and contact the rooms for urgent review and imaging
- 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

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 long until I can weight bear after bone graft surgery?

Typically the progression runs over roughly 6–12 weeks, but it is criteria-based rather than calendar-based: you advance as pain settles AND X-rays show the defect filling in AND your team gives the go-ahead. Cemented defects usually advance earlier because cement supports load almost immediately; grafted defects wait for biological healing. Larger defects, defects near a joint surface, and lower-limb weight-bearing bones are protected longest. Your operation record sets your starting level, if you are unsure what yours is, ask.

Why is my bone weaker after the tumour was removed?

Curettage scrapes the lesion out from inside the bone, which leaves a cavity, and until that cavity fills in, the wall of the bone at that spot is thinner and weaker than normal. The soft tissues heal in weeks; the bone takes months. That temporary weakness is why the whole plan revolves around protected, graduated weight bearing: the hazard here is a fracture through the residual cavity, not the wound.

What is the difference between bone cement and bone graft?

They fill the same cavity on different clocks. Bone cement hardens within minutes of surgery, so it gives mechanical support almost immediately, which is why cemented defects can usually take weight earlier. Bone graft is a scaffold that your body gradually converts into living bone; that biological healing takes months, so grafted defects are protected longer. Neither is "better" in general: your surgeon chooses based on the lesion, its size and its position, and your weight-bearing plan follows from that choice.

What are the warning signs of a fracture after curettage?

Four things: a sudden increase in pain; a crack or snap you feel or hear; a new inability to take weight you could take yesterday; and any new deformity: a change in the shape or line of the limb. If any of these happens: stop weight bearing, get back on the crutches, and contact the rooms for urgent review and imaging. Do not walk on it to "see how it goes". A promptly checked false alarm costs an X-ray; a walked-on fracture costs far more.

Will the tumour come back?

These lesions are benign or locally aggressive, but "locally aggressive" earns its name: giant cell tumours in particular come back in a meaningful minority of patients after curettage. That is not a reason for alarm; it is the reason for the follow-up plan. Surveillance imaging continues after the bone has healed, on a schedule your team sets, so that if a recurrence ever happens it is caught small and dealt with early. Keep the appointments even when you feel completely normal, and report any new or returning pain between them.

Do crutches mean I can put no weight on the leg at all?

Not necessarily: "protected weight bearing" comes in levels, from touch weight through partial weight to a set share of your body weight, and your operation record states yours. What matters is sticking to that level precisely: most people take more weight than they think, so ask your physiotherapist to check your technique, standing on bathroom scales is a simple way to calibrate what your permitted weight actually feels like.

How long does a bone graft take to heal?

Months, not weeks. The graft is a scaffold that your body converts into living bone, and that biological process cannot be rushed. You will not feel it happening, which is exactly why the X-rays matter: each review X-ray shows how the defect is filling in, and each advance in your weight bearing follows what the X-ray shows. The reviews at around 6 weeks and 3 months are the gates your recovery advances through.

The wound has healed and I feel fine: why am I still on crutches?

Because the wound and the bone heal on completely different timelines. The skin and muscle are usually settled within a few weeks; the cavity in the bone takes months to fill in, and it does not report its progress as pain, feeling good is not the same as being healed. The crutches are the treatment during that gap. The X-rays, not how the leg feels, tell your team when the bone is ready for more.

When can I drive after curettage and grafting?

There is no fixed week: it depends on which limb was operated on, your permitted weight bearing, and the standard criteria: off strong painkillers, able to sit comfortably, able to perform an emergency stop at full force without hesitation, and not relying on an aid in the car. For a right-leg defect that usually means waiting until your weight bearing has advanced enough to brake hard safely. Agree the timing with your team at a review, and practise in a stationary car first.

Can I exercise the rest of my body while the bone heals?

Yes: please do. Protecting the operated bone is not resting the rest of you: upper-body training, trunk work, the other limb, and (once the wound is healed) pool work are all encouraged, and the joints next to the operated bone should be doing range-of-motion work from early on. The people who transition fastest once full weight bearing is cleared are the ones who kept everything else strong in the meantime.

THE EVIDENCE BEHIND THIS GUIDE 6 sourced statements

CLAIM	SOURCE
Giant cell tumour of bone recurs locally after curettage in a meaningful minority of patients; reported rates vary widely with technique and adjuvant use	Klenke et al., giant cell tumour of bone, risk factors for recurrence, Clin Orthop Relat Res 2011 (PMID 20706812); Errani et al., 349 cases from a single institution, Cancer Treat Rev 2010 (PMID 19879054)
Most local recurrences of giant cell tumour occur within the first 2–3 years, which is what shapes the surveillance imaging schedule	Errani et al., giant cell tumour of the extremity, 349 cases from a single institution, Cancer Treat Rev 2010 (PMID 19879054); Klenke et al., risk factors for recurrence, Clin Orthop Relat Res 2011 (PMID 20706812)
Bone cement (PMMA) provides immediate mechanical stability of the defect, whereas bone graft requires biological incorporation over months before it can share load	Hirn et al., bone defects following curettage do not necessarily need augmentation, Acta Orthop 2009 (PMID 19234881); Roberts & Rosenbaum, bone grafts, bone substitutes and orthobiologics, Organogenesis 2012 (PMID 23247591). The Fraquet reference previously cited here could not be located in Europe PMC and has been replaced
Fracture through the residual cavity is a recognised complication after curettage of benign bone lesions during the healing period	Hirn et al., bone defects following curettage do not necessarily need augmentation, Acta Orthop 2009 (PMID 19234881)
Bone graft incorporation is a staged biological process: revascularisation, resorption and new bone formation: occurring over months	Roberts & Rosenbaum, bone grafts, bone substitutes and orthobiologics, Organogenesis 2012 (PMID 23247591)
Graduated, criteria-based weight bearing after curettage and grafting reflects consensus practice in orthopaedic oncology units; there are no	Unit protocol and consensus practice, not trial evidence. No randomised comparison of weight-bearing regimes after curettage and grafting exists

CLAIM	SOURCE
controlled trials of specific progressions	

Protocols after curettage and grafting are more individualised than after joint replacement: the size, site and filling of your defect all change the plan. Your operation record and your team's instructions always govern, and every advance in weight bearing is your team's call.

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
