# REHABILITATION AFTER KNEE ARTHROSCOPY: MENISCAL REPAIR

Meniscal repair recovery: a hinged brace and crutches protect the stitches early, running from about 3–4 months: the full rehab plan.

PATIENT NAME _____

DATE OF SURGERY _____

WHAT IS INSIDE



19 minutes to read. Reviews: Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks, when the brace range is reviewed. Confirmed on your discharge letter.

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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.

Two very different recoveries come out of the same keyhole operation. Your operation record says whether the torn piece was TRIMMED (partial meniscectomy: see the partial meniscectomy guide) or STITCHED (meniscal repair. This guide). If you are not sure which you had, call the rooms before following any timeline here. Patients frequently do not know which was done until they wake up, because the decision is made once the surgeon sees the tear, and the two timelines are weeks apart.

If the stitched guide is yours, your meniscus was worth saving, and the next few months are about protecting that investment. A hinged brace limits the bend, crutches share the load, and deep bending and twisting are off the menu while the stitches hold the tear together and it slowly heals. The restrictions in this guide are not caution for its own sake: they are the treatment.

One more check before you start. If a cartilage repair (microfracture, MACI, osteochondral graft) was performed, this guide does not apply: those pathways involve 6–8 weeks of protected weight bearing and 9–12 months before impact sport. Call the rooms for the specific protocol.

Every timeframe in this guide is typical, not a rule. Repairs differ, where the tear was, what pattern it had, and how it was stitched all change the plan, and root and radial repairs run slower. Dr Broadhead’s instructions for you always override the general figures here.

AT A GLANCE

**WEIGHT BEARING**
Protected weight bearing with crutches for 2–6 weeks (root and radial repairs commonly touch weight bearing for 4–6 weeks)

**WALKING AIDS**
Crutches for 2–6 weeks, depending on the repair type

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

**PRECAUTIONS**
No loaded deep bending: squatting past 90°, kneeling, lunging, and no pivoting or twisting for 3–4 months

**DRIVING**
Deferred while you are in a range-limiting brace; then the standard criteria apply: discussed at review

**DESK WORK**
Individually advised, often possible early, on crutches, once off strong pain relief

**PHYSICAL WORK**
Individually planned: the deep-bending and twisting restrictions apply for 3–4 months

**SPORT & ACTIVITY**
Running from about 3–4 months on a quiet knee with strength gates met; pivoting sport about 4–6 months, longer for root repairs

**REVIEWS**
Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks, when the brace range is reviewed. Confirmed on your discharge letter

## WHAT WAS DONE IN YOUR OPERATION

The meniscus is a C-shaped cushion of fibrous cartilage between the thigh bone and the shin bone: a shock absorber and load spreader. Each knee has two, and losing one substantially raises the long-term risk of arthritis in that part of the knee. That is why a repairable tear gets repaired.

In a knee arthroscopy, the surgeon works through two or three small keyhole cuts using a camera and fine instruments. In a meniscal repair, the torn edges are held back together with stitches or anchor devices so the tear can heal. Some repairs are at the meniscal root, where the meniscus anchors to the bone, and these are reattached to the bone itself; root and radial repairs are the slowest healers and carry the most cautious timelines.

Here is the biology that drives everything in this guide: only the outer quarter or so of the meniscus has a blood supply, so a 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 IDEAS THAT MAKE EVERYTHING ELSE MAKE SENSE

> **1. Check the operation record first**
>
> Trimmed and stitched are different operations with timelines weeks apart, done through identical keyholes. This guide is for a STITCHED (repaired) meniscus only. If your operation record says the torn piece was trimmed away, stop here and use the partial meniscectomy guide, and if you are not sure, call the rooms before following any timeline.

> **2. The stitches set the pace, not the pain**
>
> A repaired meniscus often feels good long before it is healed. Only the outer quarter or so of the meniscus has a blood supply, so healing takes three months and more, and early deep bending and twisting shear the repair regardless of how the knee feels. The brace, the crutches and the precautions are the treatment. Protecting the repair now buys you a meniscus for life; a failed repair means another operation and a higher long-term risk of arthritis.

> **3. The quadriceps switch off: waking them up is job one**
>
> Swelling switches the quadriceps off. This is universal and expected, not a sign anything went wrong. It happens by reflex whenever a knee joint swells. Quadriceps work starts on day one, inside the brace: static quadriceps sets and straight leg raises, little and often, from the recovery room onwards.

**4. Not all repairs are equal**

Where the tear was and how it was stitched change the plan. Root and radial repairs commonly mean touch weight bearing for 4–6 weeks and a longer road back to pivoting sport. Your discharge letter and reviews set your version of the timeline. The figures in this guide are the typical frame around them.

**5. Cartilage repairs follow a different book**

If a cartilage repair (microfracture, MACI, osteochondral graft) was performed, this guide does not apply: those pathways involve 6–8 weeks of protected weight bearing and 9–12 months before impact sport. Call the rooms for the specific protocol.

## WEIGHT BEARING AND WALKING AIDS

WEIGHT BEARING

### PROTECTED WEIGHT BEARING WITH CRUTCHES FOR 2–6 WEEKS, SET BY THE REPAIR TYPE

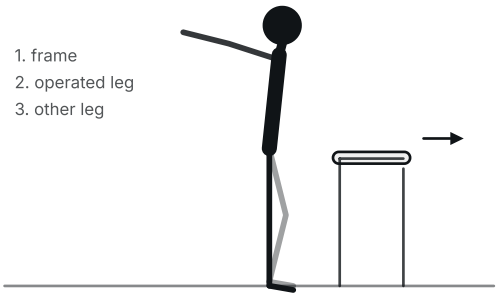
Unlike a meniscectomy, a repaired meniscus needs protecting from load while it heals. You will use crutches for somewhere between 2 and 6 weeks. Your discharge letter says exactly what your repair allows.

Root and radial repairs commonly mean touch weight bearing (the foot rests on the ground for balance only) for 4–6 weeks, because these repair types are the most vulnerable to load.

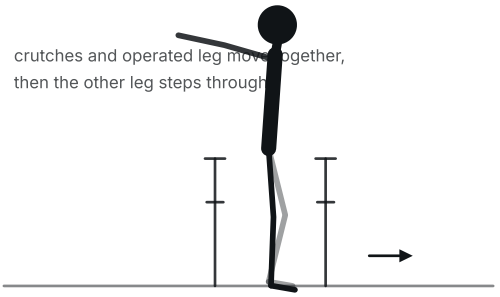
The brace stays on for walking throughout this period, and weight bearing is progressed at your reviews, not by feel. A knee that feels fine at week three is not evidence the repair has healed.

| STAGE | TYPICAL TIMING | MOVE ON WHEN |
|---|---|---|
| **Two crutches, brace on, weight bearing as your repair allows** | From day 0 | As set on your discharge letter: touch weight bearing for 4–6 weeks is common for root and radial repairs |

| STAGE | TYPICAL TIMING | MOVE ON WHEN |
|---|---|---|
| **Weaning from two crutches to one, then none** | Between 2 and 6 weeks, per your repair type | Cleared at review; walking without a limp in the brace |
| **No aids, brace range unlocked** | From 4–6 weeks, as advised at review | Cleared at review; comfortable, quiet knee |



Frame first, then the operated leg, then the other leg



Crutches and operated leg together, then step through

## PROTECTING THE REPAIR

BRACE RANGE 0–90° FOR THE FIRST 4–6 WEEKS; NO LOADED DEEP BENDING OR PIVOTING FOR 3–4 MONTHS

Only the outer quarter or so of the meniscus has a blood supply, so a 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 |
|---|---|---|
| **No squatting past 90 degrees** | Deep knee bending under body weight squeezes and shears the back of the meniscus: exactly where many repairs sit. | Squat only to a right angle, and only when your phase allows loaded work. Use higher chairs and avoid low couches early on. |
| **No kneeling** | Kneeling forces the knee into deep, loaded flexion and drives the thigh bone back against the repair. | For floor-level tasks, sit on a low stool or the floor with the operated leg out in front instead. |
| **No lunging** | A deep lunge loads the meniscus through a large arc of bend, shearing the healing tear. | Keep strength work within the ranges set for your phase: shallow, controlled, both feet planted. |
| **No pivoting or twisting for 3–4 months** | Rotation of the shin under load is the exact mechanism that tears menisci, and re-tears repairs. | Turn with small steps rather than spinning on a planted foot. No cutting, sidestepping or racquet-sport movements until cleared. |

### EVERYDAY SITUATIONS

**Getting in and out of a car.** Passenger seat pushed well back, lower yourself in bottom-first, then swing both legs in together, keeping the operated knee within its brace range.

**Stairs.** On crutches: up with the good leg first, down with the crutches and operated leg first. Take one step at a time and use the rail.

**Low chairs, couches and toilets.** Avoid anything that sinks your knee past 90 degrees. Choose firm, higher chairs; a raised toilet seat helps in the crutch phase if your toilets are low.

**Picking things up off the floor.** Do not squat or kneel for it. Keep the operated leg out behind you and hinge at the hips, or use a reacher, or leave it for someone else in the early weeks.

**Showering.** Follow the brace-fitting advice about whether the brace comes off for showering. A non-slip mat and a shower chair make the crutch phase much safer.

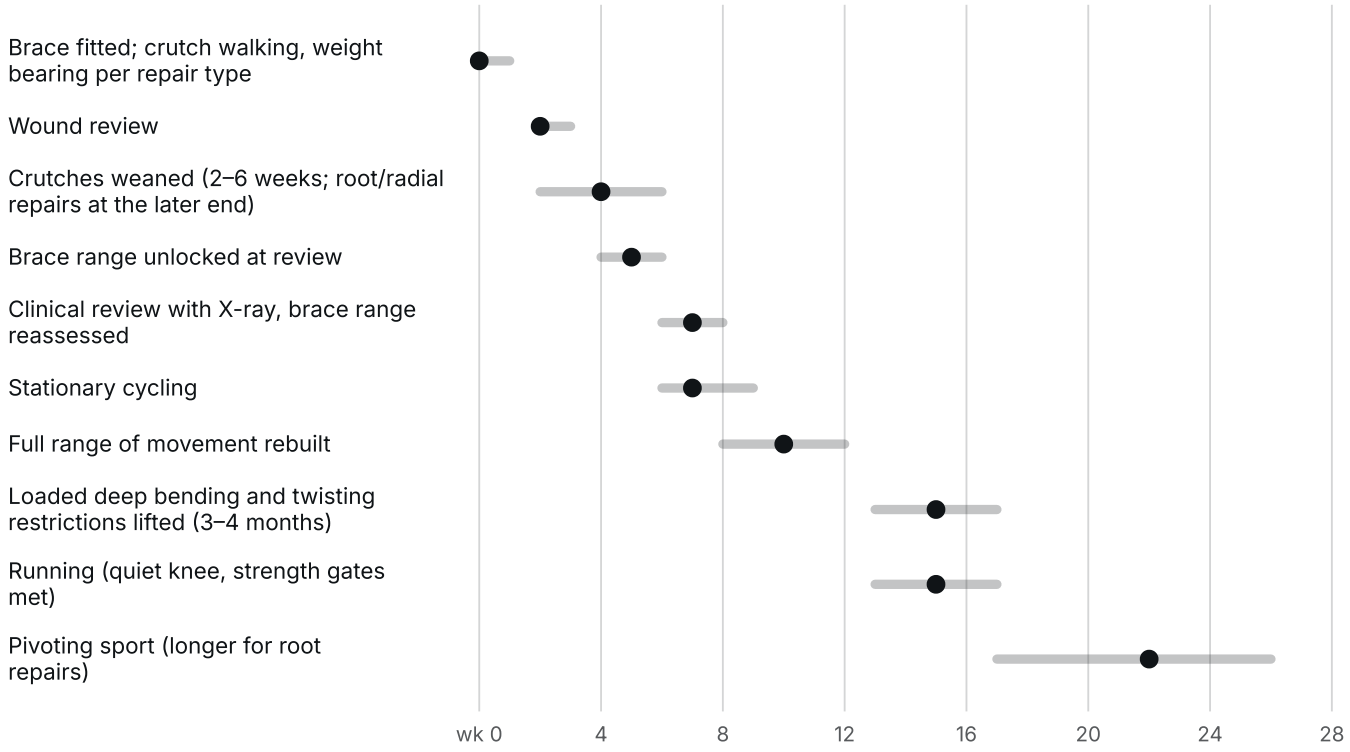
## YOUR BRACE: HINGED KNEE BRACE WITH AN ADJUSTABLE RANGE-OF-MOTION DIAL

| PERIOD | INSTRUCTION |
|---|---|
| Weeks 0 to 4–6 | Worn whenever you are up on your feet: standing and walking. Follow the instructions given at fitting for rest and sleep, which vary with the repair. |
| From 4–6 weeks | The range is unlocked and the brace is weaned as advised at your review. |

| PERIOD | PERMITTED RANGE |
|---|---|
| Weeks 0 to 4–6 | 0–90 degrees, set on the dial: full straightening allowed, bend capped at a right angle |
| From 4–6 weeks | Progressively unlocked at review, as your repair allows |

- Never change the dial settings yourself. The range is part of the operation plan and is adjusted at your reviews.
- Straps snug but not tight: you should fit a finger under each strap. Numbness, pins and needles or colour change in the foot means loosen and re-check.
- Check the skin under the straps and hinges daily; call the rooms about any rubbing or pressure areas rather than padding it yourself.
- Check before each walk that the hinges sit level with the top of the kneecap crease and have not slid down the leg.

## 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

WEEKS 0–2

Guard the repair: brace on, crutches as prescribed, swelling controlled, and the quadriceps switched back on from day one.

### GOALS: TICK THEM OFF

- [ ] Brace worn and managed correctly; weight bearing exactly as your discharge letter sets
- [ ] Safe, confident crutch walking, including stairs
- [ ] Quadriceps firing: a firm static quads contraction and a straight leg raise without sag
- [ ] Knee fully straight when resting (the brace allows full extension)
- [ ] Swelling settling; wounds clean and dry

### DO THIS

- Static quadriceps sets from day one, swelling switches the quadriceps off, and this is the switch that turns them back on.
- Ankle pumps every waking hour, straight leg raises with the brace on, and heel props for full straightening.
- Ice 15–20 minutes at a time and elevate properly (lying down, foot above heart level) several times a day.
- Practise the crutch pattern until it is automatic: smooth, small steps, brace on.

### AVOID THIS

- Bending past the brace limit "just to test it": the repair cannot tell the difference between a test and an injury.
- Standing or walking without the brace.
- Squatting, kneeling, lunging, pivoting or twisting. These are off the menu for months, not weeks.
- A pillow under the knee at rest: the knee must keep full straightening.

### READY FOR THE NEXT PHASE WHEN…

- Wound review complete (around 2 weeks)
- Straight leg raise with no lag
- Confident with the brace and crutches
- Swelling stable or falling

## PHASE 2: PROTECTED RANGE

WEEKS 2–6

Move within the brace limit: build the bend towards (never past) 90 degrees, keep the quadriceps working, and wean the crutches as your repair type allows.

### GOALS: TICK THEM OFF

- [ ] Bend built gradually up to the 90-degree brace limit, and never past it
- [ ] Full straightening maintained every day
- [ ] Crutches weaned between 2 and 6 weeks per your repair (root and radial repairs commonly stay at touch weight bearing to 4–6 weeks)
- [ ] Kneecap and scars moving freely

### DO THIS

- Heel slides and seated assisted bends, always stopping short of the brace limit.
- Inner-range quadriceps work over a roll: strength in the safe part of the range.
- Begin scar massage once the wounds are fully healed and dry.
- Progress weight bearing only as set at your review.

### AVOID THIS

- Pushing the bend past 90 degrees. This is the highest-risk error of the whole recovery.
- Loaded bending of any kind: squatting, kneeling, lunging.
- Ditching the crutches early because the knee "feels fine": comfort is not healing.

### READY FOR THE NEXT PHASE WHEN…

- Cleared at the 4–6 week review to unlock the brace range
- Comfortable bend to 90 degrees with full straightening
- Walking in the brace without a limp as weight bearing allows

## PHASE 3: RESTORE AND STRENGTHEN

WEEKS 6–12

With the brace range unlocked, rebuild full movement and real strength, still without loaded deep bending, pivoting or twisting.

### GOALS: TICK THEM OFF

- [ ] Full range of movement rebuilt gradually
- [ ] Walking normally without aids or brace, as cleared at review
- [ ] Stationary cycling established
- [ ] Strength building towards symmetry: sit-to-stands, shallow squats, step-ups, calf raises, balance work

### DO THIS

- Start the stationary bike once the bend allows a full pedal revolution: saddle high at first.
- Progress sit-to-stands, mini squats (never past 90 degrees under load), heel raises, step-ups and single-leg balance.
- Keep icing after bigger sessions while the knee still reacts.

### AVOID THIS

- Loaded deep bending: squatting past 90 degrees, kneeling, lunging, and any pivoting or twisting: these stay off the menu until 3–4 months.
- Running: it is not part of this phase, however good the knee feels.

### READY FOR THE NEXT PHASE WHEN…

- Quiet knee, no swelling reaction to daily life and gym work
- Full range of movement
- Strength approaching the other side on sit-to-stand and step-up

### PHASE 4: RETURN

MONTHS 3–6

Earn the way back: running from about 3–4 months on a quiet knee with the strength gates met, pivoting sport from about 4–6 months: later for root repairs.

GOALS: TICK THEM OFF

- [ ] Running from about 3–4 months, on a quiet knee (no swelling reaction), with strength gates met and clearance at review
- [ ] Progression from straight-line running to change-of-direction drills
- [ ] Pivoting sport from about 4–6 months, longer for root repairs, when cleared
- [ ] A twice-weekly strength habit that outlasts the rehab

DO THIS

- Reintroduce deep bending and rotation gradually from 3–4 months as cleared: control before speed, speed before contact.
- Add step-downs and standing knee bends; progress single-leg strength and balance under fatigue.
- Build running in stages: intervals, then continuous, then tempo, and let any swelling reaction veto the progression.

AVOID THIS

- Jumping from jogging straight to competition. The graduated middle steps are where re-injuries are prevented.
- Treating the 4–6 month figure as a promise if you had a root repair. Those timelines run longer, and your reviews set them.

READY FOR THE NEXT PHASE WHEN…

- Cleared for full training and then competition at review
- No swelling or giving-way with sport-specific drills

## 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.

Pull up and point away, from the ankle only

## ANKLE PUMPS

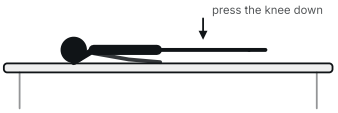
PHASE 1

Keep blood moving in the calf while you are on crutches and less active than usual.

**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 limit the ankle: move it fully.



Tighten the front of the thigh and hold 5 seconds

## STATIC QUADRICEPS SETS

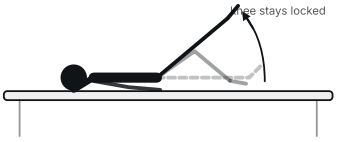
PHASE 1

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

**10 holds of 5 seconds, 3–4 times daily, from day one**

1. Lie with the leg straight: the brace can stay on.
2. Push the back of the knee down 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 weak, flickery contraction on day one is normal. It sharpens quickly.




Lock the knee straight, lift, lower slowly

## STRAIGHT LEG RAISE (BRACE ON)

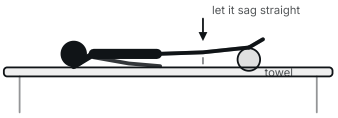
PHASE 1

Quadriceps strength with the knee held straight: completely safe for the repair.

**10 lifts, hold 3 seconds, 3 times daily**

1. Lie on your back with the brace on, 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.




Nothing under the knee, 5 to 10 minutes

## HEEL PROP (EXTENSION STRETCH)

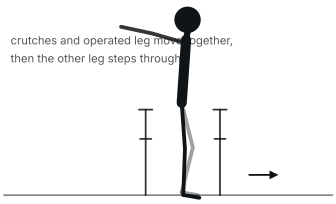
PHASE 1

Keep the knee fully straight: the brace allows it, and losing straightening is the avoidable complication.

**5 minutes, 2–3 times daily**

1. Lie or sit with the heel propped on a rolled towel, nothing under the knee.
2. Let the knee sag towards straight under its own weight.

**Feel:** A gentle stretch behind the knee is right. Never rest with a pillow under the knee.



Crutches and operated leg together, then step through

## CRUTCH WALKING PATTERN

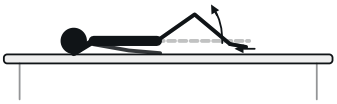
PHASE 1

A smooth, safe walking pattern that keeps the load on the repair exactly where it should be.

**Every walk, until weaned at review**

1. Crutches move first, then the operated leg steps between them, taking only the weight your repair allows.
2. The good leg steps through past the crutches.
3. Keep the steps small and even.

**Feel:** For touch weight bearing, the foot rests on the ground for balance only, like standing on a bathroom scale you are not allowed to move past a few kilograms.


Slide the heel towards you so the knee bends up

## HEEL SLIDES (TO THE BRACE LIMIT)

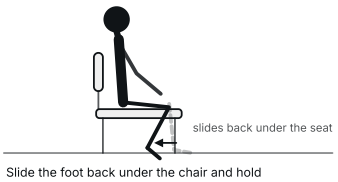
PHASE 2

Build the bend gradually towards, never past: the 90-degree limit.

**10 slow slides, 3 times daily**

1. Lie on your back.
2. Slide the heel towards your bottom, stopping short of the brace limit.
3. Hold 5 seconds.
4. Slide slowly back to straight.

**Feel:** Stop short of 90 degrees every time. The limit is a wall, not a target to touch at speed. A towel under the heel makes it slide easier.



Slide the foot back under the chair and hold

## SEATED ASSISTED KNEE BEND (TO THE BRACE LIMIT)

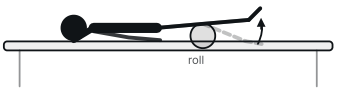
PHASE 2

Progress the bend within the permitted range using gravity and the other leg.

**10 bends, hold 5 seconds, 3 times daily**

1. Sit on a chair, feet on the floor.
2. Slide the operated foot back under the chair, stopping short of the 90-degree limit.
3. Hold, release, repeat.

**Feel:** A right angle at the knee is the absolute ceiling in this phase: work below it, not at it.



Thigh stays on the roll, lift the heel until straight

## INNER-RANGE QUADRICEPS OVER A ROLL

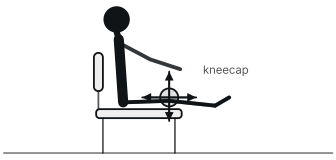
PHASE 2

Quadriceps strength in the safest part of the range: small bend to full straight.

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

1. Lie with a firm roll under the knee so it rests slightly bent.
2. Tighten the thigh and lift the heel until the knee is fully straight.
3. Hold, then lower slowly.

**Feel:** The knee stays on the roll throughout, only the heel lifts. You should feel the lowest part of the thigh, just above the kneecap.



Gentle glides up, down and side to side

## KNEECAP MOBILISATION

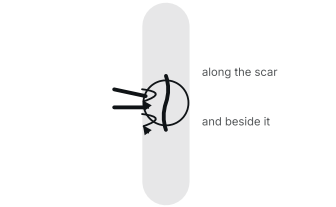
PHASE 2

Keep the kneecap and the portal scars gliding freely while the range is restricted.

**1–2 minutes in each direction, twice daily, once the dressings are off**

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: a glide, not a push.

**Feel:** It should feel odd, not painful.



Firm small circles, 2 to 3 minutes twice daily

## SCAR MASSAGE

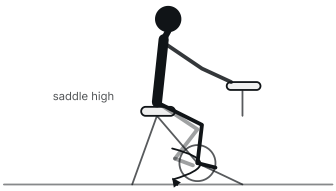
PHASE 2

Soften and desensitise the small portal scars once fully healed.

**2–3 minutes, twice daily, once healed and dry**

1. Use a bland moisturiser.
2. Firm, small circles over and beside each portal scar.

**Feel:** Firm enough to move the skin; it should not be painful.



Saddle high at first, build time before resistance

## STATIONARY CYCLING

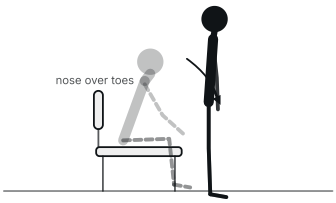
PHASE 3

Range, circulation and endurance with almost no shear on the repair: the workhorse of Phase 3.

**10–20 minutes, most days, once the bend allows a full revolution**

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:** The knee should feel looser after a ride, not hotter and tighter.



Nose over toes, push up evenly through both legs

## SIT-TO-STAND

PHASE 3

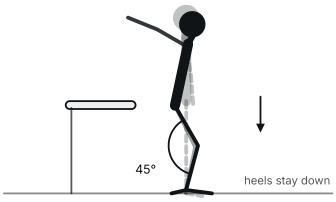
Real-world leg strength through a safe range.

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

1. Sit on a firm, higher chair. The knee should not pass 90 degrees at the bottom.
2. Feet back, lean forward, push up through both legs.
3. Lower back down slowly with control.

**Feel:** Share the load evenly between the legs.

**Harder:** Slow the lowering phase; shift more weight to the operated side over time.



Bend to about 45 degrees, knees over toes, heels down

## MINI SQUAT

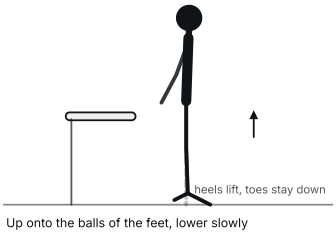
PHASE 3

Thigh and hip strength: always inside the loaded-bending rule.

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

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

**Feel:** Shallow on purpose: loaded squatting past 90 degrees stays off the menu until 3–4 months.



Up onto the balls of the feet, lower slowly

## HEEL RAISES

PHASE 3

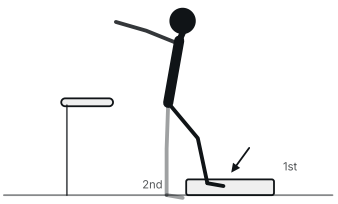
Calf strength for a normal push-off and, later, running.

**2–3 sets of 10, once or twice daily**

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

**Feel:** Even weight through both feet.

**Harder:** Single-leg raises on the operated side.



Operated leg goes up first, the other foot joins it

## STEP-UPS

PHASE 3

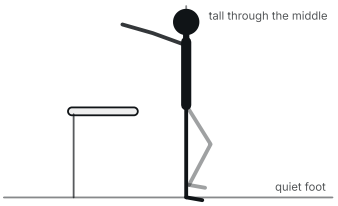
Single-leg strength for stairs, slopes and the running program ahead.

**2–3 sets of 8 each leg, once daily**

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:** Push through the whole foot; keep the knee tracking over the toes, not diving inward.

**Harder:** Raise the step height, then reduce hand support: keeping the knee bend under 90 degrees.



Quiet foot, tall posture, build to 30 seconds

## SINGLE-LEG BALANCE

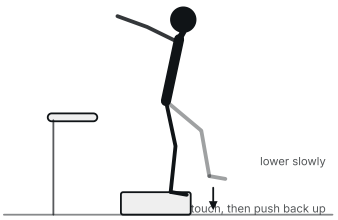
PHASE 3

Joint control and steadiness: the foundation for the return to running and, eventually, pivoting.

**Build to 3 holds of 30 seconds each leg, daily**

1. Stand near a 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.

**Feel:** Quiet foot, tall posture.



Lower slowly with the operated leg, touch, return

## STEP-DOWNS (CONTROLLED LOWERING)

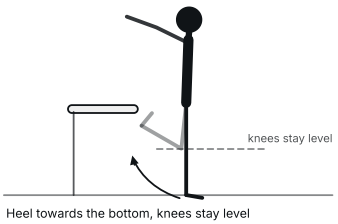
PHASE 4

The braking strength that controls descents and deceleration: essential before change-of-direction work.

**2–3 sets of 8 each leg, alternate days**

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.




STANDING KNEE BEND PHASE 4

Active hamstring and bend strength through range, unloaded.

**2–3 sets of 10, once daily**

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

**Feel:** Keep the knees level with each other; move only below the knee.

## SWELLING, ICE AND ELEVATION

### WHAT IS NORMAL

- Some swelling after arthroscopy is universal. The knee was filled with fluid during the operation, and the joint lining reacts to surgery. It is at its worst in the first days and settles over the following weeks.
- A knee that is puffier or achier the morning after activity did too much the day before. That is feedback, not damage.
- Swelling is also the reason your thigh muscle feels switched off: the two go together, and both improve together.
- Later in the recovery, a "quiet knee": one that does not swell in response to training, is one of the gates for running and sport. A knee that swells after a session is voting against the next progression.
- What is not normal: rapid, tense, ballooning swelling in the first 24–72 hours (which can mean bleeding into the joint), or swelling that increases after initial improvement, especially with fever or wound discharge. Both are reasons to call the rooms: see the red flags section.

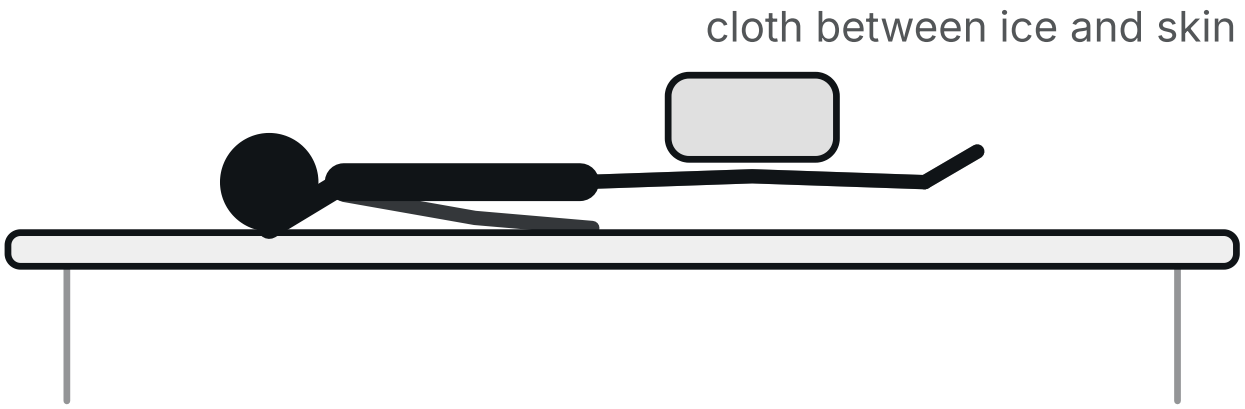
### ICE

- 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.

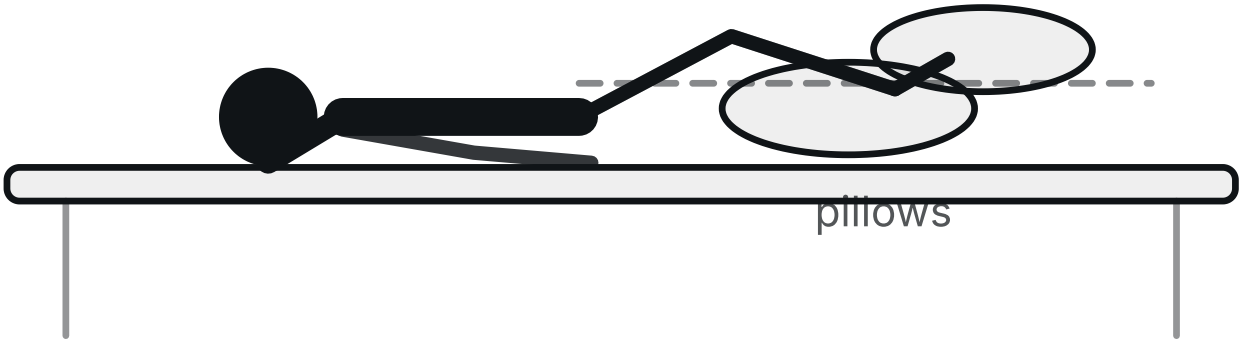
- Always place a thin cloth between the ice and your skin. Never sleep with ice on. Never ice over numb skin or a fresh wound dressing without checking with the rooms first.
- Stop and call the rooms if the skin becomes white, mottled or numb.

### 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.
- 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 the instructions given at your brace fitting about whether the brace stays on in bed. This varies with the repair, so your discharge letter wins.

If you want the leg supported, place a pillow under the whole lower leg from calf to heel so the knee stays straight, never a pillow under the knee itself.

Side sleeping with a pillow between the knees is usually comfortable once the early soreness settles; keep the operated knee within its permitted range.

Disturbed sleep in the brace phase is common and temporary. Ice before bed and timing pain relief for the night both help.

## PAIN, MEDICATION AND WHAT TO EXPECT

Pain after a meniscal repair is usually front-loaded: the first days need regular pain relief, then it tapers to occasional simple analgesia. Discomfort from the brace and crutches is often as noticeable as the knee itself.

Take pain relief ahead of your exercise sessions rather than chasing pain afterwards, and come off the strongest medication first.

Routine blood thinners are not used for low-risk day-case arthroscopy. The clot risk is low and the trials do not support routine medication. Your individual risk factors (previous clots, some medical conditions and medications, long travel plans, and the longer period on crutches) are assessed, and if you need prevention it will be prescribed specifically.

A key warning: a repaired knee often feels good well before it is healed. Low pain at week three is welcome, but it is not permission to bend, load or twist: the stitches, not the pain, set the pace.

#### 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 (brace and crutches)** | From day 0 | Weight bearing exactly as your discharge letter sets | Root and radial repairs commonly touch weight bearing for 4–6 weeks |
| **Desk work** | Individually advised, often early, on crutches | Off strong pain relief; transport sorted (you cannot drive in the brace) | Elevate the leg under the desk; short walking breaks hourly |
| **Driving** | Deferred while in a range-limiting brace | Out of the brace, off strong pain relief, able to emergency-stop at full force: see the driving criteria | Discussed at the review where the brace comes off |

| ACTIVITY | TYPICAL | WHEN IT'S RIGHT | NOTES |
|---|---|---|---|
| **Swimming** | After the brace phase, once cleared | Wounds fully healed; brace range unlocked; ask at review first | Avoid whip-kick (breaststroke) until the twisting restriction lifts at 3–4 months |
| **Stationary cycling** | From about 6 weeks | Brace range unlocked; bend allows a full revolution | Saddle high at first |
| **Gym strength work** | Weeks 6–12 | Within the precautions, no loaded bending past 90°, no lunges, no pivoting | Shallow, controlled, progressive |
| **Physical work** | Individually planned | Depends on kneeling, squatting, ladder and lifting demands: the 3–4 month restrictions apply | Raise it early at review so modified duties can be arranged |
| **Running** | From about 3–4 months | Quiet knee (no swelling reaction); strength gates met; cleared at review | Straight-line first, built in stages |
| **Pivoting and cutting sport** | About 4–6 months | Full training completed without swelling or giving-way; cleared at review | Longer for root repairs: your reviews set the date |
| **Kneeling and deep squatting** | From 3–4 months, as cleared | Restrictions formally lifted at review | Reintroduce gradually: padded surface, short exposures first |

### 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

- Rapid, tense swelling of the knee in the first 24–72 hours. A hot, ballooning joint can mean bleeding into the joint
- Increasing pain and swelling after initial improvement, particularly with fever, shaking chills, or wound discharge, infection after arthroscopy is uncommon but urgent
- A locked knee: stuck and unable to fully straighten
- Inability to put weight through the leg (beyond your prescribed restriction), or a sudden new catch, clunk or giving-way

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

**Was my meniscus trimmed or stitched, and does it matter?**

It matters enormously. Two very different recoveries come out of the same keyhole operation. Your operation record says whether the torn piece was TRIMMED (partial meniscectomy: the other guide, with a days-to-weeks timeline and no brace) or STITCHED (meniscal repair. This guide, with a brace, crutches and a months-long timeline). The decision is often made during surgery, so many patients do not know which was done until they wake up. If you are not sure which you had, call the rooms before following any timeline here.

**Why can’t I bend my knee for six weeks after a meniscal repair?**

Because bending is exactly what shears the stitches. Only the outer quarter or so of the meniscus has a blood supply, so a repaired meniscus heals slowly. Three months and more, and deep bending and twisting in that window can pull the healing tear apart. The brace caps the bend at 90 degrees for the first 4–6 weeks so the repair is never taken into its danger zone. Protecting it now buys you a meniscus for life; a failed repair means another operation and a higher long-term risk of arthritis.

### When can I drive after a meniscal repair?

Driving is deferred while you are in a range-limiting brace. A brace that caps your knee movement is incompatible with working the pedals safely, and with meeting the emergency-stop standard. Once the brace comes off at 4–6 weeks, the usual criteria apply: off strong pain relief, able to perform an emergency stop at full force without hesitation, practised in a stationary car first. We discuss your specific timing at the review where the brace is weaned.

### How long will I be on crutches, and how much weight can I take?

Between 2 and 6 weeks, with the amount of weight set by your repair type. Your discharge letter has your exact prescription. Root and radial repairs commonly mean touch weight bearing (foot resting on the ground for balance only) for 4–6 weeks, because those repairs are most vulnerable to load. Weight bearing is progressed at your reviews, not by how the knee feels.

### When can I run again?

From about 3–4 months, on a quiet knee. One that does not swell in response to training, with the strength gates met and clearance at your review. Running restarts as straight-line work in stages; change-of-direction drills come later. If the knee swells after a run, that is a vote against the next progression, not a reason to push through.

### When can I get back to pivoting sport: football, netball, basketball, skiing?

Typically about 4–6 months, and longer for root repairs. Pivoting and twisting under load is the exact mechanism that re-tears repairs, which is why it is the last thing restored: no pivoting or twisting at all for the first 3–4 months, then a graduated build through drills and full training before competition. Your reviews set the actual clearance date.

### The trimming operation recovers in weeks. Why was mine stitched instead?

Because your tear was worth saving. The meniscus is the knee’s shock absorber, and losing part of it raises the long-term risk of arthritis in that compartment. When a tear sits

where it can heal and has a repairable pattern, stitching it preserves the meniscus for life: a slower recovery now in exchange for a better knee for decades. Trimming is the right operation when the tear cannot heal; repair is the right operation when it can.

### Do I sleep in the brace?

Follow the instructions given at your brace fitting, practice varies with the repair, and your discharge letter is the authority. What never varies: do not change the range dial yourself, keep the straps snug but not tight, and call the rooms about rubbing or pressure areas rather than padding the brace yourself.

### When can I go back to work?

Desk work is often possible early, on crutches, once you are off strong pain relief and have transport sorted, since you cannot drive in the brace. Physical work is individually planned, because the no-kneeling, no-squatting, no-twisting restrictions run for 3–4 months and most manual jobs collide with at least one of them. Raise your job demands at the first review so modified duties can be arranged early.

### My knee feels fine at three weeks. Can I ditch the brace and crutches?

No, and this is the most important question in the guide. A repaired meniscus routinely feels good long before it is healed, because the stitches hold everything still and comfortable. Healing takes three months and more; comfort at week three tells you nothing about the strength of the repair. The stitches, not the pain, set the pace: the brace and crutches come off when your review says so.

### What happens if the repair fails?

A failed repair usually declares itself with new catching, locking, or pain and swelling in the joint line, sometimes after a specific twist, sometimes gradually. It generally means another operation, most often trimming the failed portion, and it carries a higher long-term risk of arthritis, which is exactly why the restrictions in this guide are worth taking seriously. If you get new mechanical symptoms at any stage, call the rooms.

### What if my operation record mentions microfracture, MACI or a cartilage graft?

Then this guide does not apply to you. Cartilage repair procedures follow a completely different pathway, typically 6–8 weeks of protected weight bearing and 9–12 months before impact sport. Call the rooms for your specific protocol rather than following any timeline here.

### THE EVIDENCE BEHIND THIS GUIDE 8 sourced statements

| CLAIM | SOURCE |
|---|---|
| Only the peripheral 10 to 25% of the meniscus is vascular: the biological basis for slow healing of repairs and for repair-site selection | Arnoczky & Warren, Am J Sports Med 1982, microvasculature of the human meniscus (PMID 7081532) |
| Meniscal repair preserves the meniscus and is associated with lower long-term arthritis risk than meniscectomy, at the cost of a higher reoperation rate | Paxton, Stock & Brophy, Arthroscopy 2011, meniscal repair versus partial meniscectomy systematic review (PMID 21820843) |
| Post-repair rehabilitation protocols (brace, 0–90° range restriction 4–6 weeks, protected weight bearing 2–6 weeks) vary by repair type and are surgeon-directed; root and radial repairs are managed most conservatively | O'Donnell et al., Am J Sports Med 2017, systematic review of rehabilitation protocols after isolated meniscal repair (PMID 28256906); LaPrade et al., Am J Sports Med 2017, root repair outcomes (PMID 27919916) |
| Return to sport after meniscal repair typically 4–6 months, with pivoting sport last and root repairs slower | Eberbach et al., Knee Surg Sports Traumatol Arthrosc 2018, sport-specific outcomes after isolated meniscal repair (PMID 28243702) |
| Braking after right knee arthroscopy was SLOWER at 1 week than before surgery (920 ms against 736 ms) and had recovered by 4 weeks; a 2021 review of 8 studies put the average return to driving at about 6 weeks. A range-limiting brace defers driving regardless | Driving reaction time after right knee arthroscopy, Knee Surg Sports Traumatol Arthrosc 2000 (PMID 10795670); return to driving after hip and knee arthroscopy, systematic review and meta-analysis 2021 (PMID 34977666) |

| CLAIM | SOURCE |
| --- | --- |
| Routine pharmacological thromboprophylaxis not indicated after low-risk knee arthroscopy; individual risk assessment instead | van Adrichem et al., N Engl J Med 2017, POT-KAST and POT-CAST trials (PMID 27959702) |
| Joint swelling reflexively inhibits the quadriceps (arthrogenic muscle inhibition): universal after knee surgery and a primary early rehab target | Rice & McNair, Semin Arthritis Rheum 2010, quadriceps arthrogenic muscle inhibition review (PMID 19954822) |
| Degenerative-tear context for the companion guide: arthroscopic partial meniscectomy no better than exercise/sham at 1–2 years, informing Australian restraint in worn knees | Sihvonen et al., N Engl J Med 2013, FIDELITY (PMID 24369076); Katz et al., N Engl J Med 2013, METEOR (PMID 23506518); Kise et al., BMJ 2016 (PMID 27440192). Australian practice context from Choosing Wisely Australia and the 2018 MBS item changes, which are policy positions rather than trials |

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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