REHABILITATION AFTER KNEE ARTHROSCOPY: PARTIAL MENISCECTOMY

Partial meniscectomy recovery: walking immediately, driving about a week, sport in 4–6 weeks, and honest advice on degenerative tears.

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

15 minutes to read. Reviews: Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks. 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. This guide) or STITCHED (meniscal repair: see the meniscal repair 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 trimmed guide is yours, the news is good: a partial meniscectomy is one of the quickest orthopaedic recoveries there is. You walk on the leg immediately, crutches are for comfort only, and there is no brace and no movement restriction. The work in this guide is about settling the swelling, switching the thigh muscle back on, and building back to sport in a sensible order.

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. Your knee, your tear and your operation are your own, and Dr Broadhead’s instructions for you always override the general figures here.

AT A GLANCE

WEIGHT BEARING
Full weight bearing immediately

WALKING AIDS
Crutches for comfort only, typically 0–3 days

BRACE
No brace

PRECAUTIONS
No movement restrictions: full range from day one, paced by swelling

DRIVING
About 1 week, once off strong pain relief and able to emergency-stop: discussed with us

DESK WORK
A few days to a week

PHYSICAL WORK
2–4 weeks

SPORT & ACTIVITY
Stationary bike week 1–2, gym 2–3 weeks, graduated return to sport 4–6 weeks once the gates below are met

REVIEWS
Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks. Confirmed on your discharge letter

WHAT WAS DONE IN YOUR OPERATION

The meniscus is a C-shaped cushion of fibrous cartilage sitting between the thigh bone and the shin bone: a shock absorber and load spreader. Each knee has two, one on the inner (medial) side and one on the outer (lateral) side.

In a knee arthroscopy, the surgeon works through two or three small keyhole cuts using a camera and fine instruments, with the knee filled with fluid. In a partial meniscectomy, the torn, unstable fragment of meniscus. The piece that was catching, clicking or locking, is trimmed away back to a smooth, stable

rim. As little as possible is removed; the healthy remainder is left to keep doing its job.

Because nothing was stitched, nothing needs protecting while it heals. That is the whole reason this recovery is so different from a meniscal repair: there is no repair to shear, so the knee can move and take weight straight away.

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 TRIMMED meniscus only. If your operation record says the tear was repaired (stitched), stop here and use the meniscal repair guide, and if you are not sure, call the rooms before following any timeline.

> **2. 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, and it is why the leg feels wobbly and gives-way early on. Quadriceps work starts on day one: static quadriceps sets and straight leg raises, little and often, from the recovery room onwards.

> **3. Swelling sets the pace**
>
> There is no brace and no restriction, so the throttle is swelling. A knee that is more swollen or achier the morning after activity did too much the day before. Ice, elevate, and let the knee, not the calendar: decide when to add the next step.

> **4. An honest word about degenerative tears**
>
> Where the meniscal tear is part of general wear rather than a discrete injury, high-quality randomised trials, including sham-controlled evidence, show arthroscopic partial meniscectomy is no better than a good exercise programme for pain and function at one to two years. That is why Australian practice (in line with Choosing Wisely Australia and the 2018 Medicare item changes) reserves it for mechanical symptoms and failed conservative treatment. Where it is done, the pre-existing cartilage wear, not the operation, sets the ceiling; recovery is slower (6–12 weeks) and some ache commonly persists.

> **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

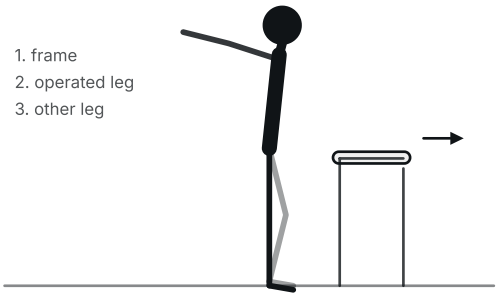
FULL WEIGHT BEARING IMMEDIATELY

You can put all of your weight through the leg from the moment you wake up. Nothing was stitched inside the knee, so there is nothing that walking can damage.

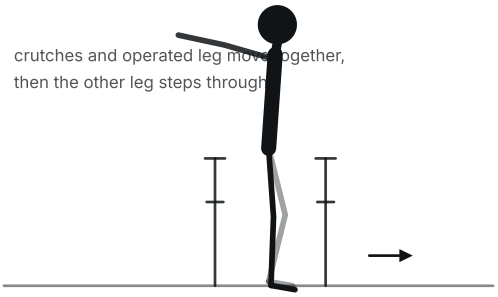
Crutches are offered for comfort only. Most people use them for somewhere between zero and three days, then put them in the cupboard. Use them for exactly as long as they make walking easier, and not a day longer.

The goal in the first days is a normal walking pattern: heel down first, knee straightening fully as you step through. A short, frequent walk beats one long outing while the knee is swollen.

STAGE	TYPICAL TIMING	MOVE ON WHEN
Two crutches, for comfort only	Day 0 to about day 3	Use them while they genuinely help; there is no minimum time
No aid	From the first few days	Walking without a limp: a limp means slow down, not push through

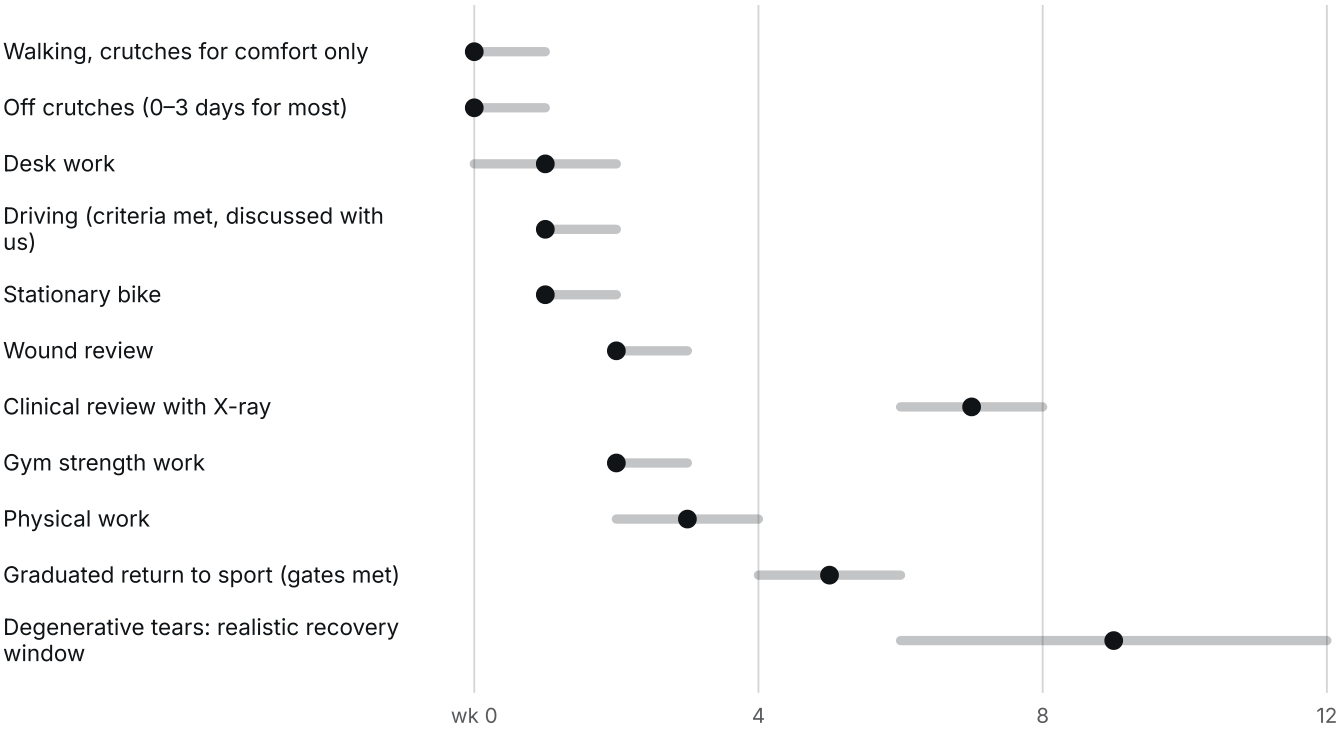


Frame first, then the operated leg, then the other leg



Crutches and operated leg together, then step through

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: SETTLE

DAYS 0–3

Let the knee calm down: control swelling, wake the quadriceps up, keep the knee moving through comfortable range, and walk little and often.

GOALS: TICK THEM OFF

- [ ] Swelling controlled with ice and proper elevation
- [ ] Quadriceps firing: a firm static quads contraction and a straight leg raise without the knee sagging
- [ ] Knee straightening fully and bending comfortably
- [ ] Walking short distances hourly, with or without crutches
- [ ] Wounds clean and dry under the dressings

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, heel slides and straight leg raises as set out in the exercise section.
- Ice 15–20 minutes at a time and elevate properly (lying down, foot above heart level) several times a day.
- Walk short distances often; drop the crutches as soon as they stop helping.

AVOID THIS

- One long walk to "test it out": the knee will answer with swelling.
- Sitting for long periods with the leg hanging down.
- Kneeling or squatting on the fresh wounds while the dressings are on.

READY FOR THE NEXT PHASE WHEN…

- Walking without crutches and without a marked limp
- Straight leg raise with no lag
- Swelling stable or falling

PHASE 2: RESTORE

WEEKS 1–2

Get back to normal life: full range of movement, a normal walking pattern, the stationary bike, desk work, and driving once the criteria are met.

GOALS: TICK THEM OFF

- [ ] Full range of movement, matching the other knee
- [ ] Walking normally, including stairs
- [ ] Stationary cycling started (week 1–2)
- [ ] Back at desk work (a few days to a week)
- [ ] Driving from about 1 week, once off strong pain relief and able to emergency-stop: discussed with us

DO THIS

- Start the stationary bike in week 1–2: saddle high at first, time before resistance.
- Add sit-to-stands and kneecap mobilisation; keep the quadriceps work going daily.
- Begin scar massage once the wounds are fully healed and dry.
- Ice after exercise while the knee still swells with activity.

AVOID THIS

- Running, jumping or twisting. The knee is not ready, even when it feels good at walking pace.
- Judging progress by pain alone; swelling the next morning is the more honest scorecard.

READY FOR THE NEXT PHASE WHEN…

- Full range of movement
- Comfortable on the bike for 10–20 minutes
- Walking and stairs without a limp

PHASE 3: REBUILD AND RETURN

WEEKS 2–6

Rebuild strength in the gym from 2–3 weeks, then a graduated return to sport at 4–6 weeks: gates, not dates.

GOALS: TICK THEM OFF

- [ ] Gym-based strength work from 2–3 weeks
- [ ] Physical work from 2–4 weeks, depending on the job
- [ ] Single-leg strength and balance rebuilt
- [ ] Graduated return to sport at 4–6 weeks once: swelling has settled, range is full, quadriceps strength is at least about 90% of the other side, and sport-specific drills are pain-free

DO THIS

- Progress mini squats, step-ups, step-downs, heel raises and single-leg balance.
- Return to the gym at 2–3 weeks; build the leg work gradually rather than resuming your old program on day one.
- Reintroduce sport in stages: straight-line running, then change of direction, then training drills, then play.

AVOID THIS

- Skipping the gates: swelling settled, full range, quadriceps at least about 90%, pain-free drills. A knee that swells after training is telling you the answer.
- Comparing your week number to anyone else’s, especially if your tear was degenerative, where 6–12 weeks is the realistic window.

READY FOR THE NEXT PHASE WHEN…

- Back at sport, training and playing without the knee swelling afterwards
- No sense of the knee "giving way" under load

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

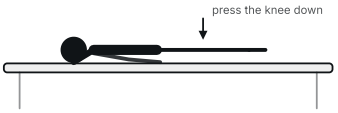
PHASE 1

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

10 firm pumps, every waking hour, for the first week

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.



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

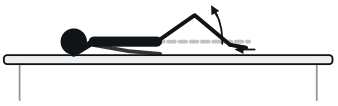
1. Lie or sit with the leg straight.
2. Push the back of the knee down by tightening the front of the thigh.
3. Watch the kneecap draw upward slightly.
4. Hold, then fully relax.

Feel: You should feel this in the front of the thigh. A weak, flickery contraction on day one is normal. It sharpens quickly with practice.

Harder: Add a rolled towel under the ankle so the knee presses down through a fuller range.

HEEL SLIDES

PHASE 1



Slide the heel towards you so the knee bends up

Keep the full bend: there is no restriction, so use the range you have.

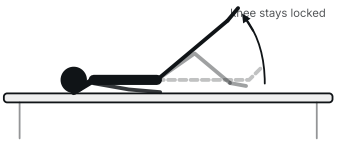
10 slow slides, 3 times daily

1. Lie on your back.
2. Slide the heel towards your bottom as far as comfortable.
3. Hold 5 seconds at the top of the bend.
4. Slide slowly back to straight.

Feel: A stretching feeling is fine; sharp lingering pain means ease off. A towel or plastic bag under the heel makes it slide easier.

STRAIGHT LEG RAISE

PHASE 1



Lock the knee straight, lift, lower slowly

Quadriceps strength with the knee locked straight, lifting without a sag is the early milestone.

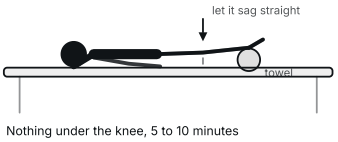
10 lifts, hold 3 seconds, 3 times daily

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

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

HEEL PROP (EXTENSION STRETCH)

PHASE 1



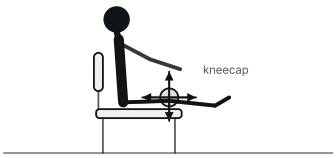
Nothing under the knee, 5 to 10 minutes

Keep the knee fully straight: a knee that rests slightly bent limps and aches.

5 minutes, 2–3 times daily while any swelling persists

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. Do not rest with a pillow under the knee.



Gentle glides up, down and side to side

KNEECAP MOBILISATION

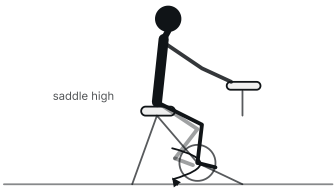
PHASE 2

Keep the kneecap and the portal scars gliding freely.

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.



Saddle high at first, build time before resistance

STATIONARY CYCLING

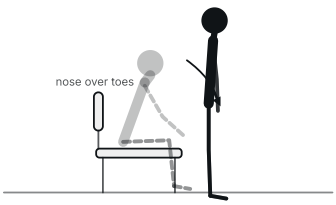
PHASE 2

Range, circulation and endurance with almost no joint load: the workhorse of week 1–2.

10–20 minutes, most days, from week 1–2

1. Saddle high at first: a higher seat needs less bend.
2. Start with light resistance and let the legs spin.
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 2

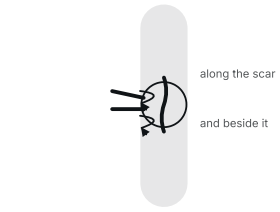
Real-world leg strength: the movement you will do more than any other.

2–3 sets of 8–10, once or twice daily

1. Sit on a firm chair.
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, no swinging or flopping.

Harder: Lower the chair height, then slow the lowering phase further.



Firm small circles, 2 to 3 minutes twice daily

SCAR MASSAGE

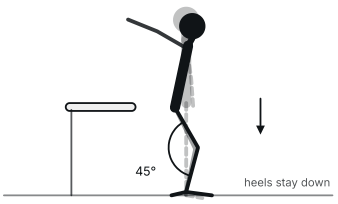
PHASE 2

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.



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

MINI SQUAT

PHASE 3

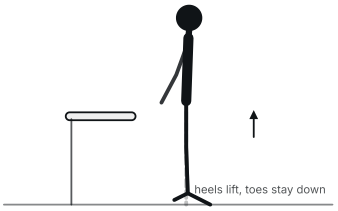
Thigh and hip strength through a small, safe range.

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, as if starting to sit.
3. Keep the heels down and knees over the toes.
4. Push back up.

Feel: You should feel the thighs working, not the knee pinching.

Harder: Deeper range and added load in the gym from 2–3 weeks, guided by swelling.



Up onto the balls of the feet, lower slowly

HEEL RAISES

PHASE 3

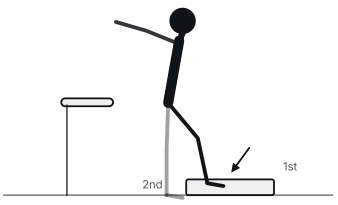
Calf strength for a normal push-off and the first step back towards running.

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

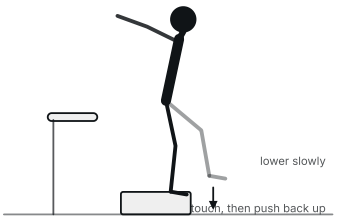
Single-leg strength for stairs, slopes and sport.

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.



Lower slowly with the operated leg, touch, return

STEP-DOWNS (CONTROLLED LOWERING)

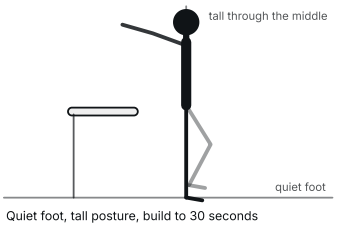
PHASE 3

The control that protects the knee on descents and in deceleration: a key return-to-sport strength.

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.



Quiet foot, tall posture, build to 30 seconds

SINGLE-LEG BALANCE

PHASE 3

Steadiness and joint control: the foundation for change-of-direction work.

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.

SWELLING, ICE AND ELEVATION

WHAT IS NORMAL

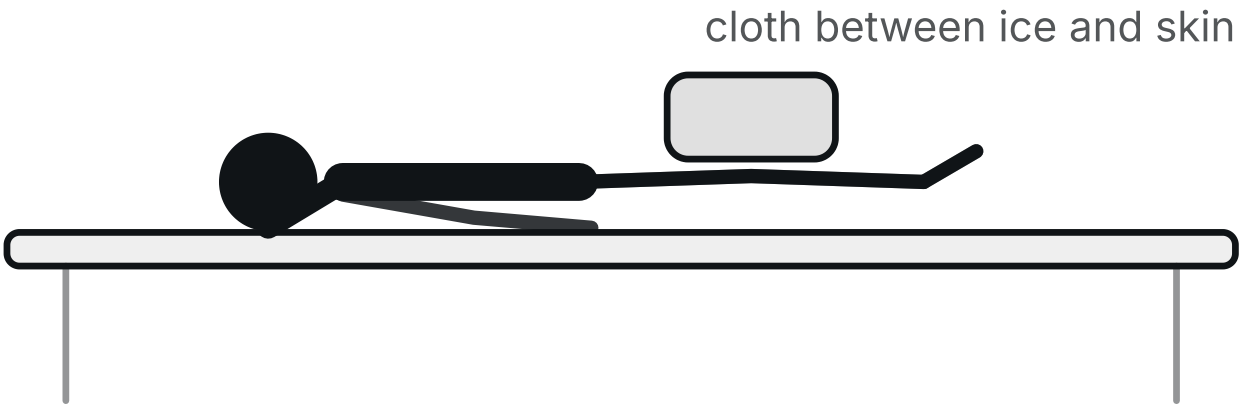
- Some swelling after arthroscopy is universal. The knee was filled with fluid during the operation, and the joint lining reacts to surgery. It is at its worst in the first days and settles over the following weeks.
- A knee that is puffier or achier the morning after activity did too much the day before. That is feedback, not damage.
- Swelling is also the reason your thigh muscle feels switched off: the two go together, and both improve together.
- 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

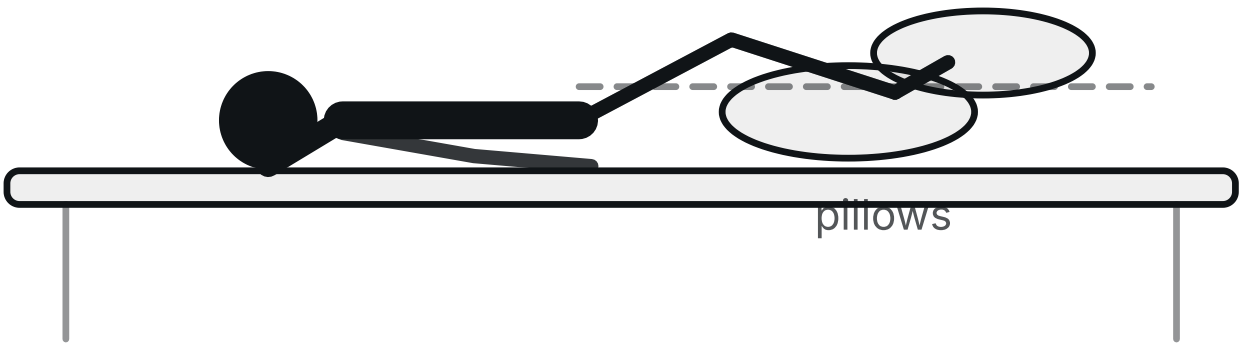
- Ice is safe, cheap and comfortable, and probably gives a small benefit for pain and swelling in the first few days.
- Use it for 15–20 minutes at a time, 4–6 times a day for the first 2 weeks, then as needed after activity and physiotherapy. It is particularly useful in the hour after exercise.
- Always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

Sleep in whatever position is comfortable. There are no positional restrictions after a partial meniscectomy.

If you want the leg supported, place a pillow under the whole lower leg from calf to heel so the knee stays straight, not a pillow under the knee itself.

Icing before bed and timing simple pain relief for the night help in the first few days.

PAIN, MEDICATION AND WHAT TO EXPECT

Pain after a partial meniscectomy is usually modest and short-lived: most people manage with simple pain relief (paracetamol, and an anti-inflammatory

if prescribed) within a few days, keeping anything stronger for the first night or two if needed at all.

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) are assessed before surgery, and if you need prevention it will be prescribed specifically.

An ache with weather, at night, or after big days can persist for some weeks, and where the tear was degenerative, some ache commonly persists longer. Pain that is increasing rather than settling is a reason to call, not wait.

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	Immediately	Comfort; crutches for comfort only, 0–3 days	Short and frequent beats long and heroic in week one
Desk work	A few days to a week	Comfortable sitting; off strong pain relief	Elevate the leg under the desk where possible
Driving	About 1 week	Off strong pain relief; able to emergency-stop at full force: see the driving criteria	About a week is usual in this practice. The criteria are the real test, not the date: simulator studies are more conservative, so if you are not certain of a full-force emergency stop, wait and tell us
Stationary cycling	Week 1–2	Comfortable range; wounds settled	Saddle high at first; time before resistance
Swimming	Once the wound is healed and reviewed	No baths, spas, pools or ocean swimming until the wounds are fully healed	Usually cleared at the wound review
Gym strength work	2–3 weeks	Swelling settled; full range	Build the leg work gradually: do not resume the old program on day one
Physical work	2–4 weeks	Strength and endurance for the actual duties	Modified duties in between where available
Graduated return to sport	4–6 weeks	Swelling settled; full range; quadriceps at least about 90% of the other side; sport-specific drills pain-free	Gates, not dates. Degenerative tears run slower: 6–12 weeks is the realistic window

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

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. This guide) or STITCHED (meniscal repair: the other 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.

When can I drive after knee arthroscopy?

Typically about 1 week after a partial meniscectomy, once you are off strong pain relief and can perform an emergency stop at full force without hesitation. The braking studies show performance returns to normal at about a week after a right knee arthroscopy. Practise the movements in a stationary car first, and confirm your own timing with us: the criteria matter more than the date.

How long will I need crutches?

Usually 0–3 days, and only for comfort. You can take full weight immediately, nothing was stitched inside the knee, so there is nothing walking can damage. Use the crutches for exactly as long as they help and put them away as soon as you can walk without a limp.

When can I go back to work?

Desk work within a few days to a week, once you are comfortable sitting and off strong pain relief. Manual and physical work typically takes 2–4 weeks, depending on how much kneeling, squatting, lifting and ladder work the job involves, modified duties in between are ideal where available.

When can I get back to sport?

The stationary bike in week 1–2, the gym at 2–3 weeks, and a graduated return to sport at 4–6 weeks, provided the gates are met: swelling settled, full range of movement, quadriceps strength at least about 90% of the other side, and sport-specific drills pain-free. Gates, not dates: a knee that swells after training is not ready, whatever the calendar says.

Will the arthroscopy fix my arthritis?

No, and it is important to be honest about this. Where a meniscal tear is part of general wear rather than a discrete injury, high-quality randomised trials, including trials against sham (placebo) surgery, show that trimming the meniscus is no better than a good exercise programme for pain and function at one to two years. That is why Australian practice, in line with Choosing Wisely Australia and the 2018 Medicare changes, reserves arthroscopy for mechanical symptoms and failed conservative treatment. Where surgery is done in a worn knee, the pre-existing cartilage wear, not the operation: sets the ceiling on the result.

Why is my recovery slower than the 4–6 weeks this guide describes?

The 4–6 week sport timeline describes a discrete tear in an otherwise healthy knee. Where the tear was degenerative: part of general wear, recovery is slower, typically 6–12 weeks, and some ache commonly persists even after that. That is not a failed operation; it is the underlying knee showing through. If pain is increasing rather than plateauing, call the rooms.

Why does my thigh muscle feel switched off?

Because it is: temporarily. Swelling in a knee joint switches the quadriceps off by reflex. It is universal and expected after any knee surgery, and it is why quadriceps work starts on day one: static quadriceps sets and straight leg raises are the switch that turns the muscle back on. The wobbliness improves as the swelling settles and the muscle wakes up.

Do I need a brace or blood thinners?

Neither, routinely. There is no brace after a partial meniscectomy because there is no repair to protect, full movement from day one is encouraged. And routine blood thinners are not used for low-risk day-case arthroscopy; your individual risk factors are assessed, and prevention is prescribed only where your history calls for it. Keep up the ankle pumps and regular walking regardless.

How much swelling is normal, and what is not?

Some swelling is universal and settles over the following weeks; a knee that puffs up after a big day did too much the day before. Two patterns are different: rapid, tense, ballooning swelling in the first 24–72 hours (which can mean bleeding into the joint), and swelling that increases after initial improvement, especially with fever or wound discharge (infection: uncommon but urgent). Both mean call the rooms the same day.

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
Arthroscopic partial meniscectomy no better than sham surgery for degenerative meniscal tears	Sihvonen et al., N Engl J Med 2013, FIDELITY trial (PMID 24369076)
Arthroscopic partial meniscectomy plus physiotherapy no better than physiotherapy alone at 6–12 months (meniscal tear with osteoarthritis)	Katz et al., N Engl J Med 2013, METEOR trial (PMID 23506518)

CLAIM	SOURCE
Exercise therapy as effective as partial meniscectomy for degenerative meniscal tears in middle-aged patients at 2 years	Kise et al., BMJ 2016, exercise therapy versus arthroscopic partial meniscectomy (PMID 27440192)
Australian practice reserves arthroscopy for mechanical symptoms and failed conservative treatment in degenerative knees	Choosing Wisely Australia recommendations and the 2018 MBS item changes restricting knee arthroscopy in osteoarthritis. These are policy positions, not clinical trials
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	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)
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)
Return to sport 4–6 weeks after partial meniscectomy with strength and swelling gates (quadriceps ≥~90% of contralateral side)	Conventional practice rather than trial evidence: there is no randomised trial defining return-to-sport timing after partial meniscectomy, so these gates reflect expert consensus

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