REHABILITATION AFTER TOTAL KNEE REPLACEMENT

Total knee replacement recovery: full weight bearing from day one, driving typically 4–6 weeks, and the week-by-week rehab plan.

PATIENT NAME _____

DATE OF SURGERY _____

WHAT IS INSIDE

22 minutes to read. Reviews: Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks. Then reviews with X-rays at 6 months and 12 months. A 3-month review is added only if you are not progressing as expected.

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

This guide walks you through recovery after a total knee replacement, week by week, what to do, what to expect, and when to call us. Keep it somewhere handy; most patients come back to it many times in the first three months.

One sentence matters more than any other in this guide: a knee replacement is a rehabilitation operation, not just an operation. The surgery creates the opportunity; the result is earned in the first twelve weeks. The work described here is not optional extra credit. It is the treatment.

Every timeframe in this guide is typical, not a rule. Your knee, your health 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 as tolerated from day one

WALKING AIDS
Frame or crutches 1–3 weeks, then a stick as needed to about 6 weeks

BRACE
No brace routinely

PRECAUTIONS
No movement restrictions: full extension is the daily priority

DRIVING
Typically 4–6 weeks for a right knee, individually assessed; often sooner for a left knee in an automatic

DESK WORK
Typically 4–6 weeks

PHYSICAL WORK
Around 3 months

SPORT & ACTIVITY
Walking, swimming and stationary cycling from the outset; most sports from around 6 months

REVIEWS
Wound review at about 2 weeks. Clinical review with an X-ray at 6 to 8 weeks. Then reviews with X-rays at 6 months and 12 months. A 3-month review is added only if you are not progressing as expected

WHAT WAS DONE IN YOUR OPERATION

The knee is a hinge between the thigh bone (femur) and the shin bone (tibia). In a total knee replacement, the worn surfaces at the end of the thigh bone and the top of the shin bone are removed and resurfaced with shaped metal components, with a smooth plastic (polyethylene) bearing between them. Often a plastic button is fitted to the back of the kneecap as well.

The ligaments around the knee are balanced during surgery so the new joint is stable through its whole range of movement. The metal and plastic are fixed and stable immediately, which is why you can stand on the new knee straight away.

THE IDEAS THAT MAKE EVERYTHING ELSE MAKE SENSE

1. This is a rehabilitation operation

The surgery creates the opportunity; the result is earned in the first twelve weeks. Patients who do the daily work get better knees. This is the single most important idea in this guide.

2. Straightening beats bending, and both need daily work

A knee that will not fully straighten limps and aches. Prioritise full extension (a completely straight knee) every single day from day one: heel props, prone hangs, and never a pillow behind the knee.

3. Swelling limits bending

Swelling and bending are inversely related: the more swollen the knee, the less it bends. Control the swelling with elevation, ice and pacing, and the range of movement follows.

4. The timeline is long, but it has an end

Most of the improvement happens in the first 3 months, and useful gains continue to about 12 months. Scores generally plateau after the first year, significant improvement between 12 and 24 months is not the average experience, though some people, particularly those who started stiffer, do keep gaining. Warmth, tightness, clicking, occasional sharp twinges and a numb patch beside the scar are all normal along the way.

5. Honest expectations are part of the treatment

Australian registry data show about 80% of patients are satisfied or very satisfied, and about 82% say the knee is "much better" at 6 months. Roughly 1 in 10 are clearly dissatisfied and a further 1 in 10 are neutral, so about 1 in 5 are not fully satisfied. The strongest known predictor of dissatisfaction is not the implant or the surgeon: it is unmet expectations, a nearly 11-fold effect. That finding is the reason this guide exists, knowing what is normal is half the battle.

WEIGHT BEARING AND WALKING AIDS

WEIGHT BEARING

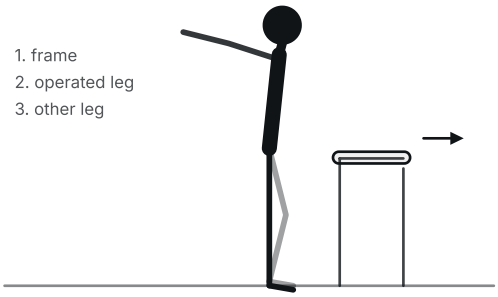
FULL WEIGHT BEARING AS TOLERATED FROM DAY ONE

You will stand and walk on the new knee, taking as much weight as comfort allows, on the day of surgery or the day after. Walking early is safe and gets you home sooner.

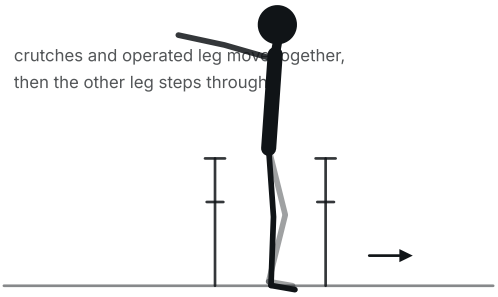
Early mobilisation is recommended by the major enhanced-recovery and physiotherapy guidelines, and is part of preventing blood clots. Getting moving early shortens hospital stay by about 1.8 days with no increase in problems.

In Australia, most patients stay two to four nights; rapid-recovery pathways in the private sector routinely achieve one to two nights in suitable patients.

STAGE	TYPICAL TIMING	MOVE ON WHEN
Wheeled frame or two crutches	Day 0 to about 1 week	Safe balance; walking without a lurch
Two crutches	To about 2 weeks	Confident on level ground; managing stairs with help
One crutch or a stick (opposite hand)	About 2–4 weeks	Level walking without a limp
No aid	About 4–6 weeks	No limp; confident indoors and outdoors; able to manage a kerb

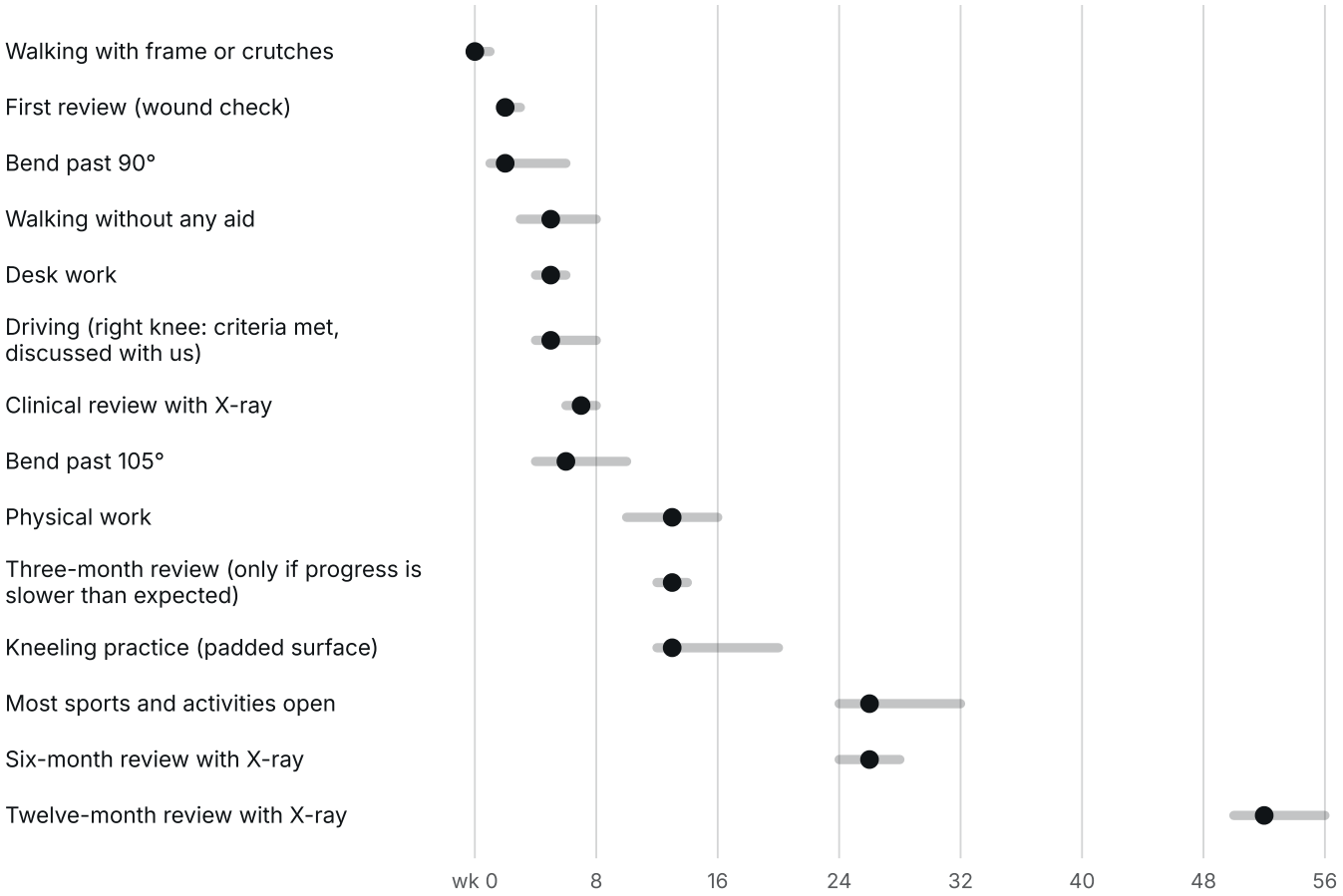


Frame first, then the operated leg, then the other leg



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: PROTECT AND SETTLE

WEEKS 0–2

Get the knee straight, keep the swelling down, wake the quadriceps up, and walk little and often.

GOALS: TICK THEM OFF

- [ ] Knee fully straight (matching the other side) when resting
- [ ] Bend past 90 degrees
- [ ] Straight leg raise without the knee sagging
- [ ] Swelling settling rather than building
- [ ] Walking short distances hourly with your aid
- [ ] Wound clean, dry and settled

DO THIS

- Heel props and gravity-assisted straightening several times every day, full extension is the number one priority.
- Quadriceps sets, ankle pumps, heel slides and straight leg raises as set out in the exercise section.
- Ice 15–20 minutes, 4–6 times a day, and elevate properly (lying down, foot above heart) several times a day.
- Short, frequent walks: hourly while awake beats one long outing.

AVOID THIS

- A pillow under the knee: comfortable now, costly later. It teaches the knee to rest bent.
- Sitting with the leg hanging down for long periods.
- Doing nothing on a “good day” or everything on a “bad day”: steady beats heroic.

READY FOR THE NEXT PHASE WHEN…

- Knee straightens fully to match the other side
- Bend beyond 90 degrees
- Straight leg raise with no lag
- Swelling stable or falling

PHASE 2: RANGE AND RHYTHM

WEEKS 2–6

Build the bend towards 105 degrees and beyond, walk normally, and wean off the aids.

GOALS: TICK THEM OFF

- [ ] Full extension maintained every day
- [ ] Bend past 105 degrees by 6 weeks (a target we work towards, not a pass mark)
- [ ] Walking without a limp; wean from crutches to a stick to nothing
- [ ] Stationary cycling once the bend allows
- [ ] Managing stairs normally

DO THIS

- Keep the extension work daily: it still leads.
- Add sit-to-stands, mini squats, heel raises and step-ups as comfort allows.
- Start the stationary bike when the knee bends far enough to turn the pedals: saddle high at first.
- Ice after exercise sessions.

AVOID THIS

- Forcing the bend through sharp pain: work firmly into stretch, not through pain that lingers.
- Comparing yourself to anyone else’s week number.

READY FOR THE NEXT PHASE WHEN…

- Full extension held
- Bend at or beyond about 105 degrees
- Walking unaided without a limp

PHASE 3: STRENGTH AND CONFIDENCE

WEEKS 6–12

Turn a healing knee into a working one: strength, balance, endurance and stairs without thinking.

GOALS: TICK THEM OFF

- [ ] Bend working towards 115–125 degrees by 3 months (again, a target, not a test)
- [ ] Single-leg balance 30 seconds
- [ ] Stairs step-over-step both directions
- [ ] Walking distance building week on week

DO THIS

- Progress squats, step-ups and step-downs; add single-leg balance work.
- Walk, swim and cycle for endurance, low-impact volume is your friend.
- From about 3 months, practise kneeling on a padded surface, going down onto the non-operated knee first.

AVOID THIS

- Impact work: running and jumping are not part of knee replacement rehabilitation.
- Ignoring a knee that is stuck: if the bend is not progressing by 6 weeks, contact the rooms early rather than waiting.

READY FOR THE NEXT PHASE WHEN…

- Confident daily function: shopping, stairs, car, garden
- Strength near-symmetrical on sit-to-stand and step-up

PHASE 4: RETURN TO LIVING

MONTHS 3–12

Back to the activities that matter, at the right pace, with realistic expectations of the finish line.

GOALS: TICK THEM OFF

- [ ] Return-to-activity list progressing (see the table below)
- [ ] Kneeling tolerance improving with practice
- [ ] The knee gradually “disappearing” from daily thought

DO THIS

- Keep a twice-weekly strength habit. It protects the result for years.
- Push distance and hills in walking and cycling.
- Raise anything that worries you at your 6-month or 12-month review, or sooner by contacting the rooms.

AVOID THIS

- Contact sport, jumping sports and singles tennis on hard courts, not recommended long term.
- Running as regular exercise: this is a wear-and-longevity judgement rather than a proven risk of failure, and it is the standard advice.

READY FOR THE NEXT PHASE WHEN…

- Twelve-month review complete; knee accepted as “yours” rather than “new”

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

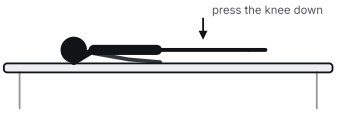
PHASE 1

Keep blood moving in the calf: your main clot-prevention exercise.

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

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

Feel: You should feel the calf muscles working. Move through the full range each time.



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, and everything else depends on it.

10 holds of 5 seconds, 3–4 times daily

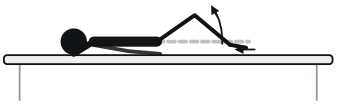
1. Lie with the leg straight.
2. Push the back of the knee down into the bed by tightening the front of the thigh.
3. Watch the kneecap draw upward slightly.
4. Hold, then fully relax.

Feel: You should feel this in the front of the thigh. The heel may lift slightly off the bed as the knee flattens: good.

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

Restore the bend, gently and often.

10 slow slides, 3–4 times daily

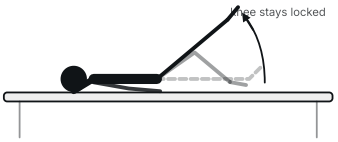
1. Lie on your back.
2. Slide the heel towards your bottom as far as comfortable, letting the knee bend.
3. Hold 5 seconds at the top of the bend.
4. Slide slowly back to straight.

Feel: A firm stretching feeling at the front of the knee is right; sharp lingering pain means ease off. A towel or plastic bag under the heel makes it slide easier.

Easier: Loop a towel around the ankle and assist the slide with your arms.

STRAIGHT LEG RAISE

PHASE 1



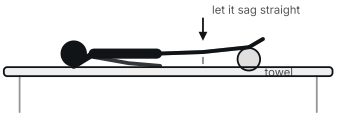
Lock the knee straight, lift, lower slowly

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

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.



Nothing under the knee, 5 to 10 minutes

HEEL PROP (EXTENSION STRETCH)

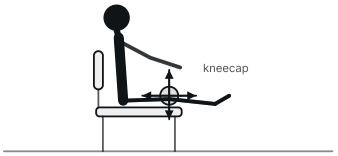
PHASE 1

Full straightening: the highest-priority exercise in this entire guide.

5–10 minutes, 2–3 times daily

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

Feel: A firm stretch behind the knee is exactly right. Never put a pillow under the knee to “rest” it afterwards.



Gentle glides up, down and side to side

KNEECAP MOBILISATION

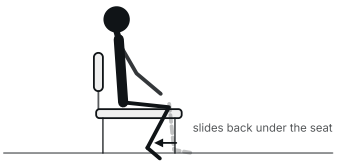
PHASE 1

Keep the kneecap gliding freely so the bend and the scar do not tether.

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

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

Feel: It should feel odd, not painful.



Slide the foot back under the chair and hold

SEATED ASSISTED KNEE BEND

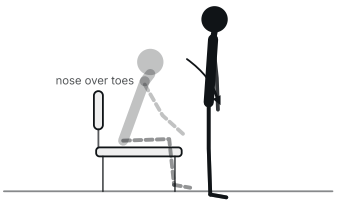
PHASE 2

Progress the bend using gravity and the other leg.

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

1. Sit on a chair, feet on the floor.
2. Slide the operated foot back under the chair as far as comfortable.
3. For more, cross the other ankle in front of the shin and press gently back.
4. Hold, release, repeat.

Feel: Work to a firm stretch; back off from sharp pain.



Nose over toes, push up evenly through both legs

SIT-TO-STAND

PHASE 2

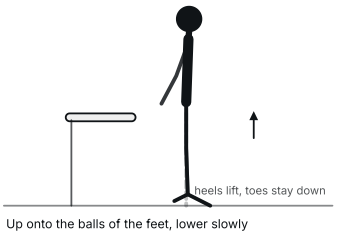
Real-world leg strength: the movement you will do more than any other.

2–3 sets of 8–10, once or twice daily

1. Sit on a firm chair with arms.
2. Feet back, lean forward, push up through both legs, use the arms only as needed.
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 progress to no hands.



Up onto the balls of the feet, lower slowly

HEEL RAISES

PHASE 2

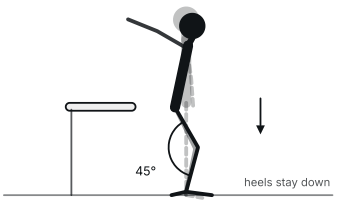
Calf strength for a normal push-off when walking.

2–3 sets of 10, once or twice daily

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

Feel: Even weight through both feet.

Harder: More weight onto the operated side over time.



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

MINI SQUAT

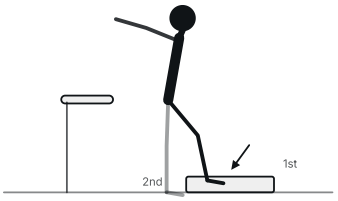
PHASE 2

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 the 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.



Operated leg goes up first, the other foot joins it

STEP-UPS

PHASE 2

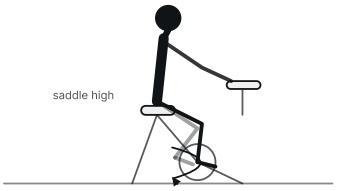
Single-leg strength for stairs and slopes.

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.



Saddle high at first, build time before resistance

STATIONARY CYCLING

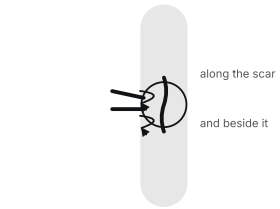
PHASE 2

Range, circulation and endurance with almost no joint load.

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: Mild stretch at the top of the pedal stroke is useful; lower the saddle gradually as the bend improves.



Firm small circles, 2 to 3 minutes twice daily

SCAR MASSAGE

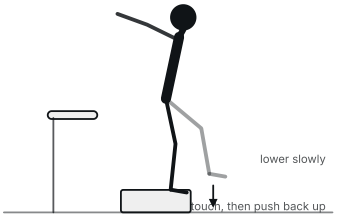
PHASE 2

Soften and desensitise the scar once fully healed.

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

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

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



Lower slowly with the operated leg, touch, return

STEP-DOWNS (CONTROLLED LOWERING)

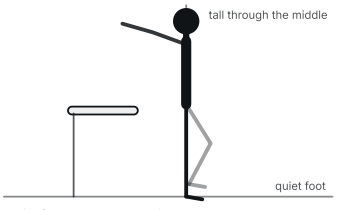
PHASE 3

The strength that controls stairs going down: the last thing to feel normal.

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

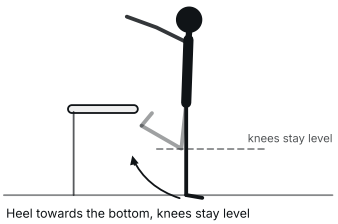
PHASE 3

Steadiness and confidence: protects you from trips and falls.

Build to 3 holds of 30 seconds each leg, daily

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

Feel: Quiet foot, tall posture.



STANDING KNEE BEND PHASE 3

Active bend strength through range.

2–3 sets of 10, once daily

1. Stand holding the 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

- Swelling is the single biggest brake on progress. It peaks about 6–8 days after surgery, then settles gradually.
- Most of the swelling resolves over the first two to three months, but it is normal for the limb to puff up after a long day or a burst of activity for some months after that, measurable swelling is still present at 7 weeks in most knee replacement patients.
- A limb that is bigger the morning after activity means you did too much the day before, not that something is wrong.
- Warmth and mild redness around the wound settle over weeks.

ICE

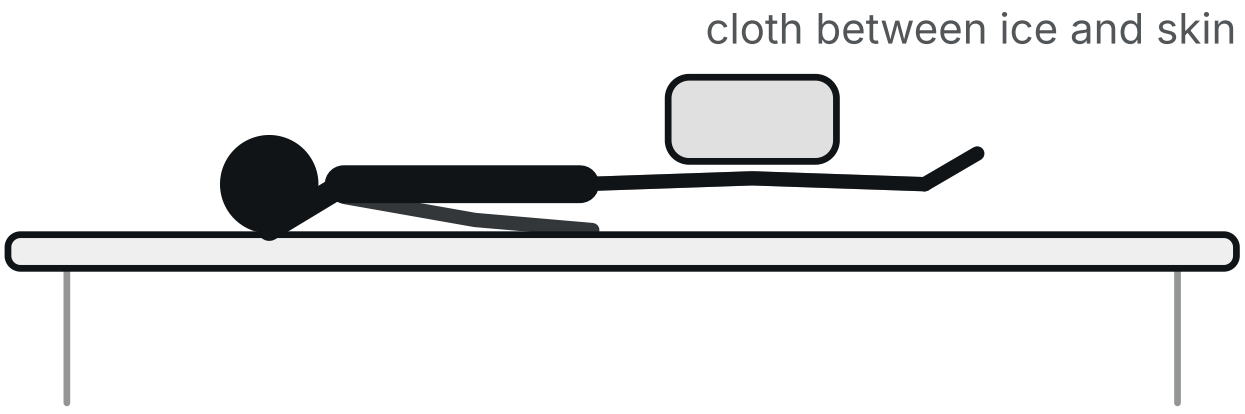
- Ice is safe, cheap and comfortable, and probably gives a small benefit for pain and swelling in the first few days.
- Use it for 15–20 minutes at a time, 4–6 times a day for the first 2 weeks, then as needed after activity and physiotherapy. It is particularly useful in the hour after exercise.
- Always place a thin cloth between the ice and your skin. Never sleep with ice on. Never ice over numb skin or a fresh wound dressing without checking with the rooms first.
- Stop and call the rooms if the skin becomes white, mottled or numb.
- An honest note about the evidence: the 2025 Cochrane review of icing after knee replacement (22 trials, 1,839 patients) found small improvements: pain at 48 hours better by 1.6 points out of 10, about 8 degrees more bend at discharge, and less blood loss: all on low-certainty evidence. The reviewers concluded the benefits may be too small to justify

routine use. Use ice because it is harmless and makes you more comfortable, not because it changes the final result.

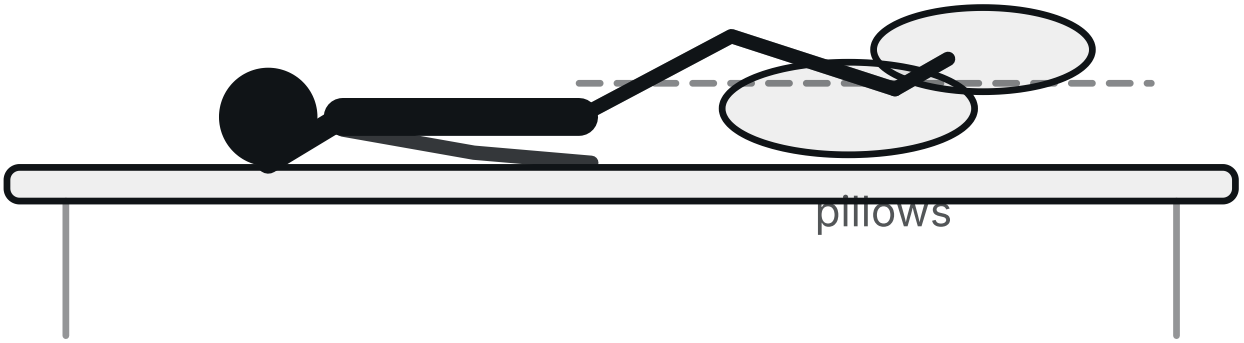
- There is no good evidence that expensive cold-compression machines work better than a bag of ice or a gel pack. The trials have never been analysed in a way that answers that question. Please do not spend money on one on our recommendation.

ELEVATION & COMPRESSION

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



15 to 20 minutes, 4 to 6 times daily



Foot above knee, knee above hip, lying flat

WOUND AND SCAR CARE

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

- Numbness in the skin around and below the scar is normal and often permanent, small skin nerves are unavoidably divided during surgery.

SLEEP AND POSITIONING

Sleep in whatever position is comfortable, on your back or either side. There are no positional restrictions after a knee replacement.

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

Disturbed sleep is very common for the first several weeks and improves as the swelling settles. Ice before bed, timing pain relief for the night, and a pillow between the knees when side-lying all help.

PAIN, MEDICATION AND WHAT TO EXPECT

Expect real pain for the first two to three weeks, needing regular pain relief: a knee replacement hurts more early on than a hip replacement, and knowing that in advance helps.

Take pain medication as prescribed and ahead of exercise sessions rather than chasing pain afterwards. Wean the strongest medications first as things settle.

You will usually be on a blood thinner for some weeks: take it exactly as directed.

Aches, warmth, tightness, clicking and the occasional sharp twinge continue for months and are normal. Pain that is increasing week on week is not, call the rooms.

How far the knee could bend before surgery is the single strongest predictor of how far it will bend afterwards, so progress is always measured against your

own starting point, not somebody else's.

PREVENTING BLOOD CLOTS

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

DRIVING: THE CRITERIA THAT ACTUALLY MATTER

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

- You are off opioid painkillers and any other sedating medication.
- You can sit comfortably in the driver's seat.
- You can perform an emergency stop at full force, without hesitation and without pain.
- You are not using a walking aid in the car, and not wearing a brace that limits the movement needed to work the pedals.
- You have practised the movements in a stationary car first.

What the driving research does and doesn't show

What the research actually measures is braking reaction time on a simulator. Those studies show braking performance returns to its pre-operative level at about 2 weeks after a right hip replacement and about 4 weeks after a right knee replacement, with movement time back to normal by 6 weeks. After knee arthroscopy the simulator evidence is more conservative than common practice: in the one study that measured it directly, braking was still slower one week after surgery than before it, and had recovered by four weeks, and a 2021 review of eight studies put the average return at about six weeks. Most people having a simple arthroscopy are driving well before that, which is why the criteria above matter more than the date. But these are averages, in one study, about one

in three right-hip patients still could not meet an emergency-stop benchmark at six weeks. Treat the timeframes in this guide as targets for discussion with us, not as permissions.

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

In Australia, your treating doctor’s advice governs: under the Austroads "Assessing Fitness to Drive" standards, temporary post-operative impairment is a matter of clinical judgement, and commercial drivers are held to a higher standard. Driving while impaired may invalidate your insurance, check your insurer’s position. Do not drive for at least 24 hours after any general anaesthetic or sedation.

GETTING BACK TO WHAT YOU DO

ACTIVITY	TYPICAL	WHEN IT’S RIGHT	NOTES
Walking for exercise	From the outset	Comfort and steadiness	Build distance gradually; it is the core of the programme
Swimming and aqua fitness	2–3 weeks	Wound fully healed and reviewed	No baths, spas or pools before the wound is checked
Stationary cycling	From the outset	Enough bend to turn the pedals	Saddle high at first
Driving	4–6 weeks	All the driving criteria	Often sooner for a left knee in an automatic: clinical judgement, not trial evidence

ACTIVITY	TYPICAL	WHEN IT'S RIGHT	NOTES
	(right knee)	below, discussed with us	
Desk work	4–6 weeks	Comfortable sitting; travel sorted	Elevate the leg under the desk where possible
Cycling on level ground; yoga	6–12 weeks	Confident balance; bend allows	Per European surgeon consensus (expert opinion, not trial data)
Physical work	Around 3 months	Strength and endurance for the actual duties	Modified duties in between where available
Kneeling	Practise from about 3 months	Padded surface, down on the non-operated knee first	Kneeling does not damage the implant, about a third kneel comfortably by one year, about half by three; with structured practice, most regain it
Golf, doubles tennis, gym weights, hiking, aerobics	From about 6 months	Strength and confidence built in Phase 3–4	21 of 47 activities are recommended from 6 months in the European consensus, squash was the only sport ruled out entirely
Running, jumping sports, contact sport, singles tennis on hard courts	Not recommended	—	Running was not among the activities recommended at 6 months; the advice against it is about implant wear and longevity, not a proven risk of sudden failure. About 70% of patients return to sport overall, mostly shifting to low-impact activity

Flying after joint replacement: an honest note

You will often hear "no flying for six weeks" after joint replacement. Be aware that this is a convention, not a proven rule: a 2025 review found

limited data and no demonstrated difference in clot risk between people who did and did not fly after hip or knee replacement: mostly within the first week.

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

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

WARNING SIGNS: ACT, DON’T WATCH

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

EMERGENCY: 000 Emergency department / call 000

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

GP TODAY See your GP today

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

CALL THE ROOMS Call the rooms: same day

- Pain that is increasing rather than decreasing after the first week
- New redness spreading out from the wound
- Wound discharge, particularly cloudy, thick or offensive fluid, or wound edges opening
- Fever of 38°C or higher, or shaking chills, or feeling generally unwell
- A fall onto the knee, or a sudden change in what the knee can do
- Bend not progressing by 6 weeks: call early rather than waiting: if a manipulation under anaesthetic is ever needed, it works best within 12 weeks (average gain about 36 degrees, versus 17 degrees when done late)

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

ARRANGING PHYSIOTHERAPY IN AUSTRALIA

- Most privately insured patients self-fund private physiotherapy or use extras cover. A GP Chronic Disease Management plan subsidises only five allied-health visits per calendar

year, not enough for a major reconstruction, so plan for this.

- Compensable patients (workers compensation, CTP) follow an insurer-approved plan.
- Tele-rehabilitation and app-supported home programmes are reasonable additions, but a sports knee reconstruction still needs periodic in-person objective strength testing.

COMMON QUESTIONS

How long will I be on crutches after a knee replacement?

Typically a frame or crutches for 1–3 weeks, a single stick to about 4–6 weeks, and nothing after that. You progress when you can walk without a limp, not on a set date. Many people keep a stick for crowds and uneven ground a little longer. That is sensible, not slow.

Can I put weight on my leg after a knee replacement?

Yes: full weight from day one. The implant is fixed and stable from the moment of surgery, so you will stand and walk on it the same day or the day after, using a frame or crutches for balance. Walking early is safe and gets you home sooner.

When can I drive after a knee replacement?

Typically 4–6 weeks for a right knee, and often sooner for a left knee in an automatic, but the date matters less than the criteria: off strong painkillers, able to emergency-stop at full force without hesitation, and practised in a stationary car. Braking studies show performance returns around 4 weeks on average after a right knee replacement; confirm your own timing with us.

How much should my knee bend two weeks after a knee replacement?

We aim for a fully straight knee and a bend past 90 degrees in the first couple of weeks, but these are targets we work towards, not a pass mark. In one Australian study only 25% of patients had even 80 degrees at hospital discharge. How far your knee bent before surgery is the strongest predictor of the final bend. Straight matters more than bent.

Do I need a CPM machine after a knee replacement?

No. The Cochrane review of 24 trials found CPM (continuous passive motion) machines add about 2 degrees of bend and make no meaningful difference to pain or function, and physiotherapy guidelines specifically advise against routine use. Active exercise, ice, elevation and walking are what work. Please don't hire one.

Can I kneel after a knee replacement?

Yes: kneeling does not damage the implant. About a third of patients kneel comfortably by one year and about half by three years; the barrier is skin and soft-tissue discomfort at the front of the knee, not the metal. In one study, everyone who completed a structured kneeling practice programme regained the ability. Practise from about 3 months on a padded surface, going down on the non-operated knee first.

How long should I ice my knee after surgery?

15–20 minutes at a time, 4–6 times a day for the first two weeks, then after exercise as needed: always with a cloth between ice and skin. Honestly: the trial evidence shows only small, short-lived benefits, so ice because it is comfortable and harmless, not because it changes the end result. An expensive cold-compression machine has never been shown to beat a bag of ice.

Is swelling normal three months after a knee replacement?

Some swelling, warmth and tightness at three months is completely normal, measurable swelling is still present at 7 weeks in most patients, and the knee can puff up after a big day for months. A knee that is bigger the morning after activity means you did too much yesterday. Swelling that is increasing week on week, or comes with fever or spreading redness, is different, call the rooms.

When can I go back to work after a knee replacement?

Desk work typically at 4–6 weeks, once you are comfortable sitting and have transport sorted. Physical work takes around 3 months, sometimes with modified duties in

between. Your own job's demands set the real date, raise it at the two-week review so a plan is in place early.

How long does the pain last after a knee replacement?

Real, medication-needing pain usually lasts two to three weeks and then steadily fades. Aches, warmth, tightness and the odd sharp twinge continue for months and are normal. Most improvement comes in the first three months, with useful gains to a year. Pain that is increasing rather than settling after the first week is a reason to call, not wait.

Do I need to go to a rehab hospital after a knee replacement?

Usually not. An Australian randomised trial (HIHO) showed a structured, monitored home programme matches inpatient rehabilitation for uncomplicated knee replacement, home-based does not mean doing nothing, it means supervised physiotherapy based at home. Patients who live alone, lack support, or have other medical or mobility problems do benefit from supervised inpatient care, and we arrange it where it is needed.

Why is the skin next to my scar numb?

A numb patch beside the scar (usually on the outer side) is expected: one small study found it in around 70% of patients. The small nerve supplying that skin crosses the incision line and cannot be avoided. It does not affect how the knee works, it did not affect satisfaction in that study, and the patch usually shrinks with time.

THE EVIDENCE BEHIND THIS GUIDE 32 sourced statements

CLAIM	SOURCE
CPM adds ~2° flexion with no meaningful benefit, not justified routinely	Harvey, Brosseau & Herbert, Cochrane Database Syst Rev 2014;2(2):CD004260 (PMID 24500904)
Physiotherapists should not use CPM after uncomplicated primary TKA	Jette et al., Phys Ther 2020: APTA clinical practice guideline (PMID

CLAIM	SOURCE
	32542403)
Pre-operative flexion is the strongest predictor of post-operative flexion (4,727 knees)	Ritter et al., J Bone Joint Surg Am 2003 (PMID 12851353)
Best results at 128–132° of flexion; function substantially compromised below 118°; flexion contracture worsens pain, walking and stairs	Ritter et al., J Bone Joint Surg Am 2008 (PMID 18381316)
Only 25% achieved ≥80° flexion at discharge; discharge extension predicts one-year extension	Naylor et al., J Eval Clin Pract 2012, Parts 1 and 2 (PMID 21414107, 21414108)
Flexion contracture associated with worse Oxford Knee Score and satisfaction	Goudie et al., Orthopedics 2011 (PMID 22146201); Su, J Bone Joint Surg Br 2012 (PMID 23118396)
Manipulation within 12 weeks gains 36.5° vs 17° late; poor results beyond 26 weeks	Issa et al., J Bone Joint Surg Am 2014 (PMID 25143495)
Best manipulation outcomes within 12 weeks (22 studies)	Gu et al., J Arthroplasty 2018 (PMID 29290334)
Stiffness defined as range <90° beyond 12 weeks; about 4% of patients	Tibbo et al., J Bone Joint Surg Am 2019 (PMID 31318813)
Monitored home programme non-inferior to inpatient rehabilitation at 26 weeks (Australian RCT)	Buhagiar et al., JAMA 2017: HIHO trial (PMID 28291891)
Home-based rehabilitation an appropriate first line with adequate social supports	Buhagiar et al., JAMA Netw Open 2019 (PMID 31026026)
Supervised physiotherapist management recommended; setting individualised	Jette et al., Phys Ther 2020 (PMID 32542403)
Self-directed rehabilitation as usual care; inpatient rehabilitation for the at-risk minority (Australian)	Sattler, Hing & Vertullo, Aust J Gen Pract 2020 (PMID 32864678)
Kneeling: 36.8% at 1 year, 47.6% at 3 years	Nadeem, Mundi & Chaudhry, Knee Surg Relat Res 2021 (PMID 34600595)

CLAIM	SOURCE
68% could kneel at 18–24 months; structured practice restores it	Wallace & Berger, J Arthroplasty 2019 (PMID 30773356)
Braking returns to baseline about 4 weeks after right TKA	van der Velden et al., Bone Joint J 2017 (PMID 28455464)
Movement time normalises by 6 weeks	Giannoudis et al., Knee 2021 (PMID 33945981)
Satisfaction: 80.8% satisfied, 10.5% dissatisfied, 81.6% "much better" at 6 months (AOANJRR)	Heath et al., Bone Jt Open 2021 (PMID 34182793)
Unmet expectations: 10.7× risk of dissatisfaction	Bourne et al., Clin Orthop Relat Res 2010 (PMID 19844772)
Cryotherapy: small benefits that may be too small to justify routine use	Aggarwal, Adie, Harris & Naylor, Cochrane Database Syst Rev 2025;10(10):CD007911 (PMID 41165130)
Function plateaus after the first year (no significant gain from 1 to 2 years)	Ekhtiari et al., Int Orthop 2024 (PMID 39007939)
No patient-reported-outcome trajectory shows decline or stagnation (reassuring)	Omran et al., JAAOS Glob Res Rev 2025 (PMID 40505133)
Swelling peaks days 6–8; still measurable at 7 weeks	Loyd et al., Disabil Rehabil 2020 (PMID 30668214)
21 of 47 activities recommended at 6 months; squash the only outright exclusion	Thaler et al., Knee Surg Sports Traumatol Arthrosc 2021: EKA consensus (PMID 33404817)
About 70% return to sport, shifting to low-impact activity	Hanreich et al., J Arthroplasty 2020 (PMID 32389409)
Prehabilitation: large effect pre-operatively and early, not significant at 6–12 months	Gränicher et al., J Orthop Sports Phys Ther 2022 (PMID 36125444)
Infrapatellar branch sensory change in 70% (n=20); no effect on satisfaction	Mistry & O'Meeghan, ANZ J Surg 2005 (PMID 16174002)

CLAIM	SOURCE
Early mobilisation recommended for clot prevention	Mont et al., J Am Acad Orthop Surg 2011: AAOS (PMID 22134209)
Early mobilisation reduces stay by 1.8 days with no increase in adverse events	Guerra, Singh & Taylor, Clin Rehabil 2015 (PMID 25452634)
ERAS pathway consensus for hip and knee replacement	Wainwright et al., Acta Orthop 2020 (PMID 31663402)
Driving criteria and pooled recommendations individualised by side and transmission	Patel et al., Hip Int 2023 (PMID 33736494)
Australian hospital-stay context (short-stay pathways)	Qurashi et al., ANZ J Surg 2022 (PMID 36221212); Lloyd et al., BMC Health Serv Res 2024 (PMID 39633364)

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