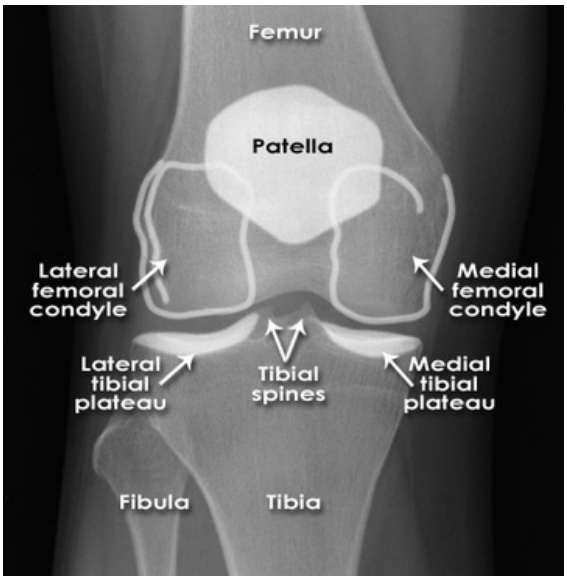
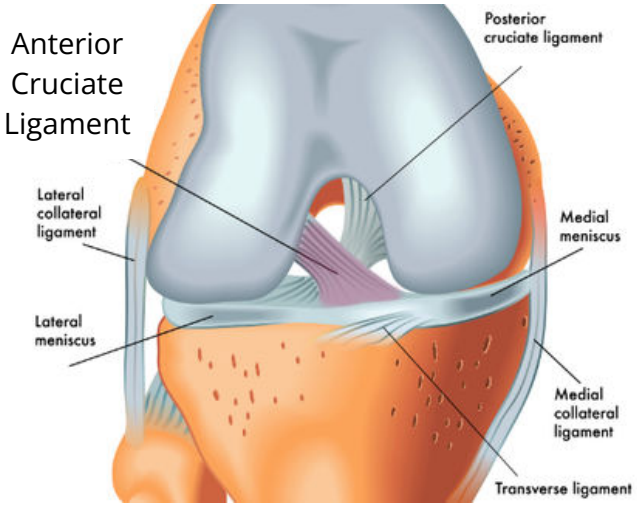
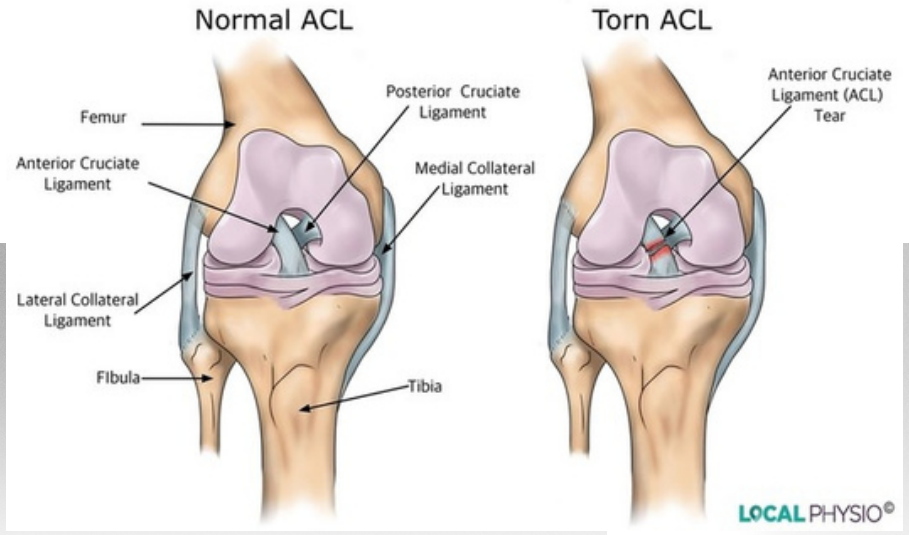
Ascension

ACL Reconstruction with Knee Arthroscopy



Anterior Cruciate Ligament





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WELCOME



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DR. CHAD CONNER

AMG PROVIDENCED ORTHOPEDICS &
SPORTS MEDICINE

Dr. Conner specializes in sports medicine and arthroscopic and reconstructive surgery of the shoulder, hip, knee, and ankle. He is board certified in orthopedic surgery by the American Board of Orthopaedic Surgery with a subspecialty certification in orthopaedic sports medicine. He grew up in Dallas, Texas and attended Lake Highlands High School. Beginning at age five, he practiced gymnastics and went on to compete for the University of Minnesota gymnastics team in Minneapolis, Minnesota.

Dr. Conner attended The University of Texas Medical Branch for his medical school training and subsequent orthopedic surgery residency training. Following this, he completed a fellowship at the world renowned Southern California Orthopedic Institute. There, he specialized in sports medicine, arthroscopy, and reconstructive surgery of the shoulder, hip, knee, and ankle. He helped care for athletes from the high school level to the professional level. His training also included specialization in total/reverse shoulder replacement surgery.

Dr. Conner currently practices at AMG Providence Orthopedic & Sports Medicine in Waco, Texas and is a team physician for a local high school team. He is a member of the Arthroscopy Association of North America, the American Orthopedic Society for Sports Medicine, and the American Academy of Orthopaedic Surgeons.

He has done extensive research on treatment of massive rotator cuff tears, ACL reconstruction, hip arthroscopy and ankle arthroscopy. He has also been involved in teaching hip arthroscopy as an associate master instructor at the Arthroscopy Learning Center in Chicago, IL. With Baylor University, he gives lectures for pre-health student information courses and is involved in the Baylor Health Science Studies internship program mentoring students interested in orthopedic surgery.

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Dr. Conner also volunteers and helps lead a monthly orthopedic and rehabilitation clinic at a community outreach organization called Mission Waco, which strives to provide Christian-based holistic, relationship-based programs that empower the poor and marginalized and was named Business of the Year by Mission Waco for 2013.

Outside of the office, Dr. Conner enjoys his wife and children, church, work outs, mountain biking, wake surfing, and the outdoors.



MEMBERSHIPS

SPECIAL SOCIETY

AMERICAN ORTHOPAEDIC SOCIETY FOR SPORTS MEDICINE
ARTHROSCOPY ASSOCIATION OF NORTH AMERICA
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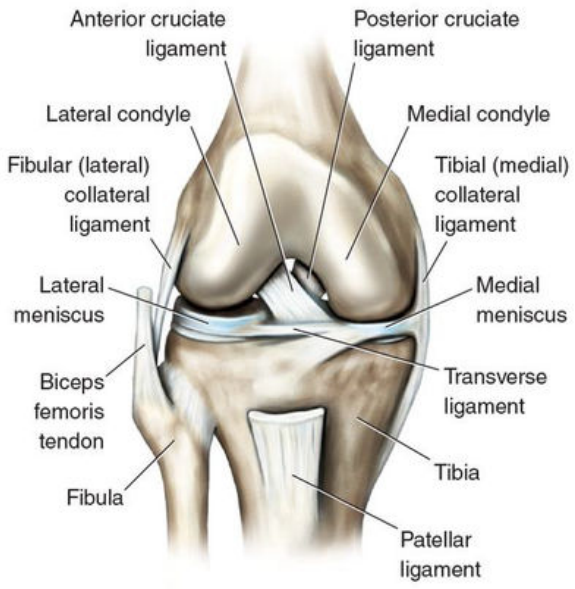
TEXAS MEDICAL ASSOCIATION

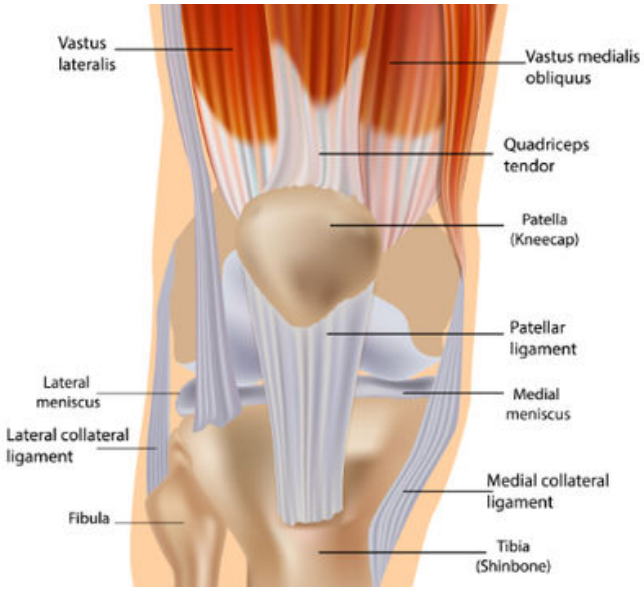
INTRODUCTION

This booklet will provide a general guide to the common indications for Anterior Cruciate Ligament reconstruction and knee arthroscopy, what to expect if undergoing the surgery, the significant risks, and a general guide to the expected recovery pathway. This document is not by any means fully comprehensive, and any specific questions should be addressed with your surgeon. The development of the techniques has improved dramatically over the last two decades and this has allowed surgeons to improve the treatment of knee injuries.

Normal Knee Joint

The knee joint acts like a hinge, with the distal femur articulating with the proximal tibia. The knee joint is a natural shock absorber as well as stabilizer and consists of several components.





Key Structures

· Bones: Femur, Tibia, Fibula and patella

· Supporting structures: articular cartilage on tibia and femur, lateral and medial menisci.

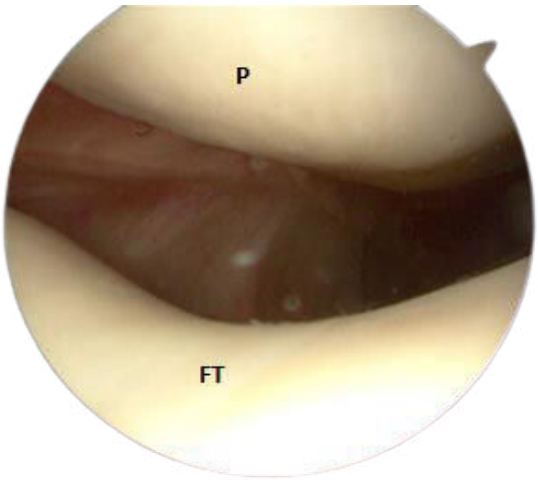
· Associated muscles: Quadriceps, hamstrings, iliotibial band, gastrocnemius, and popliteus.

· Ligaments: lateral collateral (LCL), medial collateral (MCL), anterior cruciate (ACL), and posterior cruciate(PCL), posterolateral corner and medial patella femoral ligament

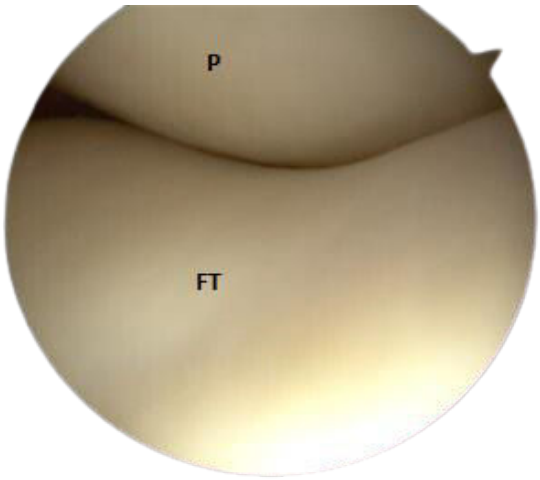
INTRODUCTION CONT.

Joint Stability

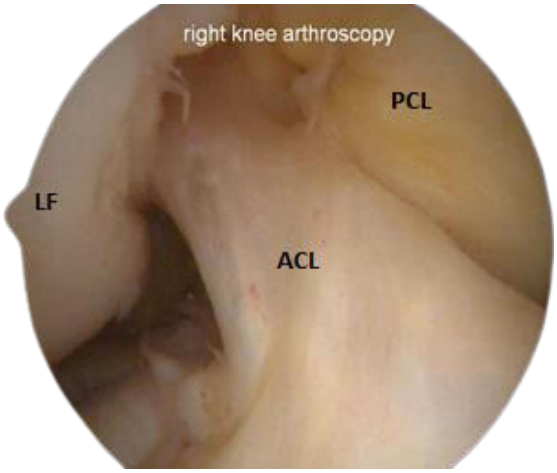
Joint stability is maintained primarily by the main four ligaments including the ACL, PCL, MCL and LCL. The joint capsule as well as the meniscus and other structures provide secondary stability.



Normal patella (P) and femoral trochlea (FT) with knee straight and arthroscopic fluid in the knee



Normal alignment of the patella (P) and femoral trochela (FT) with the knee bent 20° and arthroscopic fluid removed



Normal view of ACL and PCL ligaments which stabilize the front and back motion and knee rotation. Lateral femur (LF) is also shown

INDICATIONS FOR ARTHROSCOPY

Knee arthroscopic techniques and instruments have improved over the past two decades, resulting in many surgeons reducing the number of open joint surgeries preformed. Knee arthroscopy provides the surgeon with a direct visualization and accurate evaluation of the joint. Currently, there are many reasons for recommending knee arthroscopy. Some of the more common problems are:

1. Meniscus Tears
2. Damage to Cartilage
3. Fragments of Cartilage in the Joint (Loose Bodies)
4. Injury of Ligaments (ACL or Others)
5. Plical Band
6. Patella Tilt or Instability
7. Stiff Knee
8. Painful Total Joint Replacement
9. Arthritis of the Knee
10. Synovitis of the Knee

The most common current indication for knee arthroscopy includes injuries to the meniscus. This problem as well as anterior cruciate ligmanet reconstrution is discussed in more detail below.



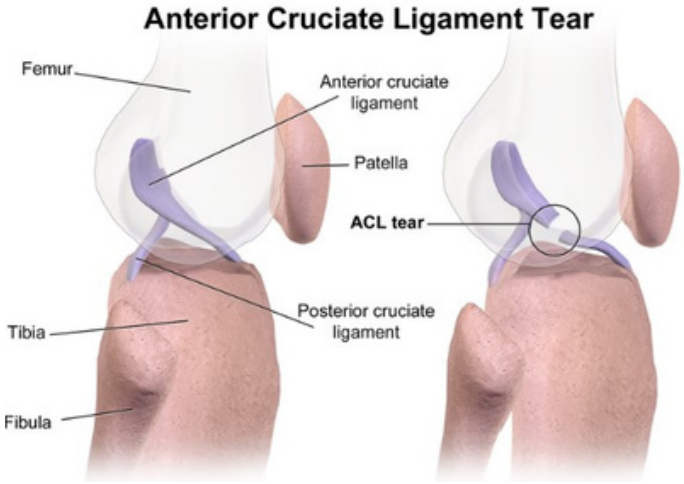
INJURIES TO THE ANTERIOR CRUCIATE LIGAMENT (ACL)

Damage to the anterior cruciate ligament (ACL) is very common in sporting injuries. A tear can happen when you change direction very rapidly, landing after a jump, or being hit in directly to the knee.

The anterior cruciate ligament (ACL) is located between the knee joint and connects the tibia (shin bone) to the femur (thigh bone). The anterior cruciate ligament (ACL) starts from the front of the tibia (shin bone) and moves toward the back of the knee attaching to the base of the femur (thigh bone). Injuries to the anterior cruciate ligament (ACL) are typically quite severe ligament injuries as it greatly reduces the stability of the knee and often requires surgery.



View of the torn ACL ligament



Normal Knee

Knee with ACL Tear

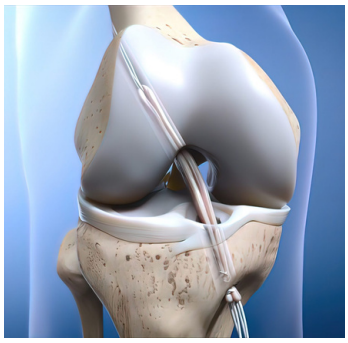
When the ACL is damaged, a variety of issues may occur:

- Hearing/feeling a pop in the knee at time of injury
- Pain along the joint line
- Stiffness and swelling
- Reduced knee movement
- Feeling of instability, buckling, or giving way



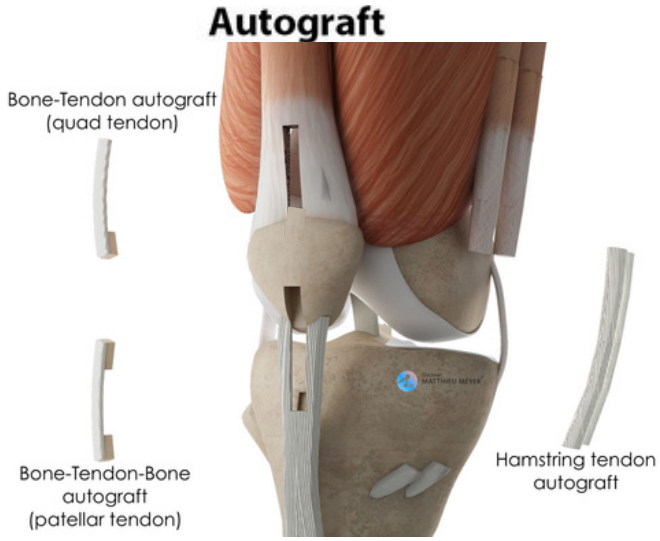
COMMON GRAFT OPTIONS

ANTERIOR CRUCIATE LIGAMENT TYPICALLY REQUIRE RECONSTRUCTION OF THE LIGAMENT INORDER TO RESTORE STABILITY IN THE KNEE.



Choosing a graft will depend on what the surgeon and you choose as the best option. An *autograft* tissue is tissue taken from your own body and reused to reconstruct the new ACL. Autograft tissues can be obtained from multiple different locations in the body such as the hamstrings and quadriceps or patella tendon. *Allograft* tissue is tissue taken from a donor cadaver and used to reconstruct the new ACL.

The hamstring tendon autograft is taken from the semitendinosis and gracilis hamstring tendon located on the inner side of the knee. Harvesting the graft from the hamstrings has shown to have fewer complications such as decreased anterior (front) knee or kneecap pain, decreased stiffness, smaller incisions, and easier recovery than patella tendon autograft. There also may be quicker incorporation of the tendon into your body than allograft.

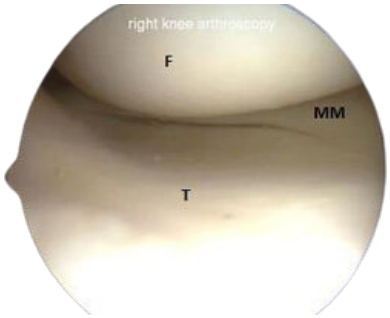


The patella tendon autograft is taken from the middle portion of the patella with a bone plug taken from the kneecap and the tibia (shin bone). The patellar tendon graft has been shown to have equivalent final results to the hamstring autograft grafts except for increased risk of postoperative pain behind the kneecap, stiffness, pain with kneeling, and patellar fracture. The benefit of the patella graft is that it can incorporate into the knee about a month sooner than the hamstring graft, but the total recovery time for rehabilitation is still typically the same.

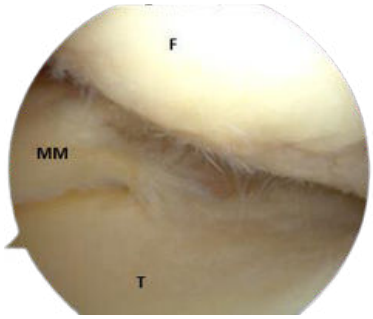
The advantages of using an allograft tissue is a decreased amount of pain from not having to take the graft from your body, a shorter surgery time, and smaller incisions. However, there is a 1 in 8 million chance for infection and it may incorporate slower compared to autograft tissue. Additionally, more recent studies have shown increased failure rates in younger patients and so allograft tissue is not used as often as the past.

INJURIES TO THE MENISCUS

The knee joint contains two menisci, one on the inside of the knee (medial) and one on the outside of the knee (lateral), which look like semicircles with raised edges. The function of the menisci is to act as a shock absorber for the knee and help stabilize the femoral condyles on the tibial plateau. The menisci are made out of fibrocartilage and have a poor blood supply that limits them from healing on their own effectively.

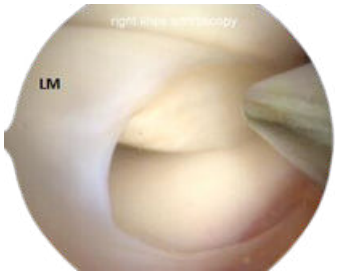


Normal medial meniscus (MM) and articular cartilage on femur (F) and tibia (T)



Degenerative medial meniscus (MM) tear with the degeneration of the cartilage surfaces (arthritis) to the femoral (F) and tibial (T) surfaces

Damage to the meniscus can be from an acute injury or from degeneration over time. A twist while the knee is bent is a common injury mechanism. Individuals 40 years old and older are more likely to experience a degenerative tear.



Lateral meniscus (LM) bucket handle tear with the probe pointing to the flipped out meniscus between the femur and tibia



Diagram of a bucket handle tear. Note how the meniscus is torn in a horseshoe type fashion and the meniscus is flipped out



Diagram of a complex meniscus tear which is common in people over 40

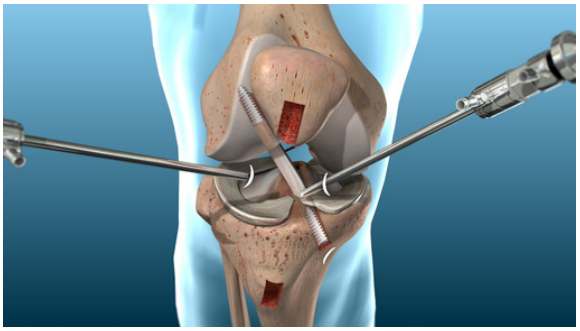
When a meniscus is damaged, a variety of issues can arise:

- Pain in the knee joint
- Stiffness and swelling
- Catching or locking of the knee due to loose pieces of either menisci or cartilage moving between the joint surfaces
- Knee giving way from instability of the knee
- Decreased range of motion

WHICH PATIENTS SHOULD CONSIDER ACL RECONSCTUCTION?

Patients with symptoms of a painful condition that have not responded well to nonsurgical treatment and/or have a significant injury to the knee. Your surgeon will help you understand and decide when surgical treatment is needed verses treatment without surgery.

Treatment for an ACL tear will depend on the individual needs of the patient. Young athletes will generally require surgery inorder to safetly return to sports. Older, less active individuals may be able to return to a quieter lifestlye without surgery. An ACL tear will not typically heal without surgery. However, older, lower activity level patients do have nonsurgical treatment options such as bracing and physical therapy. A brace my be recommened by your doctor to protect the knee from instability and crutches to keep you from putting weight on the leg initially. Physical therapy is also usefull to help reduce swelling and restore function to the knee and strengthen the leg for support.



Nonsurgical treatment includes rest, physical therapy, and medications or injections that can reduce inflammation. Inflammation is one of your body's normal reactions to injury or disease. In an injured or diseased knee joint, inflammation causes swelling, pain, and stiffness.

Injury, overuse, and age-related wear and tear are responsible for most knee problems. Knee arthroscopy may relieve painful symptoms of many problems that damage the menisci, ligaments, articular cartilage, and other soft tissues surrounding the joint. X-rays and a preoperative MRI can help to confirm the diagnosis of these problems prior to the arthroscopy.

Risks Associated with Knee Arthroscopy and ACL Reconstruction

Most patients do not experience complications from knee arthroscopy. As with any surgery, however, there are some risks. These are usually minor and treatable. Potential risks with any surgery include but are not limited to pain, bleeding, infection, damage to surrounding structures like nerves or blood vessels, failure to heal or cure, need for additional procedures, stiffness, blood clot, and any medical or anesthetic complication. Loss of limb or death would be exceedingly rare with knee arthroscopy surgery. Most patients will have some numbness on the front of the knee following knee surgery from the incisions but the numbness will usually get less over time. Your surgeon will discuss the possible complications with you before your operation and you should ask any questions that you may have.



KNEE ARTHROSCOPY AND ACL RECONSTRUCTION

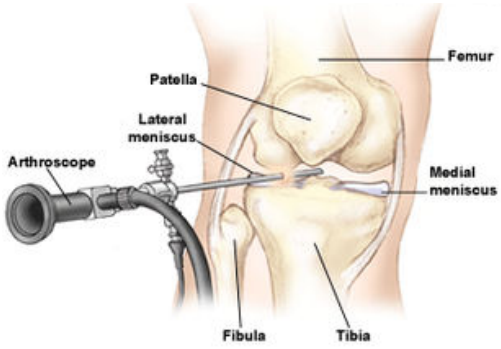
Phase 1: Autograft/Allograft Preparation

Once anesthesia has been provided in the operating room you will be positioned carefully on your back. Following this the surgeon will examine the ligaments of your knee while you are under anesthesia in order to confirm your ACL injury and check for other more subtle ligament injuries that might not be revealed when the knee is examined while you are awake. Following this, the nurse will prepare your leg with a sterile prep. Sterile drapes are then placed around the leg to create a sterile operating field.

The surgeon typically begins by harvesting your ACL graft or preparing the donor ACL graft (allograft). For hamstring grafts, we make about a 2 in. incision over the inside area of the leg just below the knee where we then identify the hamstring tendons and then carefully harvest them with a tendon stripper once we have released them from their insertion on the tibia. For patella tendon grafts, about a 4 in. incision is made over the front of the knee and then a wedge of bone is cut with a saw from the end of the patella bone and then from the tibia tubercle (shin bone) where the tendon inserts. The middle aspect of the tendon is then incised and about a 10 mm patella tendon graft is removed from your knee. The quadriceps graft is taken from above the patella (usually including a small amount of bone) with about a 10mm strip of tendon taken from the central portion of the quadriceps. Sutures (a stitch) is placed around the ends of the graft in order to have control of the graft to place it in the knee later in the surgery.



Phase 2: Knee Arthroscopy

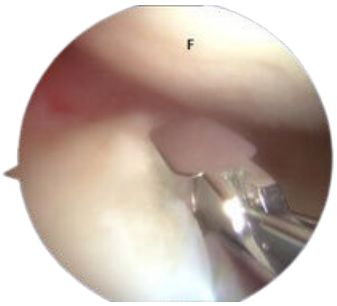


Once this has been performed, the surgeon then performs knee arthroscopy. Typically two to three small incisions are made at the front of your knee to allow the surgeon to visualize your knee and work with small instruments to repair and treat your knee problems. A 4mm camera called an arthroscope is placed into the knee joint to begin this part of the operation. The camera displays pictures in high definition onto a television screen. Saline is pumped into the knee joint to allow the surgeon to see clearly and remove debris from the joint.

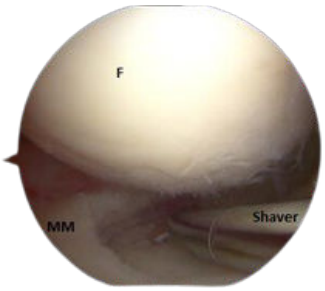
The first procedure performed is a systematic view looking at all of the important structures of the knee joint to evaluate for any damage. Once the injured tissues have been assessed, the surgeon begins working to repair and/or treat as possible all of the pathology thought to be causing pain. This typically correlates with the preoperative imaging and evaluation.

KNEE ARTHROSCOPY AND ACL RECONSTRUCTION CONT.

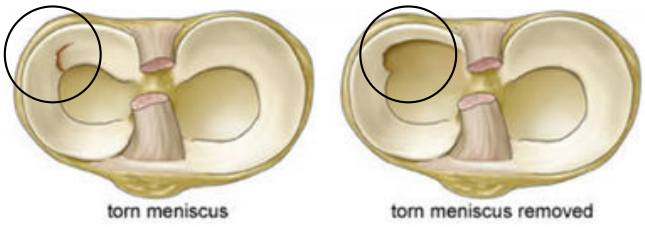
If there is a non-repairable tear then an arthroscopic biter or shaver is placed into the knee joint and the torn meniscus tissue is resected leaving the remaining meniscus smooth and well contoured. The remaining functional meniscus can still work to cushion and stabilize the knee joint.



Arthroscopic biter used to remove and resect a torn meniscus. (F) femur.



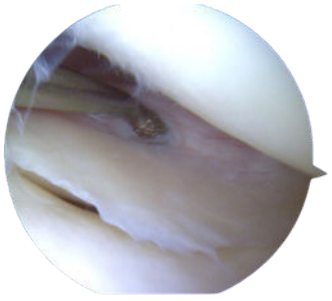
Arthroscopic shaver used to smooth the resected medial meniscus (MM) and the irregular cartilage surfaces (arthritis)



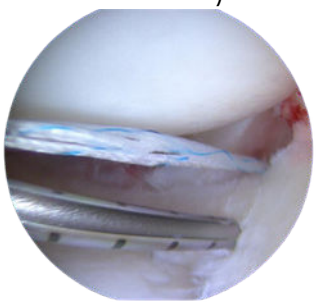
Before

After

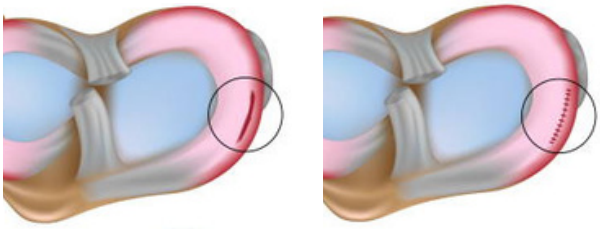
When the meniscus is able to be repaired, (>98% in young patients and most in older patients) the meniscus and capsular tissue are prepared to create a good healing surface for the tissue. A small arthroscopic rasp and the shaver are used to clean the tissue to remove any fibrous layer and stimulate the tissue for a healing response. Following this the tissue is sewn to the capsule or back to the remaining meniscus with an arthroscopic device/suture designed to secure the meniscus back to the capsule (surrounding knee joint tissue) or meniscus.



Arthroscopic rasp used to help prepare the meniscus and capsular tissue for meniscus repair.



Meniscus repair device used to repair the torn meniscus to the capsule. The first stitch has been placed and the second stitch is about to be placed.



Before

After

KNEE ARTHROSCOPY AND ACL RECONSTRUCTION CONT.

Phase 3: ACL Reconstruction

Once any menicus pathology or other injuries have been addressed then the surgeon will begin working on the ACL reconstruction. A shaver, radiofrequency device (a device that can vaporize or coagulate tissue using radiofrequency energy), or curret (small sharp spoon shaped instrument) is used to remove the torn ACL tissue. Once this is done the anatomic origin on the femur bone and the insertion on the tibia bone of the old ACL is marked. In order for the graft to heal in the body, tunnels are drilled to secure the graft and allow the graft to heal to your bone. The tibia is drilled with a guide from the front of the tibia bone just beneath the knee (through the same incision that was used to harvest the ACL graft or a new small incision if allograft tissue was used). Following this the femur tunnel is drilled through another small horizontal incision to allow the appropriate angle.

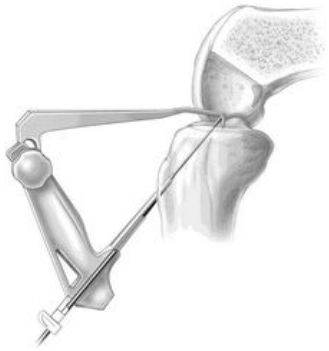
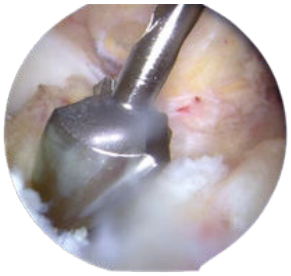


Diagram of ACL guide used to find proper placement of Femoral and Tibial tunnels

For both tunnels a guide wire is placed and then a cannulated drill bit is used to create the socket or tunnel to hold the graft. For hamstring and allograft grafts, the femur socket is only drilled part of the total distance of the tunnel and a smaller 4.5 mm tunnel is drilled out of the outside aspect of the bone to allow placement of an endobutton outside the bone to secure the graft on the femur.



Cannulated drill bit creating a socket or tunnel to hold the graft



Endobutton used to hold the graft in place

Once the tunnels are completed, the bone debrie is irrigated from the knee and the graft is then pulled through the knee and into the tunnels and the graft is secured with the endobutton (hamstring or allograft tissue) or screw (patella tendon/quad). The knee is then cycled to help remove any laxity in the graft and then it is secured by a sheath and screw typically on the tibia followed by a back up fixation device.

The stability of the knee is then checked and then the incisions are irrigated and closed and the knee is placed into a brace locked in extension.

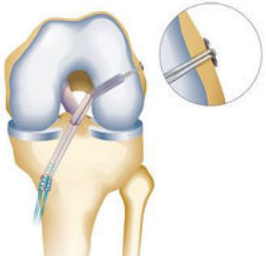
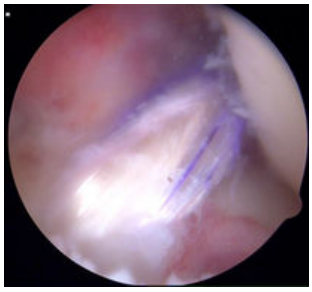


Diagram of endobutton fixation. The femoral and tibal tunnels are also shown

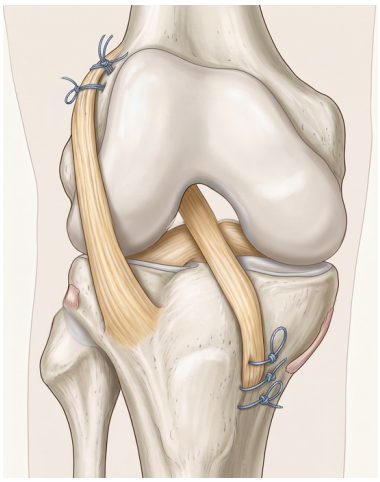


View of ACL graft after the reconstruction. The Femur and Tibia are also shown.

KNEE ARTHROSCOPY AND ACL RECONSTRUCTION CONT.

Pediatric Considerations

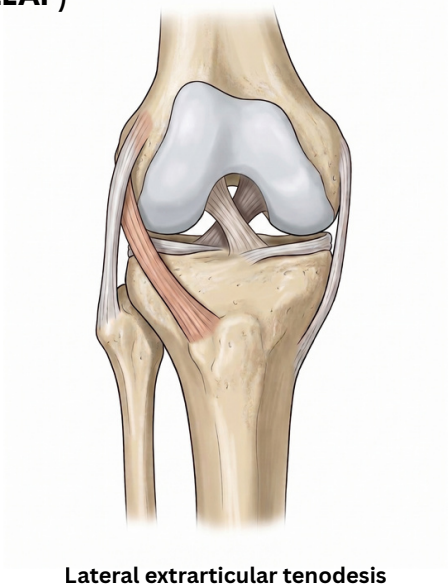
If patients are younger and have not matured skeletally (growth plates are still open) then different techniques are perfomed to decrease the risk to damage of the growth plates that could lead to abnormal/stunted growth of the limb. For patients that have not undergone puberty, a special reconstruction using the patients iliotibial band (IT band) is used to reconstruct the knee without tunnels to prevent injury to the growth plate. For patients in puberty a special hybrid technique is done that allows for drilling across the growth plate that is maturing but not yet fully closed to recreate the normal anatomy of the ACL, but the tibial fixation uses 2 anchors in the bone below the growth plate. This technique avoids putting a screw across the growth plate that would increase the risk of a growth disturbance in this age group.



Prepubescent IT Band ACL reconstruction

Lateral Extrarticular Tenodesis (LET or LEAP)

The lateral extrarticular tenodesis is a secondary procedure designed to stabilize the front outside capsular tissue/ligment of the knee that is stretched or injured when the ACL tears. When this tissue/ligament is insufficient for stabilizing the knee more stress is transfered to the new ACL ligament. In the LET procedure a small strip of the Iliotibial band (IT band) is left attached to the tibia then rerouted beneath the lateral collateral ligament (LCL) and then secured around the intermuscular septum, which is near the back outerside of the femur. This stabilizes both the anterior and rotational forces that are directed through the knee with pivoting and sporting activities. With the addition of the LET with the ACL reconstruction there is double support to the knee joint which has been shown to decrease failure of ACL surgery by about half.



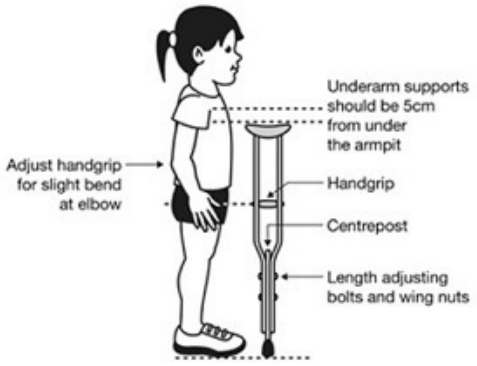
Lateral extrarticular tenodesis (LET or LEAP)

PREPARING YOURSELF & YOUR HOME BEFORE SURGERY

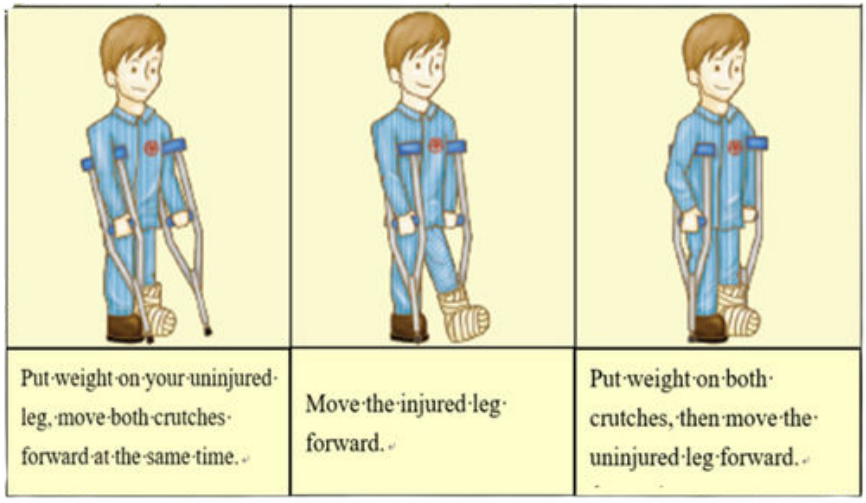
Recovery is a gradual process and will take time after surgery. Plan for your return home before you enter the hospital. Most patients return home the same day of surgery.

- Ask your spouse, children, or friends if they can assist you with activities of daily living for about two days.
- Before surgery, it maybe helpful to practice daily activities that will be affected by surgery.
- Ensure that your crutches are at a comfortable height. There should be about 5 cm (2-3 fingers width) space between the top of the crutch pad and your armpit. Additionally, the hand grips should be at wrist level when your arms are hanging by your side. Practice using your crutches before your surgery to ensure you are familiar with using them.

How to Fit Crutches



How to Use Crutches



If you're interested in assistance from a home healthcare agency or public health nurse, select the agency before hospitalization. Your doctor's office can help you with these arrangements. Most of the time, your insurance will cover the cost of home health care for a few days (7-10) after surgery. It can be arranged that you have a nursing assistant come to your house and help with day to day things you may need as well as help with physical therapy exercises if needed.

BEFORE SURGERY CHECKLIST

SLEEP



A good night's rest is important before surgery.

NO FOOD/DRINK



Before surgery, do not eat or drink anything after midnight. Your stomach must be empty before you receive the anesthetic. This helps prevent nausea, vomiting and other complications during and after anesthesia.

SUPPLEMENTS



Supplements: in general, you should discontinue all herbal over-the-counter supplements one week before surgery. You may continue multivitamins, vitamin C and D, and essential amino acids. Some supplements affect bleeding tendencies and may cause problems with wound healing.

POST-OP MEDICATIONS

Please make sure you have picked up your post-op medications **PRIOR** to your surgery. Failing to do so can lead to delays in receiving the medications and pain relief.

SHOWER



Take a shower or bath the evening before surgery. This will help decrease the amount of bacteria on your skin.

OTHER MEDICATIONS

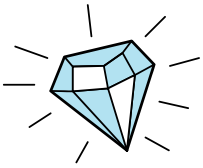


You should stop all medications that have a potential to cause bleeding before surgery. The most common medications that fall into this category include aspirin (14 days prior), anti-inflammatories (such as Advil, Motrin, Naprosyn) (7 days prior) and blood thinners such as Plavix and Coumadin. (ask your PCP or refer to the surgery medication sheet you were given by Dr. Conner's office)

DAY OF SURGERY CHECKLIST

You will be provided a time to come and check into the surgery center or hospital. It is important to follow these instructions:

☐ NO VALUABLES



Leave your valuables at home.

☐ SHOES



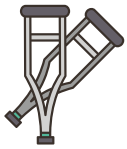
Comfortable, non-skid walking or athletic shoes. Elastic laces are available, eliminating the need to tie your shoes. Athletic shoes are available with hook and loop fasteners. Another option are slip on shoes or slippers.

☐ CLOTHES



Clothes that are soft and loose fitting. Bring comfortable clothes that open in the front with buttons or a zipper. Women can bring pants with elastic waistbands. For men, gym pants are easiest.

☐ CRUTCHES/WALKER



Please remember to bring your crutches or walker!

☐ MAKEUP



Do not wear makeup the morning of surgery. This includes nail polish.

☐ USUAL MEDICATIONS



Take only the medications your physician or nurse tells you to take on the morning of your surgery. (with a small sip of water)

Do **NOT** bring your medications that you usually take. It is important to have a list with the appropriate dosages. This will be requested from you at the time of registration.

☐ KNEE BRACE



IF APPLICABLE: Please bring the post op brace you received in our office.

YOUR SURGERY CENTER OR HOSPITAL STAY

You will be provided a time to come and check into the surgery center or hospital.

MORNING OF SURGERY

- After admission, the nursing staff will take your temperature, pulse, respiration rate, and blood pressure.
- The anesthesiologist will discuss the types of anesthesia to be used.

GOING TO SURGERY

- You will be asked to empty your bladder and pregnancy test will be done as applicable
- Remove all jewelry (including rings), dentures, and contact lenses.
- You may wear your glasses/hearing aid if necessary.
- You will be taken to the operating room on a hospital bed.
- An intravenous (IV) line will be started before surgery.
- The affected knee may have the hair clipped.

ANESTHESIA

The surgery is most commonly performed under general anesthetic. In most cases a regional local anesthetic block is performed by the anesthesiologist prior to the surgery. This is a nerve block that will numb the nerves to your knee to help decrease or minimize postoperative pain for the first 6-18 hrs after the surgery. You may notice some tingling in the knee as the block wears off. There is a very small risk of nerve injury with this procedure but the benefits of pain relief are typically thought to outweigh the risks.



WHAT TO EXPECT AFTER SURGERY

IMMEDIATELY AFTER SURGERY: 

After surgery, you will stay in the recovery room for 1 to 2 hours before being discharged home. Nurses will monitor your responsiveness and provide pain medication, if needed. You will need someone to drive you home and stay with you for at least the first night.

DRESSING: 

The big bulky knee dressing should remain intact and dry for about 48 hours following your operation. Thereafter you may take it off. However, be sure to keep on the smaller steri-strips on until your follow up visit.



Illustration of steri-strips over the surgical incision

SHOWERING: 

We prefer that you take a bath and keep your leg out of the water, if at all possible. If showering is done, you should use a large plastic bag or saran wrap to cover your leg to prevent water leakage onto the dressing.

BLEEDING: 

In some cases, oozing at the point of incision can persist for several hours. If this should persist with the continued use of the compression dressing, contact our office. If the steri-strips covering the incisions are removed, this sometimes does remove the clot covering the wound, which is why we ask that you leave the steri-strips on until your first post op appointment.

SWELLING: 

Swelling is common to experience especially around the knee joint. This will cause stiffness and discomfort. This may last for several weeks after surgery. To minimize the swelling, utilize ice on the knee for 20 minutes every 1-4 hours if desired.

WHAT TO EXPECT CONT.

PAIN MEDICATION: 

You will be prescribed pain medication to be used at home after your surgery. This is a narcotic pain reliever. Take 1-2 tablets every 4-6 hours as needed for pain. It is usually recommended to take the pain medicine every 4 hours for the first 24-48 hours, and then take it as needed. Keep in mind that the medication will cause drowsiness and should not be used with alcohol. Also, taking this medication on an empty stomach may result in nausea. It is common to feel discomfort when lying down to sleep at night, so you may find it beneficial to take the pain pill at bedtime. If unusual side effects occur, please discontinue the medication and contact our office. We recommend taking 1000mg of Tylenol every 6-8 hours for pain around the clock to help get ahead of the pain.

DIET:  

The day after surgery, drink lots of fluids and eat soft, nutritious foods. An adequate diet is essential for the healing process.

NAUSEA AND VOMITING: 

Although unusual, both can be experienced after anesthesia. If you have a tendency for this, please discuss it with the anesthesiologist. Otherwise, it is usually alleviated with a clear liquid diet.

DROWSINESS: 

After anesthesia, drowsiness may persist for quite a while. It should cause no undue concerns. Do not drive until you feel clear-headed.

ACTIVITIES: 

Crutches have been supplied for your comfort, as well as a brace to limit range of motion. Partial weight bearing is permitted with crutches after surgery. (unless told otherwise) The exercise in which you were instructed should be performed at your tolerance and comfort, starting the day after your surgery. Do not engage in sports or heavy work until your physician gives you permission to do so.

WHAT TO EXPECT CONT.

COMMON COMPLAINTS AFTER SURGERY:

At times, patients complain of sensation of liquid within the knee joint; this is the reabsorbing of fluid from the surgery. Other complaints can be occasional clicking with movement; this is the readjustment of your muscles and control of the knee joint, which is usually alleviated with your ice and exercise program.

RETURN TO WORK: 

The decision to return to work is made depending on your job requirements. With most occupations that involve office and/or computer work, you may be able to return to work in a few days. If your job requires significant manual labor and lifting, then return to work may be prolonged to 12-16 weeks for complete release depending on the procedure.

POST-OPERATIVE:

Patient's are typically given a physical therapy appointment at the time their surgery is scheduled for 2 to 5 days after surgery. Patients are also se in the clinic typicall by the PA or NP for their first post op appointment between 5-10 days as well. If you do not have these appointments scheduled for after the surgery, please call our office to make sure the post op appointment and PT appointment was made for you.



RETURN TO SPORT:

Typically, return to sport will vary depending on the specific knee procedure performed and sport. An ACL reconstruction typically requires 6-9 months before being able to return to your sport. Your therapist and/or trainer will be following and directing your progressive preparation for you return to your sport under our guidance.



POST-OP KNEE EXERCISES

Exercise and movement are important following surgery. Muscle contractions through exercise release nitric oxide, which decreases inflammation, aid wound healing and help prevent stiffness. You should begin these exercises when you return home from your surgery the same day. You should begin in a gentle manner and then progress under the guidance of your therapist.

Exercises: Repeat each exercise 10-30 times and repeat each set 3-4 times daily. Begin the day after surgery.

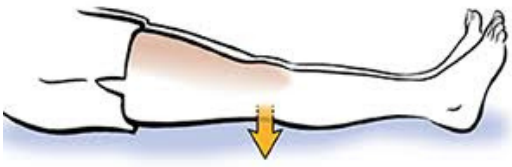
1. Ankle Pumps

Point your foot down like pushing on the gas pedal of a car and then move your foot back to the starting position. (begin day of surgery)



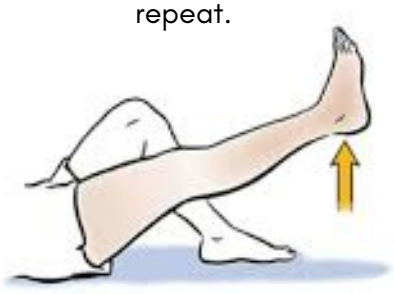
2. Quad Sets

Either lying down or sitting straighten your leg tightening up your quadriceps muscle making it as straight as possible and hold for 3-5 seconds then relax.



3. Straight Leg Raises:

Either lying down or sitting bend the unaffected leg and keep the leg that has been operated on straight. Tighten thigh muscle of the straight leg and slowly raise the leg keeping it perfectly straight. Hold the leg in the air for 3-5 seconds. Relax the leg and repeat.



FREQUENTLY ASKED QUESTIONS

1 HOW LONG IS MY SURGERY?

About 2 hours for the ACL/LET and an hour for meniscus repair

2 HOW LONG WILL I BE KEPT AT THE FACILITY?

Patients can typically leave to go home within a few hours following surgery.

3 WILL MY FAMILY BE ABLE TO KEEP ME COMPANY?

At the hospital you will be in the recovery room for 1-2 hours and then rejoin your family in day surgery, and at the surgery center, family may join you in recovery usually 30 minutes after the surgery.

4 IS IT NORMAL TO HAVE SWELLING OR POPPING FOLLOWING THE SURGERY?

It is normal to have swelling in the knee the first week after surgery as this is from the surgical fluid. Swelling after this may be indicative that the knee is not fully healed yet and is becoming irritated from excessive use. Occasional popping can occur while the knee is healing from readjustment of the muscles while the strength returns to the knee.

5 IS IT NORMAL TO HAVE NUMBNESS TO MY KNEE AFTER SURGERY?

It is normal to have some numbness around the incision made from performing the ACL surgery. This may be located around the incision or to the outside of the incision as nerves typically too small to be seen are cut with the incision.

6 WHEN CAN I DRIVE?

Usually, you can drive within a few days once you are off of the narcotic pain medicine, and can ambulate well. You should feel comfortable moving the leg quickly to hit the brakes in case of an emergency situation.

7 WHAT ELSE SHOULD I DO TO PROTECT MY KNEE AS IT HEALS?

Avoid over exerting the knee in the first few weeks. This can cause swelling and irritation to the lining of the knee joint and prolong your recovery. If you get swelling in the knee then you are probably doing too much.





Ascension