



The
HIP AND KNEE
- SURGEONS -

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PATIENT INFORMATION

ACL RECONSTRUCTION

ACL RECONSTRUCTION : PATIENT INFORMATION

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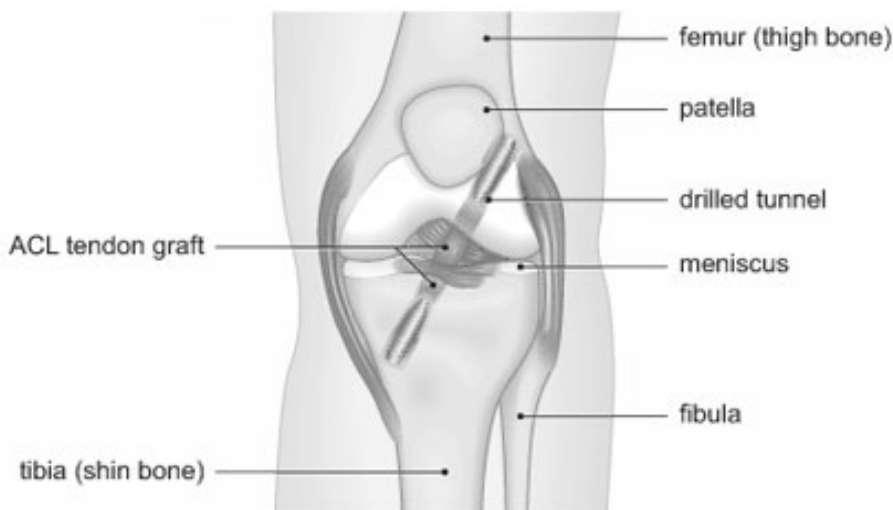
An ACL reconstruction involves replacing the anterior cruciate ligament in your knee. This is done using a tendon from another part of your body. ACL reconstruction can improve the stability and the function of your knee, following an injury.

You and the surgeon carrying out your procedure will discuss your care. It may differ from what is described here as it will be designed to meet your individual needs.

About anterior cruciate ligament reconstruction

The ACL is a strong ligament that runs diagonally through the middle of your knee. It helps to keep your knee stable, especially when you turn, or when your knee joint moves from side to side.

The ACL is one of the most commonly injured ligaments. It's usually torn when you slow down very quickly while turning or sidestepping at the same time. You're more likely to injure your ACL if you play sport, particularly rugby or football, and if you ski.



ACL reconstruction involves replacing your torn ligament with a graft. The graft is usually taken from a tendon in another part of your knee, but sometimes it can be a graft from a donor (an allograft). Your surgeon will discuss the different graft options with you.

ACL reconstruction is carried out to try to make your knee stable. This means that you may be able to return to playing sport, but that will depend on whether there are other problems with your knee such as torn cartilages, other ligament injuries or arthritis.

What are the alternatives to anterior cruciate ligament reconstruction?

Some people with an ACL tear may not need an operation to repair it. You may be



offered physiotherapy, exercises and a hinged knee brace to give your knee support. Your doctor may suggest this type of treatment if:

your knee is stable

you have partially torn your ligament, rather than fully torn it

you don't want to play sports that place a lot of strain on your knees

However, if your knee is unstable (gives way) and you want to return to playing sport, have an active job, or if you have other damage to your knee, then your surgeon is likely to suggest a reconstruction. If you're at risk of osteoarthritis later in life, then your surgeon may also suggest reconstruction.

Preparing for an anterior cruciate ligament reconstruction

You will usually have ACL reconstruction between one and eight weeks after your injury. This allows any swelling to go down. Your surgeon may ask you to have physiotherapy during the weeks after your injury. This is to make sure you can move your knee as fully as possible before your operation.

ACL reconstruction can be done using either local or general anaesthesia. A [local anaesthetic](#) completely blocks pain from your knee area and you will stay awake during the operation. If you have a [general anaesthetic](#), it means you will be asleep during the procedure.

You will be asked to follow fasting instructions. This means not eating or drinking, typically for about six hours beforehand. However, it's important to follow your anaesthetist's advice.

Your surgeon will discuss with you what will happen before, during and after your procedure, and any pain you might have. This is your opportunity to understand what will happen, and you can help yourself by preparing questions to ask about the risks, benefits and any alternatives to the procedure. This will help you to be informed, so you can give your consent for the procedure to go ahead, which you may be asked to do by signing a consent form.

What happens during an anterior cruciate ligament reconstruction

Your surgeon will examine your knee to check how badly your ligament is torn and whether any other tendons or ligaments have been damaged.

Your surgeon will make a number of small cuts in the skin over your knee that is being treated. He will insert an arthroscope and other surgical instruments into your knee through these cuts. An arthroscope has a thin, flexible tube with a light and camera on the end of it. It allows your surgeon to see inside your knee.

Your surgeon will remove the piece of tendon that will be used as the graft. He will usually take the graft from one of your hamstring tendons at the back of your knee, or your patella tendon, which connects your kneecap and shin bone.



Your surgeon will drill a tunnel through your upper shin bone and lower thigh bone. He will put the graft into the tunnel, attach it to the bones and fix it in place, usually with screws. These are normally left inside your knee permanently. Your surgeon will close the cuts with stitches or adhesive strips. The operation usually lasts between one and two hours.

What to expect afterwards

You may need to rest until the effects of the anaesthetic have passed. You may need pain relief to help with any discomfort as the anaesthetic wears off. After a local anaesthetic it may take several hours before the feeling comes back into your treated knee. Take special care not to bump or knock the area, and it is best to keep your leg elevated as much as possible.

General anaesthesia temporarily affects your co-ordination and reasoning skills, so you must not drive, drink alcohol, operate machinery or sign legal documents for 24 hours afterwards. If you're in any doubt about driving, contact your motor insurer so that you're aware of their recommendations, and always follow your surgeon's advice.

Dressings will cover the small wounds. You may occasionally have a knee brace to give some support to your joint as it heals.

You will be encouraged to get up, put weight through your knee and move it as soon as you're able to after your surgery. You will need to arrange for someone to drive you home. You should try to have a friend or relative stay with you for the first 24 hours after your operation.

Recovering from an anterior cruciate ligament reconstruction

If you need pain relief, you can take over-the-counter painkillers such as paracetamol or ibuprofen. Always read the patient information that comes with your medicine and if you have any questions, ask your pharmacist for advice.

You can also apply ice packs, for example, frozen peas wrapped in a towel, to your knee to help reduce any pain and swelling. Don't apply ice directly to your skin as it can damage your skin. It usually takes about six months to make a full recovery from ACL reconstruction but this varies between individuals, so it's important to follow your surgeon's advice. If you have a desk job, you may be able to go back to work three to four weeks after your operation. It may take up to six weeks if you have an active job.

If you want to play sport after your operation, follow your surgeon's advice about when it's safe to do so. You may not be able to play some sports that involve lots of twisting and turning.



What are the risks?

As with every procedure, there are some risks associated with ACL reconstruction. We have not included the chance of these happening as they are specific to you and differ for every person. Ask your surgeon to explain how these risks apply to you and see the procedure specific patient consent form which you will be asked to sign.

Side-effects are the unwanted but mostly temporary effects you may get after having the procedure.

After ACL reconstruction you may have side-effects, including:

- pain
- swelling and bruising
- stiffness

Complications are when problems occur during or after the operation. Most people aren't affected. The possible complications of any operation include an unexpected reaction to the anaesthetic, infection, excessive bleeding or developing a blood clot, usually in a vein in the leg (deep vein thrombosis, DVT).

The main complications of ACL reconstruction are listed below.

Tearing of the graft used to repair the ACL.

Numbness along the outside of your upper leg, near where the surgical cuts were made. This may be temporary or permanent.

Your knee joint may remain unstable. This can happen if the tendon used as the graft tears or stretches.

Stiffness in your knee, or less movement than you had before your injury.

The tendons your graft was taken from may weaken and tear.

Long-term knee pain, or pain when you kneel down.



POST-OP ACL RECONSTRUCTION : REHABILITATION PROTOCOL

Please remember that this is a guideline for rehabilitation. It is not a race. Every knee and every patient are different.

This information is to be used in combination with ongoing advice from the physiotherapist supervising your rehabilitation.

POST-OPERATIVE DAYS 1-7

Follow the guidelines within this section for the first seven days after your surgery
IT IS EXTREMELY IMPORTANT THAT YOU WORK ON EXTENSION IMMEDIATELY.

Goals:

- * Control pain and swelling
- * Early range of motion exercises
- * Achieve and maintain full passive extension
- * Prevent shutdown of the quadriceps muscles
- * Gait training

Control Swelling. Following discharge from the hospital you should go home, elevate your leg and keep the knee iced. You may get up to use the bathroom and eat, but otherwise you should rest with your leg elevated. Liberal use of ice during this phase is recommended. It will be more effective once the dressing is changed. The first dressing change will be done by us in 10-14 days. The ice should be applied 4-5 times per day for 20 minutes.

DO NOT SIT FOR LONG PERIODS OF TIME WITH YOUR FOOT IN A DEPENDENT POSITION, AS THIS WILL CAUSE INCREASED SWELLING IN YOUR KNEE AND LEG. WHEN SITTING FOR ANY SIGNIFICANT PERIOD OF TIME, ELEVATE YOUR LEG AND FOOT.

Control Pain. You will be sent home with a prescription for a strong narcotic medication. You should take this for severe pain, as directed on the prescription bottle label. You may also be given a special anti-inflammatory such as Celebrex. Take this as directed for the first 5 days.

As your pain and swelling decrease you can start to move around more and spend more time up on your crutches.



Early Range of Motion and Extension

1) Passive extension of the knee by using a rolled towel. Note the towel must be high enough to raise the calf and thigh off the table.



- Position the heel on a pillow or rolled blanket with the knee unsupported
 - Passively let the knee sag into full extension for 10 - 15 minutes. Relax your muscles, and gravity will cause the knee to sag into full extension.
- This exercise can also be done by sitting in a chair and supporting the heel on the edge of a stool, table or another chair and letting the unsupported knee sag into full extension.

2) Active-assisted extension is performed by using the opposite leg and your quadriceps muscles to straighten the knee from the 90 degree position to 0 degrees. Hyperextension should be avoided during this exercise.



3) Passive flexion (bending) of the knee to 90 degrees.

- Sit on the edge of a bed or table and letting gravity gently bend the knee.
- The opposite leg is used to support and control the amount of bending.
- This exercise should be performed 4 to 6 times a day for 10 minutes.



Exercising Quadriceps

You should start quadriceps isometric contractions with the knee in the fully extended position as soon as possible.

- Do 3 sets of 10 repetitions 3 times a day.
- Each contraction should be held for a count of 6 sec.

This exercise helps to prevent shut down of the quadriceps muscle and decreases swelling by squeezing fluid out of the knee joint.



Begin straight leg raises (SLR) 3 sets of 10 repetitions 3 times a day. Start by doing these exercises while lying down.

This exercise is performed by first performing a quadriceps contraction with the leg in full extension. The quadriceps contraction "locks" the knee and prevents excessive stress from being applied to the healing ACL graft.

The leg is then kept straight and lifted to about 45-60 degrees and held for a count of six.

- The leg is then slowly lowered back on the bed. Relax the muscles.

REMEMBER TO RELAX THE MUSCLES EACH TIME THE LEG TOUCHES DOWN
Once you have gained strength, straight leg exercises can be performed while seated.



Exercising Hamstrings

For patients who have had ACL reconstruction using the hamstring tendons it is important to avoid excessive stretching of the hamstring muscles during the first 6 weeks after surgery.

- The hamstring muscles need about 6 weeks to heal, and excessive hamstring stretching during this period can result in a "pulled" hamstring muscle and increased pain.
- Unintentional hamstring stretching commonly occurs when attempting to lean forward and put on your socks and shoes, or when leaning forward to pick an object off the floor.
- To avoid re-injuring the hamstring muscles, bend your knee during the activities described below, thus relaxing the hamstring muscles.



The hamstring muscles are exercised by pulling your heel back producing a hamstring contraction.

- **This exercise should be performed only if your own patellar tendon graft or an allograft was used to reconstruct your ACL.**
- If a hamstring tendon graft from your knee was used to reconstruct the ACL, this exercise should be avoided for the first 4 - 6 weeks, as previously mentioned.

POST-OPERATIVE DAYS 8-14

Goals:

Suture removal
Physical therapy
Maintain full extension
Returning to work

Suture Removal

- 1) Schedule an office follow-up for suture removal 10-12 days after your surgery.
- 2) Once the sutures have been removed, you may get the incisions wet.
- 3) The steri-strips will peel off over time
- 4) After the sutures are removed, you may also apply vitamin E oil or another emollient to the incisions, as this will improve their appearance.
- 5) The appearance of your incision can be improved further if you keep direct sunlight off of it for one year. When exposed to the sun the incisions can be covered with a bandage, sunscreen with SPF of 30 to 50, or zinc oxide paste.

Physical Therapy and Full Extension

Outpatient physical therapy will be arranged during the first postoperative office visit. Continue doing the quadriceps isometrics, SLR, active flexion, and active-assisted extension exercises.

Returning to Work

As far as returning to work, if you have a desk type job you can return to work when your pain medication requirements decrease, and you can safely walk with your crutches. Typically this is between 10 - 12 days after surgery.

Patients who have jobs where light duty is not permitted; policemen, firemen, construction workers, laborers, will be out of work for a minimum of 6 - 12 weeks.



POST-OPERATIVE WEEK 3

Goals:

- * Maintain full extension
- * Achieve 90-100 degrees of flexion
- * Develop muscular control of the knee
- * Control swelling in the knee

MAINTAINING FULL EXTENSION AND DEVELOPING MUSCULAR CONTROL ARE IMPORTANT

Maintain Full Extension

Continue with full passive extension (straightening), gravity assisted and active flexion, active-assisted extension, quadriceps isometrics, and straight leg raise. Work toward 90-100 degrees of flexion (bending)

Develop Muscular Control

- Place feet at shoulder width in a slightly externally rotated position.
- Use a table for stability, and gently lower the buttocks backward and downward. • Hold for 6 seconds and repeat.
- Do 3 sets of 10 repetitions each day.

You should continue to use the crutches until you can put full weight on the leg and walk with a normal heel to toe gait and no limp.

You can start using a stationary bike when you can bend your knee at least 105 degrees. Cycling is an excellent conditioning and building exercise for the quadriceps.

- The seat position is set so when the pedal is at the bottom, the ball of the foot is in contact with the pedal and there is a slight bend at the knee.
- No or low resistance used. Maintain good posture throughout the exercise.
- As your ability to pedal the bike with the operative leg improves, you may start to increase the resistance.
- Your objective is to slowly increase the time spent on the bike starting first at 5 minutes and eventually working up to 20 minutes a session.
- The resistance of the bike should be increased such that by the time you complete your work-out your muscles should "burn".



THE BIKE IS ONE OF THE SAFEST MACHINES YOU CAN USE TO REHABILITATE YOUR KNEE, AND THERE IS NO LIMITATION ON HOW MUCH YOU USE IT.



Control Pain and Swelling

At this point you should begin reducing the amount of narcotic pain medication you take. You will be instructed on how to do this during your follow-up appointment. Once you have finished the anti-inflammatory that was given to you, you can take an over-the-counter anti-inflammatory medication, provided you have no history of stomach ulcer.

When can you drive a car?

REMEMBER, IT IS ILLEGAL TO TAKE PRESCRIPTION PAIN MEDICATIONS AND OPERATE A MOTOR VEHICLE!

- First, you must not be taking any prescription pain medications.
- Patients who have had surgery on the left knee, and who have an automatic transmission may drive when they can comfortably get the leg in and out of the car.
- Patients who have had surgery on the left knee and have standard transmissions should not drive until they have good muscular control of the leg. This usually takes 2-3 weeks.
- Patients who had surgery on the right knee should not drive until they have good muscular control of the leg. This usually takes 2 - 3 weeks.



POST-OPERATIVE WEEK 4

Goals:

- * Full range of motion
- * Strength through exercise

Expected range of motion full extension to 100 - 120 degrees.

Add wall slides and hand assisted heel drags to increase your range of motion.

Continue quadriceps isometrics and straight leg raises

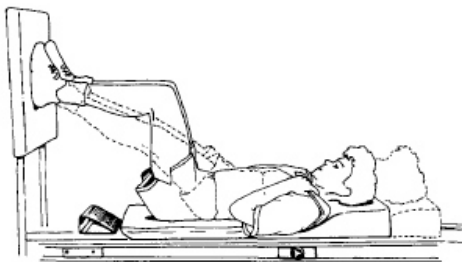
Continue partial squats and toe raises

Start tilt board exercises



If you belong to a health club or gym you may start to work on the following machines:

- Stationary bike. Set the seat position to regular height to avoid too much bending or straightening of the knee. Increase resistance as tolerated. Try to work up to 15- 20 minutes a day.
- Elliptical cross-trainer 15 - 20 minutes a day.
- Inclined leg-press machine for the quadriceps muscle (Start with knee range 10-70 degrees and gradually increase.



- Seated leg curls machine for the hamstring muscles. **Note this exercise should be delayed until the postoperative week 6 if your ACL was reconstructed with a hamstring tendon graft.**
- Upper body exercise machines.
- Swimming: pool walking, flutter kick (from the hip), water bicycle, water jogging. No diving, or whip kicks.

POST-OPERATIVE WEEKS 5-6

Goals:

- * 125 degrees of flexion pushing toward full flexion
- * Continued strength building

Your expected range of motion should be full extension to 125 degrees. Start to push for full flexion. Wall slides added if your flexion range of motion is less than desired.

Continue quad sets, straight leg raises, partial squats, toe raises, stationary bike, elliptical machine, leg presses, and leg curls.

Tilt board or balance board exercises

Bridging exercises can be started

POST-OPERATIVE WEEKS 6-12

By week 12, your range of motion should be full extension to at least 135 degrees of flexion.

Goals:

- * 135 degree of flexion
- * Continued strength
- * Introduce treadmill

Continue quad sets, straight leg raises, partial squats, toe raises, stationary bike, elliptical machine, leg presses, and leg curls.

Hamstring reconstruction patients can start leg curls in a sitting position. If you develop hamstring pain then decrease the amount of weight that you are lifting, otherwise you can increase the weight as tolerated.

IT IS IMPORTANT TO AVOID USE OF A LEG CURL MACHINE THAT REQUIRES YOU TO LIE ON YOUR STOMACH. THIS MACHINE PUTS TOO MUCH STRAIN ON THE HEALING HAMSTRING MUSCLES, AND CAN RESULT IN YOU "PULLING" THE HAMSTRING MUSCLE.

Continue tilt board and balance board for balance training.

Continue swimming program.

Start treadmill (flat only).

You may begin outdoor bike riding on flat roads.

NO MOUNTAIN BIKING OR HILL CLIMBING!



POST-OPERATIVE WEEKS 12-20

Goals:

- * Continued strength
- * Introduce jogging and light running
- * Introduce agility drills

Continue all of week 6 -12 strengthening exercises.

Start straight, forward and straight, backward jogging and light running program.

Start functional running program after jogging program is completed.

24 WEEKS POST-OPERATIVE (6 MONTHS)

This is the earliest you should plan on returning to full sports.

Goals:

- * Return to sports

To return to sports you should have:

- Quadriceps strength at least 80% of the normal leg
- Hamstring strength at least 80% of the normal leg
- Full motion
- No swelling
- Good stability
- Ability to complete a running program



FREQUENTLY ASKED QUESTIONS:

1. What are the indications to fix my knee?

Degree of instability – both subjective and objective

Complexity of associated injuries- cartilage tear, chondral injuries, other ligament injuries

Young age- this is relative

High anticipated activity level associated with pivoting sports

2. Why is the ACL reconstructed and not repaired?

The distinction rests in the fact that when you tear your ACL it is no longer possible to sew it back together as there is no slack in the fibers. Therefore, the ACL is reconstructed (replaced) with a new graft made of alternative tissue.

3. What kind of graft options are there?

There are two types of graft options: autograft (your own tissue) or allograft (donor tissue).

An autograft (your own tissue) is used in most cases. Autograft options include part of your patellar tendon or two hamstring tendons. The choice of which one to use is based on a case by case assessment but both have equal outcomes.

Allograft (donor tissue) options are numerous. These include soft tissue grafts (tendons) and composite grafts of bone and tendon (patellar tendon and Achilles tendon). The advantages of using allografts for ACL reconstruction include unaltered patellofemoral tracking, no donor-site morbidity, decreased overall surgical morbidity, decreased operative time, improved cosmesis with smaller surgical incisions, less post-operative pain, easier rehabilitation, and decreased overall cost. Allografts are particularly useful in patients for whom a previous autograft ACL reconstruction has failed or in patients who need a complex multiple ligament reconstruction. A primary disadvantage of allografts is the risk of viral or bacterial disease transmission. This risk is very low and is estimated to be approximately a 1/1.5 million chance of viral disease transmission. The results of use of allografts or autografts for ACL reconstruction are considered comparable.

4. How are the grafts fixed to the bone?

There are numerous fixation techniques. Usually they include fixation pegs that transfix the graft in the small tunnels that are drilled as well as a small either metal or bioabsorbable screw that is placed in the tunnel to tightly fix the graft against the walls of the tunnel. Small screws or staples may also be used to reinforce the fixation. In some cases these may be irritating later and require removal.

5. How long is the surgery?

Depending on the presence of other injuries to the cartilage or ligaments, the surgery takes 1-2 hours.

6. Where are the incisions?

There are two 1 cm incisions around the knee cap tendon for the arthroscopy equipment. There is a small 2-4cm incision about 4 cm below the joint along the



inside of your knee where the tunnels are drilled and where the graft is obtained. There may be a small incision just above and on the outside of the knee where the fixation for the graft on the femur is placed. These are small and cosmetically acceptable.

7. What are the risks of anterior cruciate ligament surgery?

All surgery has inherent risks even though these risks are low. The major risks are infection, swelling, wound healing problems, blood clots, stiffness, recurrent instability, arthritis, pain, and painful hardware. The risk of infection is reportedly about 0.8% and when recognized is treated with cleaning out of the joint and antibiotics. Preventative measures are taken such as: cleansing of the skin, careful surgical technique, and preoperative antibiotics. Swelling is the norm after ACL surgery but if there is a lot of swelling that limits motion or causes excess pain then aspiration of the joint may be necessary. This occurs infrequently. The incisions are quite small and therefore complications are rare. Occasionally blisters occur but these are usually treated with local salves or antibiotics. Blood clots are a concern and patients at risk include patients with family history of clotting, a history of a prior clot, patients over 40, obesity, cigarette smoking, women, birth control pills, history of cancer, and immobility. Preventative measures include a careful documentation of any of these factors, early mobilization, d/c of BCPs a week before surgery, and use of chemical prophylaxis.

Motion problems are less frequent now that earlier motion is the rule. If your motion does not progress occasionally a repeat arthroscopy or manipulation is needed. This is considered 2-3 months after your initial ACL surgery and is based on your progress with therapy. An ACL reconstruction is intended to replace your original ACL. However, in some instances, the graft does not heal to the bone or it stretches. This leaves you with recurrent instability. If this happens then a revision surgery may be needed. Fortunately this is infrequent. Once your knee is injured no matter what you do the joint is at risk for arthritis. This is due to the ACL tear and the associated injuries to the rest of the joint. Undertaking a reconstruction of your ACL does not assure that the arthritis will not occur. Keeping your joint strong and being educated about your limitations as a result of your injury helps to retard the development of arthritis. Pain associated with the knee and the hardware is not uncommon. This is usually due to scarring, arthritis, swelling, and prominent hardware. Hardware can be removed and occasionally a follow-up (tune up) arthroscopy and clean out may be necessary. Please understand that there are over 100,000 ACL reconstructions done a year and the success rate is 85-90%. These risks are few and the benefit is significant in allowing you to return to an active lifestyle of sports.

8. When can I drive?

You should not be taking any prescription pain medications as these can affect your ability to drive. If you drive an automatic car and the ACL reconstruction is on your left knee then you can drive when you feel comfortable getting in and out of the car. If the surgery is on your right knee or if you have a standard car despite the surgery being done on your left knee it usually takes about 2-3 weeks before you have adequate quadriceps or thigh muscle control to be able to operate your car safely.



9. How long is physical therapy?

The goal of therapy is to control pain and swelling, restore motion, develop strength, restore function, and to prepare you to return to your sport or sports of choice. This can vary from patient to patient but usually takes 2-3 months. Many of the exercises can be performed in a health club and therefore a membership is recommended unless you have gym equipment at home. This is usually started the first week after surgery and so it is advisable for you to set up appointments with your local therapist.

10. What happens after surgery?

You will be seen 10-14 days after surgery to remove your dressing and check your wound. Crutches are used for the first 1- 2 weeks. Initially the surgery makes your knee feel weak and unstable. This is due to the pain from the surgery and the swelling that ensues. Therefore the crutches are used for support and protection. Follow-up visits are made every 4-6 weeks to monitor your progress until you are discharged

11. When can I return to sports and do I need a sports brace?

You are allowed to run, golf, and do other non-pivoting sports at 5 months depending on how your knee is progressing and any other associated injuries. Full return to contact sports is allowed at 6 months depending on conditioning of your knee. A brace is usually not required however some patients prefer the added security of the brace for a period of time as they get back to sports. The brace is usually worn for the first year after your surgery.

Frequently Asked Questions:

How will I know I have injured my anterior cruciate ligament?

Answer

If you've damaged your anterior cruciate ligament (ACL), your knee is likely to be very swollen and painful. Your knee will either give way or feel like it would give way if you put your weight on it. Some people also hear a 'pop' when the injury happens.

Explanation

ACL injuries normally happen when you're playing sports, though sometimes an injury can develop over time. A tear in your ACL can occur when you slow down suddenly and then twist, sidestep or have an awkward landing. It can also be caused by a blow to the knee, for example, a tackle during football or rugby.

When an injury happens you will probably feel sudden pain and your knee will swell. This swelling may get worse over the next few hours. Many people also hear a 'pop' or feel something give way in their knee when the injury occurs.

Your knee may feel tender to the touch and you may also find that the movement is limited. You may find it difficult to stand and walk, or put weight through your knee.



What are the different types of graft used in ACL reconstruction?

Answer

There are two main types of graft available for ACL reconstruction – autografts and allografts. Autografts are tendons taken from your body, allografts come from a donor. Your surgeon will discuss your options with you.

Explanation

Autografts are taken from your body. They are usually taken from either:

your patella tendon, which connects your patella (kneecap) and your tibia (shin bone)

your hamstring tendon at the back of your knee

There is very little difference between a graft from your patella tendon or your hamstring. There is no research that shows that one type of autograft is better than the other.

Allografts are from donors. They are used if you have had ACL reconstruction in the past and it hasn't worked, or if you have injuries to several ligaments and tendons in your knee. Talk to your surgeon about the different options available to you.

Will I need to wear a knee brace after surgery?

Answer

At the moment, there is no evidence to support the use of a brace after knee surgery.

Explanation

Knee braces are sometimes used after surgery to support your knee and to prevent any other knee injuries. Some people also wear a knee brace when they return to playing sport.

You may find that wearing a knee brace is reassuring because your knee feels supported, although a brace can be bulky and awkward to wear. However, there is no research that shows that wearing a knee brace will help your knee to heal and recover, or prevent further injury.

Talk to your surgeon about the options available to you and any concerns you have about returning to your usual activities.





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