CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

PATIENT INFORMATION

Partial meniscectomy

Why this operation has been suggested

Dr Kieran Hirpara, an orthopaedic surgeon at Mater Private Hospital Rockhampton, matches the treatment to your specific knee problem. Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. At your appointment we take a history, examine your knee and arrange imaging if it is needed to work out what is causing your symptoms.

A partial meniscectomy is keyhole surgery to trim away the damaged part of the meniscus, the wedge of cartilage that cushions your knee. We usually offer it when a torn piece of meniscus is catching, locking or causing pain that other treatment has not settled. For wear-and-tear tears we try physiotherapy and activity change first, and consider surgery when those have not given enough improvement. Surgery may be recommended sooner if your knee locks or gives way. The operation aims to relieve that catching pain and help your knee move and work normally again. In the right patient it can settle symptoms well: most people who have this operation for a torn meniscus alone report their knee symptoms have gone.

Before the operation

Once surgery is booked, we will give you clear instructions to follow in the days beforehand. You will need to stop eating and drinking seven hours before your arrival time. We ask for seven rather than six so your operation can be brought forward if the theatre list runs early. Tell us about any medicines you take, especially blood thinners, as some may need to be paused. Bring a written list of them on the day. Arrange for someone to drive you home afterwards, and wear loose, comfortable clothing. If you have other medical conditions, you may need blood tests or a review with the anaesthetist, the doctor who gives the anaesthetic. Most people do not need either.

On the day

You will arrive at the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You will meet the anaesthetist there. This operation is done under general anaesthetic. A regional nerve block is sometimes added for post-operative pain relief; the anaesthetist will discuss this with you on the day.

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You are then taken into the operating theatre, where the operation is performed. When it is finished, you will wake up in the recovery area, where nurses monitor you while the anaesthetic wears off. Once you are stable, you either go to the ward or go home, depending on the procedure and your recovery. Many people go home the same day.

What the operation involves

A partial meniscectomy is done through two or three small keyhole cuts around your knee, each about a centimetre long. The surgeon passes a thin camera into one of the cuts so they can see inside the joint on a screen. Working through the other cuts, they use slim instruments to reach the torn meniscus, the wedge of cartilage that cushions your knee.

The aim is to trim away only the damaged, frayed part of the meniscus and leave as much healthy tissue as possible. Most tears that cannot be stitched can be carefully smoothed and contoured so the remaining meniscus keeps working as a cushion. The surgeon will also check the rest of your knee while they are inside, and can treat any loose or catching fragments they find.

Once the trimming is finished, the instruments are taken out and the small cuts are closed with stitches and covered with a dressing. Because the cuts are so small, this operation usually needs less time in hospital and a shorter recovery than older open surgery on the meniscus.

You will wake up in the recovery area with a padded dressing on your knee. We leave this dressing on for about 10 days, so you can shower over it rather than removing it at home.

After the operation

You will wake up in the recovery area, where nurses watch you while the anaesthetic wears off. Your knee will have a padded dressing on it, and you can shower over it rather than taking it off. We leave the dressing on for about 10 days; please do not take it off before then unless we tell you to. We change or remove it when we see you. Pain is usually mild to moderate, and your team will give you medicine to keep you comfortable. Most people walk on the knee the same day, often with crutches for a short time. Someone should stay with you for the first 24 hours after you get home. Your team will tell you whether you go home the same day or stay one night in hospital.

Recovery

For the first few days your knee will be sore and swollen. Pain is usually mild to moderate, and your team will give you medicine to keep you comfortable. Most people manage this well without strong painkillers. Rest, ice and keeping the leg raised ease the discomfort. The swelling settles gradually over the following weeks.

You will walk on the knee early, often with crutches for a short time. Your physiotherapist will guide you through simple exercises to build strength and movement back into the knee. These exercises matter: doing

them as directed helps your knee recover its function. You can move around the house and do light daily tasks as you feel able. Avoid twisting, pivoting or heavy lifting until your knee feels steady and your surgeon or physio clears you. The dressing stays on for about 10 days, so you can shower over it.

As the swelling settles and movement returns, everyday activities become easier. Once your surgeon clears you to drive, you will need to be able to react in an emergency stop and be off strong pain medicine. Our guide to driving after upper-limb surgery explains the rules in detail. When your knee feels strong and no longer catches, you can return to work and sport in stages, following your physiotherapist's advice.

Recovery varies from person to person. Your timeline may differ, and your surgeon and physio will guide you along the way.

What can go wrong

Most patients do well, but problems can occasionally happen. Your surgeon and the team monitor you closely to spot any issue early.

The most common disappointment is that the knee does not feel better, or only feels better for a short time. If the catching pain or locking returns after an initial improvement, tell us at your next review. Sometimes a further keyhole look inside the knee shows the meniscus is still damaged, and more treatment can be planned from there.

This operation removes part of the cushion in your knee, so it carries some added load on the joint surface over the years. For some people this shows up as wear-and-tear arthritis, which means stiffness, swelling and aching that gradually worsen rather than settle. If your knee becomes more stiff or swollen months or years later instead of easing, bring it up at review so it can be assessed.

A smaller cushion in the knee also means a higher chance of needing a knee replacement down the track compared with repairing the meniscus instead. This is not something you will feel day to day, but it is worth knowing when weighing up your options. If you have questions about how this applies to your knee, raise them before the operation or at any review.

Some people need a further operation on the same knee. This might be because symptoms never settled, or because new damage appears in the meniscus later. Watch for the return of catching, locking or giving way after a good period, and let us know if it happens.

The complications table on this page lists typical rates if you want the specifics.

When to call us

Most people recover without problems, but some symptoms need checking straight away. Call us if you have a fever, or the skin around the small cuts becomes more red, swollen or starts leaking fluid. Call us if your pain suddenly gets much worse. Go to emergency if you have swelling or pain in your calf, or shortness of breath, as

these can signal a blood clot. Go to emergency if your leg goes numb, changes colour, or you cannot move it. When in doubt, call us.

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