

Meniscus Repair (Weight-Bearing) — Pre-Operative Information

Understanding Your Meniscus

The meniscus is a C-shaped disc of cartilage that sits between the femur and tibia in your knee. There are two in each knee — one on the inside (medial meniscus) and one on the outside (lateral meniscus). Together, they act as shock absorbers, help distribute weight evenly across the joint, and contribute to knee stability.

Meniscus tears are among the most common knee injuries. In younger, active patients, the injury usually comes from a sudden twist or pivot — a sharp cut on the soccer field, an awkward landing in basketball, or a deep squat gone wrong. In older patients, the meniscus can tear more gradually from everyday wear and tear, sometimes without a dramatic event at all.

The symptoms of a meniscus tear vary depending on the severity and location. Many patients describe a pop, followed by swelling and pain along the joint line — the inner or outer edge of the knee. Some develop clicking, catching, or a locking sensation, which happens when a torn piece of meniscus gets caught in the joint. In more severe tears, you may not be able to fully straighten or bend the knee.

Diagnosis starts with a physical exam, where I test for joint line tenderness and mechanical signs. An MRI is the gold standard — it gives a detailed look at the size, type, and location of the tear, which directly influences what treatment makes the most sense.

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Treatment Options

Not every meniscus tear needs surgery. Small tears that are not unstable can often be managed without an operation. In older patients or those with lower activity demands, physical therapy and anti-inflammatory treatment can manage symptoms well. Small tears along the outer edge of the meniscus — the portion with good blood supply — may heal on their own with rest and rehab. I always begin with conservative treatment when it is a reasonable option.

When surgery is recommended, I perform it arthroscopically — through two small incisions with a camera and specialized instruments. The goal is always to preserve as much healthy meniscus as possible, because the meniscus plays a critical long-term role in protecting the cartilage of the knee.

There are two main surgical options. In a meniscus repair, I suture the torn tissue back together and allow it to heal in place. This is the preferred approach when the tear is in a location with adequate blood supply. In many cases, despite our desires, a repair is not possible, and a partial meniscectomy is performed.

Meniscus Repair

A meniscus repair is an arthroscopic procedure where I stabilize the torn meniscus with sutures, connecting the torn tissue to the healthy tissue so it can heal. The goal is to promote healing by providing a strong, stable repair. This surgery is done using small instruments in the joint with a camera for guidance.

There are many ways to stabilize the meniscus and the surgery is customized to the type and location of the tear. Generally small incisions are made around the knee to pass stitches through the meniscus. This technique, called inside-out meniscal repair, allows me to tie the sutures over the capsule of the knee. This surgery takes a little bit longer and is more technically challenging, but it is my preferred technique because it provides the strongest and most reliable repair possible.

The goal of surgery is to return your knee to the highest level of function by repairing the meniscus. There are many variables that affect healing. The biggest factor is the size and quality of the meniscus tissue being repaired. The meniscus heals best when the torn fragment is large and there is a simple tear in just one direction. If the tear is small, torn in many directions, or composed of degenerative tissue, the success rate of repair decreases.

Once the meniscus is stabilized, I usually also perform a procedure called “marrow stimulation” to increase blood supply to the repair site. The meniscus itself has poor blood supply, and blood is needed to bring healing factors to the injury. By putting small holes in the bone of the knee joint, bone marrow and blood leak into the joint to help the meniscus heal.

Even with excellent surgical technique, marrow stimulation to increase blood supply, and proper rehabilitation, meniscus repairs sometimes do not heal and can re-tear.

Surgery typically takes 60 minutes depending on the amount of work that needs to be done. With anesthesia preparation and recovery, your total time at the surgery center is usually 3 hours. This is an outpatient surgery performed at the Proliance Surgery Center at Valley (PSCV). You will go home the same day.

What happens on the day of surgery: A couple of days before surgery, the nursing staff will call you to confirm your check-in time and when to stop eating and drinking. On the day of surgery, check in at the front desk at your assigned time. You will go to the pre-op area with your family where our nurses will help you get changed, start an IV, and review your health history. You will meet with me to review the plan, and the anesthesia team will explain their approach. When the operating room is ready, you will walk back with a nurse. After anesthesia is given, you will not remember anything until the recovery room.

While you are in surgery, your family can pick up your post-operative medications at the pharmacy next to the surgery center. If you are under 18, one family member must stay at the surgery center during the entire surgery. In the recovery room, you will be monitored until you are awake, have some crackers and juice, and be made comfortable. Once ready, you will change into your clothes and be wheeled to your car. **You will need someone to drive you home and stay with you for the first 24 hours.**

Risks of surgery include stiffness, infection, blood clots (DVTs), continued pain and swelling, and numbness around the incisions. Because this is a minor procedure without reconstruction or repair, the risks are generally low. As with any procedure requiring anesthesia, there are anesthetic risks that your anesthesiologist will review on the day of surgery. We will work together to optimize your recovery and minimize these risks.

After Surgery — What to Expect

Weight bearing: You can walk with full weight on your leg from the day of surgery. Crutches are provided for comfort and safety — wean to a single crutch by weeks 2–3 and no crutch by weeks 3–4 as your gait normalizes.

Range of motion: Your knee must not bend past 90 degrees for the first six weeks. This is the single most important restriction. You can straighten the knee fully, but bending farther than a right angle puts stress on the repair before it is healed. After six weeks, bending opens up — but loaded deep squatting and kneeling past 90 degrees are still avoided until five months.

Bracing: You will wear a hinged knee brace set at 0–90 degrees for the first six weeks. Wear the brace during all activities, including sleep. You may remove it for exercises in a controlled setting under your physical therapist's supervision. The brace is discontinued at six weeks.

Physical therapy: Your meniscus was repaired and needs six weeks to begin healing properly. Physical therapy will focus on quad activation, gentle range of motion within the 90-degree limit, and stationary bike with the seat raised to prevent flexion beyond 90 degrees. After six weeks, strengthening progresses steadily.

These timeframes help answer common questions about what to expect after surgery. Your recovery may be faster or slower depending on the severity of the tear and your baseline fitness. You advance by milestones — not simply by the calendar.

Timeframe	What to Expect
Weeks 1–6	You can walk with full weight on your leg right away. You will wear a hinged brace that limits bending to 90 degrees. Crutches are for comfort — wean off by weeks 3–4. Goal: Full knee straightening (0°) by week 1–2. Bending to 90° by weeks 2–3. Straight-leg raise without quad lag. Begin quad sets every waking hour. Stationary bike with seat raised to stay within 90° limit. Your first clinic visit is around 10–14 days to check incisions and motion. Most people can return to a desk job or school at this time.
Weeks 6–12	Your 90-degree motion restriction is lifted and you can begin bending further. The brace is discontinued. You will progress to mini-squats (to 60°), step-ups, leg press, stationary bike at normal height, and single-leg balance training. Goal: Full range of motion (0–130°+) by weeks 10–12. Quad strength at least 60–70% compared to the other leg. Walking 30 minutes without pain or swelling. Important restriction: Do not squat past 90° while standing and do not kneel past 90° until the five-month mark. No impact activities (running, jumping, cutting) during this phase.
Months 3–5	This phase focuses on building real strength. You will progress to single-leg squats, step-downs, lunges, and higher-resistance bike and elliptical training. A running program may begin at weeks 18–20 with my clearance. Goal: Quad strength at least 80% compared to the other leg. Single-leg squat and step-down without pain. Running 5 minutes continuously without pain. The deep flexion and impact restrictions remain in place until 5 months to protect the repair during final tissue remodeling.
Months 5–6+	The five-month restrictions are lifted. You can now squat to full depth, kneel, and progress to sport-specific activities including impact, cutting, and pivoting. Full return to sport is anticipated at 6 months. Return-to-sport criteria: Quad strength at least 90% compared to the other leg. Single-leg hop test at least 90% symmetry. Running 20 minutes continuously without pain or swelling. No effusion after sport-specific activity. I will confirm your return to full activity based on objective strength and function tests at your 6-month follow-up.

Driving: If surgery was on your right leg, typically 3–4 weeks. If your left leg, typically 2–3 weeks. You must be off narcotic pain medications before driving.

Preparing for Surgery

Presurgical physical therapy or home exercise: In most cases, surgery is only recommended after regaining full range of motion in the knee and allowing time for swelling to decrease. The stronger you go into surgery, the stronger you come out. In some severe meniscus tears, we may have you avoid moving the knee altogether — I will discuss this if relevant to your situation.

Ice Machine — My #1 Recovery Recommendation

I highly recommend purchasing an ice machine to help your recovery. An ice machine is the single best investment you can make — it allows for continuous icing without the risk of frostbite and is far easier than using ice bags or gel pads. Our clinic staff can fit you for one before surgery and show you how to get the most out of it. Stock up on bags of ice — the machine can go through a bag a day when used regularly.

Prepare your home: Make sure you have plenty of clean clothes and clean sheets to reduce the chance of infection and limit the chores you need to do while recovering. Stock the refrigerator with healthy food and buy bags of ice if you plan on using the ice machine. You need to be comfortable with crutches — if you have stairs, it is best to practice before surgery.

Day-of-Surgery Checklist

- ☐ Verify your check-in time and make sure you know the directions and how long you need to get there
- ☐ Follow the instructions you were given about when to stop eating and drinking before surgery
- ☐ Prepare your home for your return — have your ice machine or gel pads ready and crutches available
- ☐ Arrange for someone to drive you home and stay with you for the first 24 hours after surgery
- ☐ Wear comfortable, loose-fitting clothing — shorts or loose pants that fit over a slightly swollen knee and a brace
- ☐ Bring your insurance card, photo ID, and any paperwork from the surgery center

Contact Information

Questions about your surgery:	(425) 656-5060
PSCV Surgery Center:	(425) 226-2041
Surgery Scheduling:	(425) 528-7155
Pre-op Nurse:	(425) 291-1465
Billing:	(425) 291-1414
Surgery Center Address:	4009 Talbot Rd S, Ste 200, Renton, WA 98055