

Partial Meniscectomy

Physical therapy protocol - isolated arthroscopic partial meniscectomy

Patient: _____ Surgery / procedure date: _____

This is the full Pacific Bone & Joint postoperative protocol. Patient-specific operative and discharge orders take precedence over this default pathway.

Rapid recovery when no meniscus repair was performed

Use this pathway only after an isolated partial meniscectomy or meniscal debridement. If the operative note includes a meniscus repair, root/radial repair, cartilage restoration, microfracture, osteotomy or ligament reconstruction, use the more protective combined protocol instead.

Item: Default plan

Weight bearing: Weight bearing as tolerated with crutches as needed. Wean crutches when swelling is controlled, quadriceps activation is good and gait is non-antalgic.

Brace: No routine brace.

Motion: Range of motion as tolerated. Restore full extension immediately and progress flexion without force.

Therapy start: Begin home exercises immediately and outpatient PT within the first several days when needed for motion, swelling, gait or strength.

Days 0-7

- Control swelling with elevation, compression and cold therapy as appropriate. Avoid prolonged standing or excessive walking if the knee becomes more swollen later that day.
- Prioritize full knee extension. Use heel prop or prone-hang positioning as needed; do not rest with a pillow behind the knee.
- Begin heel slides, quadriceps sets, straight-leg raise when there is no extension lag, ankle pumps, calf raises, hip strengthening and gentle hamstring/calf mobility.
- Use the stationary bike for motion once the knee can comfortably complete the pedal cycle. Resistance should be light initially.
- Wean crutches when the patient can walk without a limp and perform a straight-leg raise with good quadriceps control.

Restore strength and normal movement

Days 8-14

- Goal: full, pain-free or near-pain-free ROM, minimal effusion and a normal gait without an assistive device.
- Progress sit-to-stand, mini-squat, wall or ball squat, step-up, bridge, calf raise, hamstring curl and balance work.
- Increase cycling duration and add low-impact aerobic conditioning as swelling permits.

- Use the next-morning response to dose activity. If swelling, stiffness or pain is meaningfully worse the next day, reduce volume or load.

Weeks 2-6

- Progress leg press, squat, split squat, step-up/step-down, Romanian deadlift, lateral lunge and single-leg strengthening with good alignment and control.
- Advance balance and proprioception from stable single-leg stance to reaches, perturbations and task-specific drills.
- Elliptical, stair climber, pool running and swimming may be added as tolerated when wounds are healed and there is no reactive effusion.

Criteria before starting a running progression

- Full pain-free ROM, no or trace effusion, and a normal walking gait.
- Ten controlled single-leg squats to at least about 60 degrees without pain escalation or major valgus/trunk compensation.
- Quadriceps strength at least about 80% of the uninvolved side when objective testing is available.
- Strength session and short impact trial do not create swelling or symptoms that persist into the next day.

Return to work, running and sport

Running and higher-level activity

- Begin with a graded walk-jog program once the running criteria are met. Increase total running time before pace, hills or intervals.
- Add bilateral landing, then single-leg landing, multiplanar plyometrics and agility only after basic strength and impact tolerance are restored.
- Cutting and pivoting are the final progression for athletes who need them; they should not be the first test of the knee after surgery.

Return-to-sport criteria

- Full ROM; no effusion; no pain with sport-specific loading; confident, high-quality movement.
- Quadriceps, hamstring and hip strength approximately 90-95% or better side-to-side for unrestricted pivoting sport, with at least 95% preferred for high-demand competition.
- Hop or equivalent functional testing approximately 90-95% or better with acceptable landing mechanics when relevant to the sport.
- Complete progressive practice exposure without a next-day increase in swelling or pain before unrestricted competition.

Call or reassess

Contact the surgical team for fever, increasing redness or drainage, calf swelling, chest pain/shortness of breath, a large or recurrent effusion, true locking, persistent inability to regain extension, a new painful pop with instability, or symptoms that are worsening rather than improving. A simple meniscectomy usually progresses faster than a meniscus repair; unexpected prolonged restrictions should prompt confirmation of the operative procedure.

Clinical references: Massachusetts General Brigham Sports Medicine, Rehabilitation Protocol for Arthroscopic Partial Meniscectomy, revised 2021. Brelin AM, Rue JP. Clin Sports Med. 2016;35:669-678. Dias JM et al. J Orthop Sports Phys Ther. 2013;43:560-576. The PB&J pathway is criterion-based and assumes no concomitant repair or cartilage-protection procedure.