

PATIENT INFORMATION BOOKLET

Anterior Cruciate Ligament (ACL) Reconstruction Surgery

*Using Quadrupled Semitendinosus Graft
with Internal Brace Augmentation*

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1. Introduction

This booklet has been prepared to provide you with comprehensive information about your upcoming Anterior Cruciate Ligament (ACL) reconstruction surgery. It explains the anatomy of your knee, the nature of your injury, the surgical technique that will be used, and what you can expect during your recovery.

Mr Kenan Dehne uses a pioneering technique for ACL reconstruction that combines a quadrupled semitendinosus hamstring tendon graft with an internal brace (suture tape augmentation). This approach offers several advantages over traditional methods, including enhanced graft protection during the critical early healing period, reduced risk of graft elongation, and the potential for accelerated rehabilitation.

Your rehabilitation will follow the Melbourne ACL Rehabilitation Protocol — a criteria-driven programme developed by Randall Cooper and Mick Hughes. Unlike time-based protocols, this approach ensures you progress through each phase only when your knee has met specific functional benchmarks, optimising your recovery and reducing the risk of re-injury.

Important: Please read this booklet carefully and bring it with you to all appointments. If you have any questions that are not answered here, please do not hesitate to contact us.

2. Understanding Your Knee — The Anatomy

The knee is the largest and one of the most complex joints in the human body. It is formed by the articulation of three bones: the femur (thighbone), the tibia (shinbone), and the patella (kneecap). The knee functions primarily as a hinge joint, allowing flexion (bending) and extension (straightening), but it also permits a small degree of rotation.

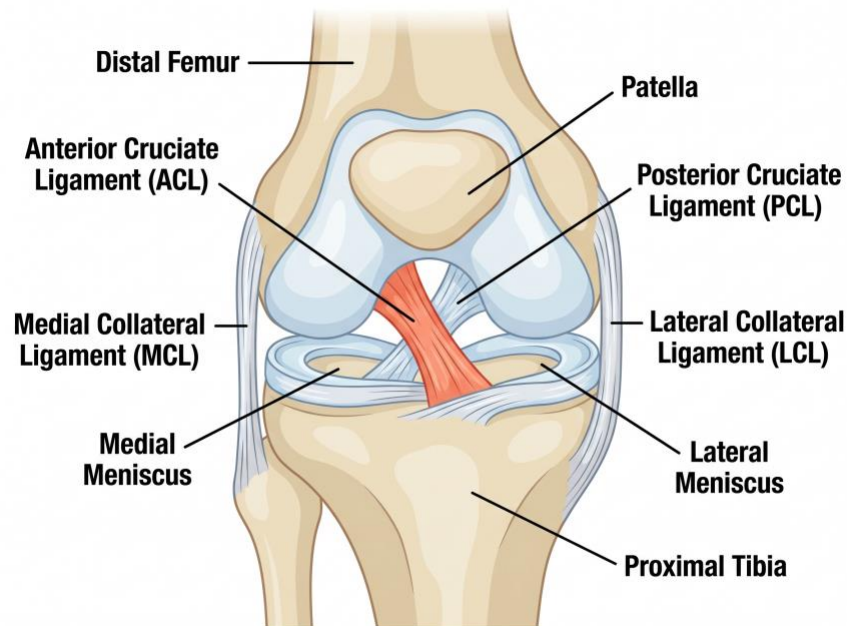


Figure 1: Normal knee anatomy showing the cruciate and collateral ligaments

The knee is stabilised by four main ligaments that act like strong ropes to hold the bones together:

Ligament	Function
Anterior Cruciate Ligament (ACL)	Prevents the tibia from sliding forward relative to the femur; provides rotational stability
Posterior Cruciate Ligament (PCL)	Prevents the tibia from sliding backward relative to the femur
Medial Collateral Ligament (MCL)	Stabilises the inner aspect of the knee against valgus (inward) forces
Lateral Collateral Ligament (LCL)	Stabilises the outer aspect of the knee against varus (outward) forces

Between the femur and tibia sit two C-shaped pieces of cartilage called menisci (medial and lateral). These act as shock absorbers and help distribute load across the joint. The articular cartilage — a smooth, white tissue covering the bone ends — allows near-frictionless movement.

3. What is the ACL and What Does It Do?

The Anterior Cruciate Ligament (ACL) is one of the two cruciate ligaments that cross inside the knee joint. It runs diagonally from the posterior (back) aspect of the lateral femoral condyle to the anterior (front) aspect of the tibial plateau. The ACL is approximately 3 centimetres long and is composed of two functional bundles: the anteromedial (AM) bundle and the posterolateral (PL) bundle.

The ACL is the primary restraint against anterior tibial translation — that is, it prevents your shinbone from sliding forward beneath your thighbone. It also plays a critical role in controlling rotational movements of the knee, particularly the combined motion of pivoting and twisting that occurs during sporting activities such as cutting, landing from jumps, and sudden deceleration.

Key Functions of the ACL:

- Prevents forward translation of the tibia on the femur
- Controls rotational stability during pivoting and cutting movements
- Provides proprioceptive feedback (position sense) to the brain
- Works in concert with other ligaments and muscles to maintain knee stability

Without a functioning ACL, the knee may feel unstable during activities that involve twisting, turning, or sudden changes of direction. This instability can lead to further damage to the menisci and articular cartilage over time, increasing the risk of early-onset osteoarthritis.

4. How Does the ACL Get Injured?

ACL injuries are among the most common serious knee injuries, particularly in young, active individuals. Approximately 70% of ACL injuries occur through non-contact mechanisms — meaning the injury happens without direct impact from another person or object.

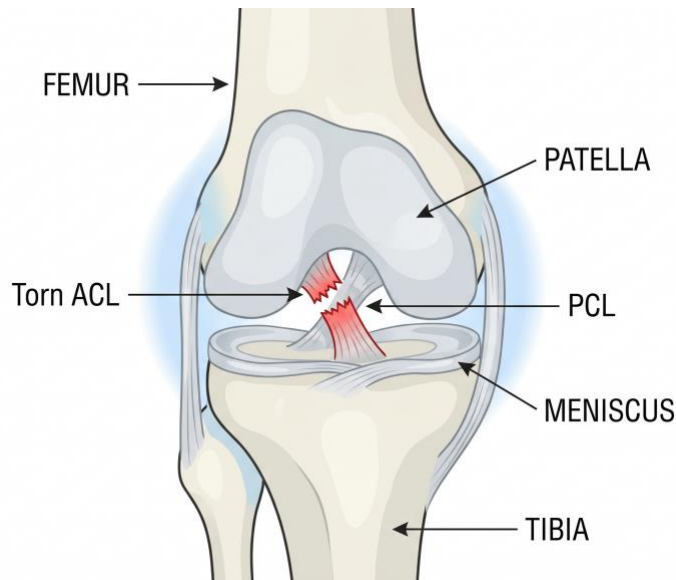


Figure 2: A torn ACL with disrupted fibres

Common mechanisms of ACL injury include:

Mechanism	Description
Pivoting or cutting	Sudden change of direction with the foot planted on the ground
Landing from a jump	Landing with the knee in a near-straight position or with inward collapse (valgus)
Sudden deceleration	Rapidly stopping while running at speed
Hyperextension	The knee being forced beyond its normal straight position
Direct contact	A blow to the outer aspect of the knee (less common, ~30% of cases)

Symptoms of an ACL tear typically include:

- A sudden "pop" or giving-way sensation at the time of injury
- Rapid swelling of the knee within hours (haemarthrosis)
- Significant pain, particularly when attempting to bear weight
- A feeling of instability or the knee "giving way" during pivoting activities
- Reduced range of motion, especially difficulty fully straightening the knee

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5. Do I Need Surgery?

Not everyone with an ACL tear requires surgery. The decision depends on several factors including your age, activity level, degree of instability, associated injuries (such as meniscal tears), and your personal goals.

Surgery is generally recommended if:

- You wish to return to sports involving pivoting, cutting, or jumping (e.g., football, rugby, basketball, skiing)
- Your knee gives way during everyday activities despite rehabilitation
- You have associated injuries such as a repairable meniscal tear
- You are young and active with high functional demands
- You have failed a period of structured non-operative rehabilitation

Non-operative management may be appropriate if:

- You do not participate in pivoting or high-demand sports
- Your knee feels stable during your normal daily activities
- You are willing to modify your activity level
- You have completed rehabilitation and achieved good muscle strength and control

Following a thorough clinical examination and review of your MRI scan, Mr Dehne will discuss the most appropriate treatment option for your individual circumstances.

6. The Surgical Technique

Quadrupled Semitendinosus Graft with Internal Brace Augmentation

Mr Dehne performs ACL reconstruction using a pioneering technique that combines a quadrupled semitendinosus hamstring tendon autograft with internal brace (suture tape) augmentation. This approach represents the latest advancement in ACL surgery, offering superior biomechanical properties and enhanced graft protection during the critical healing period.

The Graft: Quadrupled Semitendinosus

The semitendinosus is one of the three hamstring muscles located at the back of your thigh. A single tendon is harvested through a small incision below the knee. This tendon is then folded four times (quadrupled) to create a thick, robust graft bundle that closely matches the diameter and strength of the native ACL.

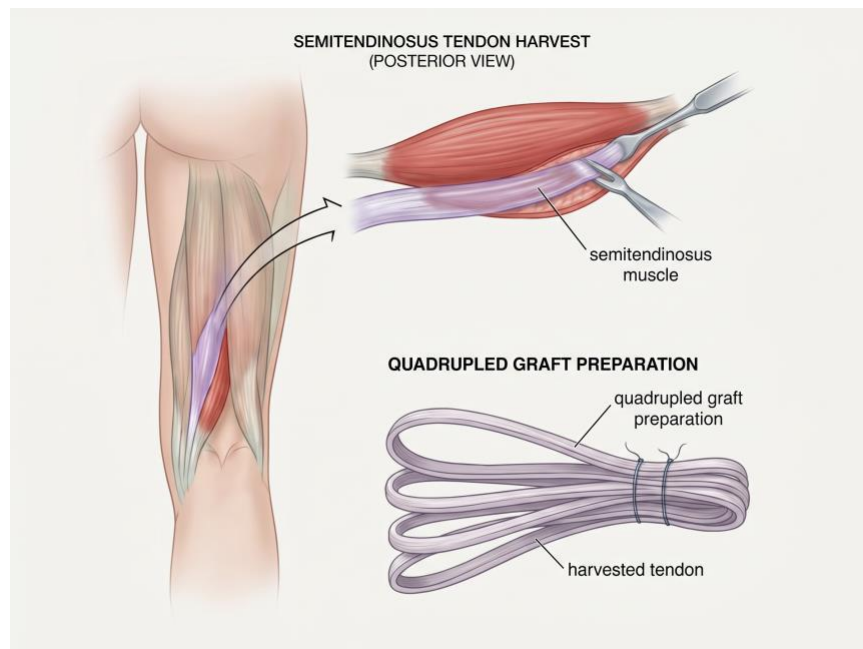
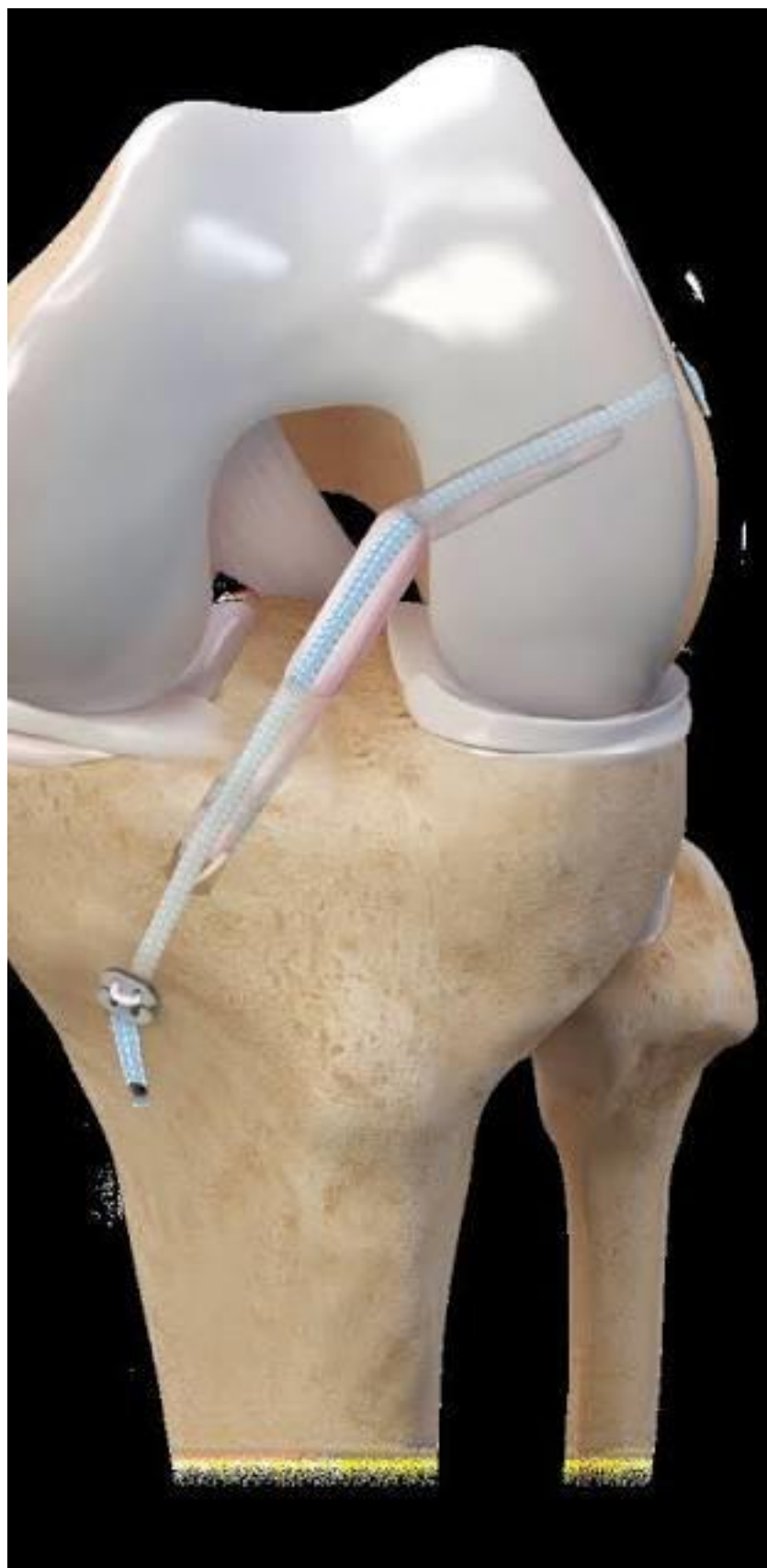


Figure 3: Semitendinosus tendon harvest and quadrupled graft preparation

Key advantages of using only the semitendinosus tendon (preserving the gracilis) include reduced donor-site morbidity, preservation of hamstring strength for deep knee flexion, and a faster return of hamstring function compared to techniques that harvest both tendons.

The Internal Brace: Suture Tape Augmentation

The internal brace is a high-strength suture tape (typically 2.0mm FiberTape) that is placed alongside the graft within the bone tunnels. It acts as a "seatbelt" for the new ligament — sharing the load with the graft and protecting it from excessive elongation during the early healing phase when the graft is at its weakest (the period of "ligamentisation").



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Figure 4: Completed ACL reconstruction with quadrupled semitendinosus graft and internal brace

How the Surgery is Performed

Step	Description
1. Anaesthesia	General anaesthetic with a nerve block for post-operative pain relief
2. Arthroscopy	Two small keyhole incisions are made to inspect the knee joint and confirm the ACL tear
3. Graft harvest	The semitendinosus tendon is harvested through a 3cm incision below the knee
4. Graft preparation	The tendon is cleaned, folded four times, and pre-tensioned on the graft preparation board
5. Tunnel drilling	Bone tunnels are drilled in the femur and tibia at the anatomical ACL attachment sites
6. Graft passage	The quadrupled graft is passed through the tunnels into the knee joint
7. Internal brace	The suture tape is placed alongside the graft and independently tensioned
8. Fixation	The graft and internal brace are secured with suspensory fixation devices (buttons)
9. Testing	The knee is taken through a full range of motion to confirm stability and graft tension
10. Closure	Incisions are closed with sutures and sterile dressings applied

The entire procedure typically takes 60–90 minutes. It is performed as a day-case procedure, meaning you will usually go home on the same day as your surgery.

7. Evidence Supporting This Technique

The combination of a quadrupled semitendinosus graft with internal brace augmentation is supported by a growing body of high-quality scientific evidence. The following summarises the key findings from the published literature.

Biomechanical Advantages

Wallace et al. (2024) demonstrated in a full-construct biomechanical model that independent suture tape augmentation of a four-strand semitendinosus graft significantly improves time-zero biomechanical properties. The study found that 2.0mm tape suture augmentation was superior to 1.3mm tape, with increased load to failure and construct stiffness. This means the reconstructed ligament is stronger from the moment of surgery.

Bachmaier et al. (2018) showed that suture tape reinforcement reduces graft elongation by 15–56% and increases overall construct stiffness. This is particularly important during the first 6–12 weeks after surgery when the biological graft undergoes remodelling and is at its weakest.

Clinical Outcomes

Wilson et al. (2023) reported the outcomes of ACL reconstruction with independently tensioned suture tape augmentation at 5-year follow-up. The study demonstrated a remarkably low failure rate of only 1.1% — significantly lower than the 5–15% revision rates reported for standard ACL reconstruction without augmentation. These results were consistent across both hamstring and patellar tendon grafts.

A systematic review by Maginnis et al. (2024), published in the American Journal of Sports Medicine, analysed 10 studies examining different graft types augmented with an internal brace. The review concluded that all graft types with suture tape augmentation showed no clinical disadvantage compared to standard reconstruction, with several studies demonstrating significant biomechanical and clinical advantages including reduced laxity (0.8mm vs 1.9mm, $P < 0.05$).

Summary of Evidence

Outcome	Finding	Reference
Reduced graft elongation	15–56% reduction in dynamic elongation	Bachmaier et al. 2018
Increased construct stiffness	Significantly improved load-to-failure	Wallace et al. 2024
Low revision rate	1.1% at 5-year follow-up	Wilson et al. 2023
Reduced laxity	0.8mm vs 1.9mm ($P < 0.05$)	Maginnis et al. 2024
No increased complications	Comparable complication profile	Maginnis et al. 2024
Graft protection	Load-sharing during ligamentisation	Thilak & Panicker 2025

The technique of using only the semitendinosus tendon (preserving the gracilis) combined with internal brace augmentation represents an evolution in ACL surgery that maximises graft protection while minimising donor-site morbidity. The internal brace acts as a secondary stabiliser during the vulnerable period of graft remodelling, after which the biological graft assumes the primary load-bearing role.

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8. Preparing for Your Surgery

Optimal preparation before surgery ("prehabilitation") has been shown to improve outcomes after ACL reconstruction. The Melbourne ACL Rehabilitation Protocol recommends achieving specific pre-operative benchmarks before proceeding to surgery.

Pre-operative Goals

Measure	Target	Rationale
Knee extension	Full passive extension (0°)	Essential for post-op recovery
Knee flexion	≥125° passive flexion	Ensures adequate pre-op ROM
Swelling	Zero to 1+ on stroke test	Indicates inflammation control
Quadriceps strength	≥90% of uninjured side	Critical for post-op recovery
Single hop test	≥90% limb symmetry index	Demonstrates functional readiness

Pre-operative Checklist

- Complete your prehabilitation exercises as prescribed by your physiotherapist
- Attend your pre-operative assessment appointment
- Stop anti-inflammatory medications (e.g., ibuprofen) 7 days before surgery
- Stop aspirin 5 days before surgery (unless otherwise advised)
- Do not eat or drink for 6 hours before your scheduled surgery time
- Arrange transport home — you will not be able to drive after surgery
- Prepare your home: place items at waist height, clear trip hazards, arrange a ground-floor sleeping area if possible
- Obtain crutches (these will be provided if not already available)
- Wear loose, comfortable clothing on the day of surgery
- Bring this booklet, your medications list, and any imaging (MRI/X-rays) to the hospital

9. What to Expect on the Day of Surgery

Understanding what will happen on the day of your surgery can help reduce anxiety and ensure you are well prepared.

Stage	What Happens
Arrival	You will be admitted to the day surgery unit, typically 1–2 hours before your scheduled procedure time.
Pre-operative checks	A nurse will check your blood pressure, heart rate, and temperature. You will be asked to confirm the correct leg and sign the consent form.
Anaesthetic	The anaesthetist will discuss your anaesthetic plan. This typically involves a general anaesthetic combined with a regional nerve block for pain relief.
Surgery	The procedure takes approximately 60–90 minutes. You will be in the recovery area for 30–60 minutes afterwards.
Post-operative	Once awake, you will be given pain relief, shown how to use crutches, and given initial exercises by the physiotherapist.
Discharge	Most patients go home the same day, once they can mobilise safely with crutches, pass urine, and have adequate pain control.

What to Bring

- Loose shorts or tracksuit bottoms (to fit over a bulky dressing)
- Comfortable, flat shoes or sandals
- Crutches (if you have been provided with them pre-operatively)
- This patient information booklet
- A list of your current medications
- A book, magazine, or device for entertainment during waiting periods

10. Post-Operative Instructions

The First 2 Weeks

The initial period after surgery focuses on managing pain and swelling, protecting the graft, and beginning gentle range of motion exercises. The internal brace provides additional protection to the graft during this vulnerable phase.

Pain Management

Medication	Dose	Frequency	Notes
Paracetamol	1g (two 500mg tablets)	Every 6 hours	Maximum 4g per day
Ibuprofen	400mg	Every 8 hours (with food)	Only if no contraindications
Codeine	30mg	Every 6 hours (as needed)	May cause constipation
Ice therapy	20 minutes	Every 2–3 hours	Use a barrier between ice and skin

Wound Care

Your wounds will be closed with dissolvable sutures and covered with waterproof dressings. Keep the dressings clean and dry for 2 weeks. If the dressings become soaked or fall off, replace them with a clean, dry dressing. Contact us if you notice increasing redness, warmth, swelling, or discharge from the wound sites.

Weight Bearing and Mobility

You may put weight through your operated leg as comfort allows from the day of surgery, using crutches for support. Most patients use crutches for 2–4 weeks. A hinged knee brace is not routinely required with the internal brace technique, as the suture tape provides additional stability during early healing.

Early Exercises (Day 1 onwards)

Exercise	Description	Dosage
Quadriceps setting	Tighten thigh muscle, press knee flat into bed	10 reps × 5 sets daily
Straight leg raise	Lift leg 15cm off bed with knee straight	10 reps × 3 sets daily
Heel slides	Slide heel towards buttock, bending the knee	10 reps × 5 sets daily
Ankle pumps	Move foot up and down at the ankle	20 reps every hour
Knee extension	Place heel on rolled towel, let knee straighten	Hold 5 min × 3 daily

Warning Signs — When to Contact Us

Seek urgent medical attention if you experience:

- Calf pain, swelling, or tenderness (possible deep vein thrombosis)
- Sudden shortness of breath or chest pain (possible pulmonary embolism)
- Fever above 38.5°C persisting for more than 24 hours
- Increasing redness, warmth, or pus from the wound (possible infection)
- Sudden severe pain not controlled by your prescribed medications
- Numbness or tingling that does not resolve

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11. Rehabilitation — The Melbourne ACL Protocol

Your rehabilitation will follow the Melbourne ACL Rehabilitation Protocol (Version 2.0), developed by physiotherapists Randall Cooper and Mick Hughes. This is a criteria-driven programme — meaning you progress through each phase only when you have met specific functional benchmarks, rather than following arbitrary time-based milestones.

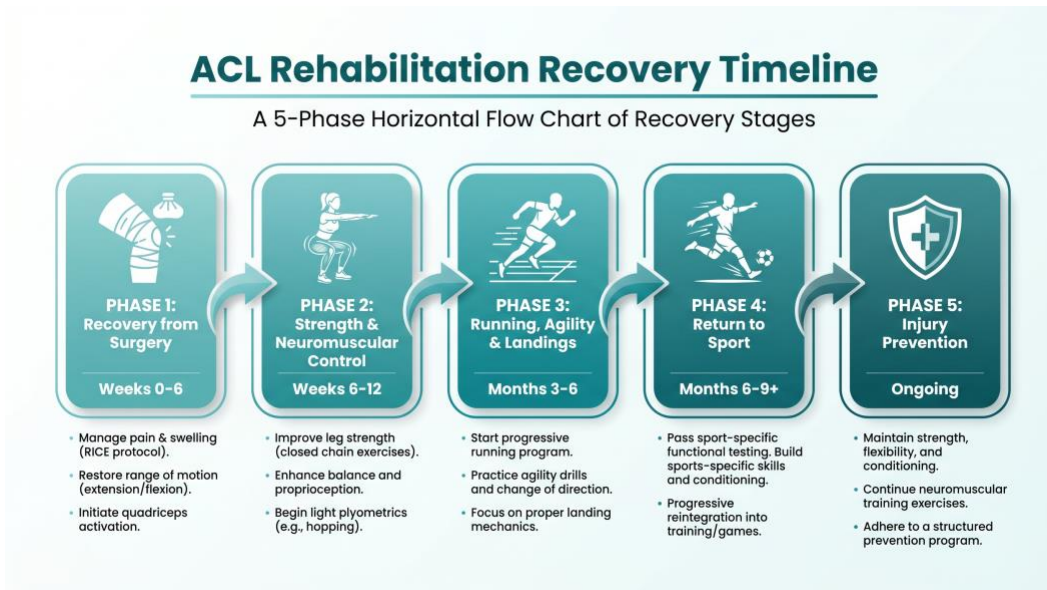


Figure 5: The five phases of ACL rehabilitation (Melbourne Protocol)

Key Principles

Criteria-driven, not time-driven: You progress at your own pace based on meeting specific goals — not calendar dates.

Pain and swelling as guides: Increased pain or swelling indicates the knee is not tolerating the workload. Reduce intensity and allow recovery.

Technique is paramount: Correct movement patterns must be established before increasing load or speed.

Build impact gradually: High-impact activities are introduced progressively to allow tissue adaptation.

Complete the full protocol: Research shows the final third of rehabilitation is the most important for reducing re-injury risk.

12. Phase 1: Recovery from Surgery

Phase 1 begins immediately after surgery and focuses on settling the knee, regaining basic range of motion, and reactivating the quadriceps muscle. This phase typically lasts 2–6 weeks but is guided by achieving the criteria below, not by time alone.

Three Most Important Goals

1. **Get the knee straight** (full passive extension to 0°)
2. **Settle the swelling** (zero to 1+ on stroke test)
3. **Get the quadriceps firing** (no extensor lag)

Criteria to Progress to Phase 2

Outcome Measure	Goal	Assessment Method
Passive knee extension	0° (full extension)	Goniometer
Passive knee flexion	≥125°	Goniometer
Swelling	Zero to 1+	Stroke test
Quadriceps lag	0–5° lag	Lag test

Typical Activities in Phase 1

- Regular icing (20 minutes every 2–3 hours)
- Compression bandaging or sleeve
- Quadriceps setting exercises (static contractions)
- Heel slides for knee flexion
- Prone hangs or towel extensions for knee extension
- Straight leg raises (once quadriceps control is adequate)
- Gentle walking with crutches, progressing to full weight bearing
- Stationary cycling (once 100° flexion achieved)

13. Phase 2: Strength & Neuromuscular Control

Phase 2 focuses on regaining muscle strength, balance, and basic coordination. It typically commences with bodyweight exercises and progresses into a gym-based programme with resistance, balance, and neuromuscular control exercises.

Three Most Important Goals

1. Regain single-leg balance
2. Regain muscle strength ($\geq 85\%$ limb symmetry)
3. Single-leg squat with good technique and alignment

Criteria to Progress to Phase 3

Outcome Measure	Goal	Assessment
Knee extension	Equal to other side	Prone hang test
Knee flexion	$\geq 125^\circ$	Goniometer
Swelling	Zero	Stroke test
Single-leg squat	"Good" rating	Crossley et al. test
Single-leg bridges	$\geq 85\%$ LSI (hurdle: >20 reps)	Freckleton et al.
Calf raises	$\geq 85\%$ LSI (hurdle: >20 reps)	Hebert et al.
Side bridge	$\geq 85\%$ LSI (hurdle: 30 sec)	McGill et al.
Single-leg rise	$\geq 85\%$ LSI (hurdle: >10 reps)	Culvenor et al.
Balance (eyes open)	43 seconds	Unipedal stance test
Balance (eyes closed)	9 seconds	Unipedal stance test

Typical Activities in Phase 2

- Lunges, step-ups, squats, and bridging exercises
- Calf raises and hip abduction strengthening
- Core stability exercises
- Balance and proprioception drills
- Gait re-education
- Non-impact aerobic conditioning (cycling, swimming, walking)
- Progressive resistance training in the gym

14. Phase 3: Running, Agility & Landings

Phase 3 introduces running, agility, jumping, and hopping activities alongside continued gym-based strength work. The knee should be pain-free and swelling-free during this phase. Emphasis is placed on correct technique, particularly for deceleration tasks such as landing from a jump.

Three Most Important Goals

1. **Attain excellent hopping performance** (technique, distances, and endurance)
2. **Progress through an agility programme and modified game play**
3. **Regain full strength and balance**

Key Criteria to Progress to Phase 4

Outcome Measure	Goal	Reference
Single hop test	≥95% LSI	Noyes et al.
Triple hop test	≥95% LSI	Noyes et al.
Triple crossover hop	≥95% LSI	Noyes et al.
Side hop test (30 sec)	≥95% LSI	Gustavsson et al.
Star excursion balance	≥95% LSI	Gribble et al.
Vestibular balance	Pass both directions	Cooper & Hughes
Single-leg rise	Hurdle: ≥22 reps both limbs	Culvenor et al.

Typical Activities in Phase 3

- Progressive running programme (walk-jog → continuous running)
- Agility drills: slalom running, shuttle runs, ladder drills
- Jumping and hopping: scissor jumps, box jumps, single-leg hops
- Landing mechanics training with emphasis on correct alignment
- Change of direction training
- Modified game play (supervised)
- Continued gym-based strength programme

15. Phase 4: Return to Sport

Phase 4 focuses on progressive return to sport-specific training and eventual competition. Current research suggests a minimum of 9 months before returning to pivoting sports, though this is guided by meeting the criteria below rather than time alone. The athlete must be physically ready, psychologically confident, and have a prevention programme in place.

Three Key Criteria for Return to Sport

- 1. Melbourne Return to Sport Score (MRSS) > 95/100**
- 2. Athlete is comfortable, confident, and eager to return (ACL-RSI > 90%, IKDC subjective score)**
- 3. ACL injury prevention programme is implemented and ongoing**

Melbourne Return to Sport Score (MRSS 2.0)

The MRSS is a comprehensive assessment tool with six components, performed over two testing sessions:

Part	Component	Scoring	Details
Part A	Clinical Examination	10 points	Effusion, stability, ROM
Part B	IKDC + ACL-RSI	20 points	Subjective knee function + psychological readiness
Part C	Tampa Scale (TSK-11)	Hurdle	Must score ≤ 18 (no kinesiophobia)
Part D	Functional Testing	50 points	Balance, hop tests, single-leg rise
Part E	General Fitness	Hurdle	Must pass fitness assessment
Part F	Fatigued Functional Testing	20 points	Repeat hop tests after fatigue protocol

16. Phase 5: Injury Prevention

Phase 5 is an ongoing commitment to injury prevention that continues for as long as you participate in sport. Research consistently demonstrates that athletes who maintain a structured prevention programme have significantly lower rates of ACL re-injury and contralateral (opposite knee) injury.

Key Components of an ACL Prevention Programme

Neuromuscular warm-up: Perform a structured warm-up programme (such as FIFA 11+) for at least 15 minutes before every training session and match.

Ongoing strength training: Maintain quadriceps, hamstring, hip, and core strength through regular gym sessions (minimum 2 per week).

Landing and cutting technique: Continue to practise correct biomechanics for landing, pivoting, and deceleration tasks.

Load management: Monitor training loads and avoid sudden spikes in volume or intensity that increase injury risk.

Proprioception and balance: Include balance challenges and perturbation training in your regular programme.

Remember: the evidence shows that the risk of ACL re-injury is highest in the first 2 years after return to sport. Maintaining your prevention programme during this critical window is essential.

17. Risks and Complications

ACL reconstruction is a commonly performed and generally safe procedure. However, as with any surgery, there are potential risks and complications that you should be aware of. Mr Dehne will discuss these with you in detail before you sign the consent form.

Frequency	Complications
Common (>5%)	Pain and swelling Stiffness (temporary) Numbness around incisions Hamstring weakness (temporary)
Uncommon (1–5%)	Infection (superficial wound) Deep vein thrombosis (DVT) Graft failure / re-rupture Residual laxity
Rare (<1%)	Deep infection (septic arthritis) Pulmonary embolism Nerve or vessel injury Complex regional pain syndrome Hardware irritation requiring removal

The addition of the internal brace has not been shown to increase the complication rate compared to standard ACL reconstruction. In fact, the reduced revision rate (1.1% at 5 years with internal brace vs 5–15% without) suggests a protective effect against graft failure.

Measures taken to reduce risks:

- Prophylactic antibiotics administered at induction of anaesthesia
- Blood-thinning medication (if indicated) to reduce DVT risk
- Early mobilisation and ankle pump exercises to promote circulation
- Meticulous sterile technique throughout the procedure
- Careful graft tensioning and fixation to optimise stability

18. Frequently Asked Questions

Q: How long will I be off work?

A: This depends on your occupation. Sedentary (desk) workers can often return within 2–3 weeks. Those with physically demanding jobs may need 3–6 months. Mr Dehne will advise you based on your specific role.

Q: When can I drive?

A: You may return to driving when you can perform an emergency stop safely and without hesitation. For left knee surgery with an automatic car, this may be as early as 2 weeks. For right knee surgery, this is typically 6–8 weeks. You must inform your insurance company.

Q: When can I return to sport?

A: Return to pivoting sports (football, rugby, basketball) is typically 9–12 months, guided by the Melbourne Return to Sport Score. Straight-line activities (running, cycling, swimming) can resume earlier once Phase 3 criteria are met.

Q: Will I need a knee brace?

A: With the internal brace technique, a post-operative brace is not routinely required. The suture tape provides additional stability during early healing. A brace may be recommended in specific circumstances.

Q: Will the internal brace need to be removed?

A: No. The suture tape is designed to remain permanently within the knee. It is biocompatible and does not cause problems long-term. In the rare event of hardware irritation, it can be removed arthroscopically.

Q: What happens to the hamstring tendon after harvest?

A: The semitendinosus tendon regenerates over time. Studies show that the tendon typically reforms within 12–18 months, though it may attach at a slightly different position. Hamstring strength returns to near-normal levels with appropriate rehabilitation.

Q: How strong will my new ACL be?

A: The quadrupled semitendinosus graft with internal brace has been shown to exceed the strength of the native ACL at time zero. Over time, the graft undergoes biological remodelling (ligamentisation) and matures into a functional ligament. The internal brace protects it during this vulnerable period.

Q: What is the success rate?

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A: With the internal brace technique, published data shows a revision rate of only 1.1% at 5-year follow-up. Over 90% of patients report good to excellent outcomes and return to their desired activity level.

Q: Can I fly after surgery?

A: Short-haul flights (under 4 hours) are generally safe after 2 weeks, provided you perform regular ankle exercises and stay hydrated. For long-haul flights, wait at least 4–6 weeks and consider compression stockings.

Q: Will I set off airport metal detectors?

A: The fixation buttons used are very small and typically do not trigger metal detectors. If they do, a letter from Mr Dehne can be provided.

19. Your Appointments & Notes

Use this section to record your appointment dates and any notes from your consultations.

Appointment	Date	Time	Notes
Pre-operative assessment			
Surgery date			
2-week post-op review			
6-week review			
3-month review			
6-month review			
9-month review			
12-month review			

Personal Notes

20. Contact Information

If you have any questions or concerns at any stage of your treatment, please do not hesitate to contact us.

Contact	Details
Mr Kenan Dehne's Secretary	Via JointClinics.co.uk
Website	www.JointClinics.co.uk
Personal Website	www.kenandehne.com
Email	kenan.dehne2@nhs.net
Emergency (out of hours)	Contact your local A&E department or call 111

In an emergency:

If you experience sudden shortness of breath, chest pain, or signs of a serious complication, call 999 or attend your nearest Emergency Department immediately.

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