KEVIN M. ROTH, MD
ORTHOPAEDIC SPORTS MEDICINE

POST-OPERATIVE INSTRUCTIONS

ACL Reconstruction

What to do, what to expect, and when to call — for the first two weeks after surgery.

At a glance

Dressing	Multi-layer bandage with a brace over the top. Outer layers come off on day 3; the small white tape strips touching the skin stay on.
Brace	Locked in full extension at all times for the first week, including sleep. Off only for showering, exercises, and the motion machine.
Weight bearing	Crutches at all times. Weight-bearing depends on graft type and whether a meniscus repair was performed — see Activity section.
Motion machine (CPM)	If prescribed: ~4 hours/day. Start at 30°, advance 10°/day. Return when you reach 100°.
DVT prophylaxis	Aspirin 81 mg daily while on crutches.
First post-op visit	5–10 days after surgery.

Diet

Begin with clear liquids — Jell-O, broth, Gatorade — along with light foods like crackers or toast. Once you tolerate these without nausea, gradually progress to your normal diet over the following day.

Wound care

You will leave the operating room with a knee brace over a multi-layer dressing. From the outside in: a stretchy tan elastic bandage (ACE wrap), then a soft white cotton wrap (Webril), then white gauze pads and a yellow ointment-coated mesh (Xeroform), and small white tape strips (Steri-Strips) directly on the skin. Keep this dressing clean and dry for the first **3 days**.

On day 3, remove the dressing in this order:

1. Unclip the brace and set it aside.
2. Unwrap or cut off the stretchy tan outer wrap.
3. Pull apart the soft white cotton wrap underneath — it tears easily with your fingers.
4. Remove and discard the white gauze pads and the yellow mesh beneath them.
5. Leave the small white tape strips on your skin. They will lift off on their own over the next 1–2 weeks. Do not pick at them.

Some blood staining on the gauze is normal. If the incisions are dry, place a Band-Aid over each. If small drainage continues, place a clean dry gauze pad daily until it stops; if drainage continues beyond a few days, call the office.

Once the incisions are completely dry for 24 hours, you may shower. Let water and soap run over the incisions; pat dry with a clean towel. Do not scrub. **Do not submerge under water** — no baths, pools, hot tubs, or ocean — until cleared at follow-up.

Understanding your pain

Some pain after surgery is normal and expected. Dr. Roth uses a 0–10 pain scale to guide medication use, where 0 is no pain and 10 is the worst pain imaginable. Pain in the 0–4 range is normal after surgery and is generally well-managed by the scheduled non-opioid regimen below. If your pain rises above a 4, the breakthrough oxycodone is available. If pain feels uncontrolled, unrelenting, or is getting worse rather than better, call the office.

Multimodal pain regimen

Your post-operative pain plan is based on multiple recent randomized controlled trials in patients undergoing the same type of surgery you are having.[1–5] These studies show that a scheduled regimen of non-opioid medications provides equal or better pain control than opioids, with fewer side effects and equally high patient satisfaction.

Your medication schedule is built around scheduled non-opioid medications. A small supply of opioid pills is provided only for breakthrough pain — moments when the scheduled medications are not enough.

Take these medications on the schedule below, even if you feel comfortable — they work best when taken consistently. Take with food when possible to reduce stomach upset.

DAYS 1–5 · SCHEDULED NON-OPIOIDS

MEDICATION	MORNING	NOON	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	—	1 tab
Gabapentin 300 mg	1 tab	1 tab	1 tab	—
Methocarbamol 750 mg	1 tab	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab	—

DAYS 6–7 · GABAPENTIN TAPER BEGINS

MEDICATION	MORNING	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	1 tab
Gabapentin 300 mg	1 tab	—	1 tab
Methocarbamol 750 mg	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab

DAYS 8–9 · GABAPENTIN TAPER CONTINUES

MEDICATION	MORNING	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	1 tab
Gabapentin 300 mg	1 tab	—	—
Methocarbamol 750 mg	1 tab	1 tab	1 tab

MEDICATION	MORNING	AFTERNOON	EVENING
Acetaminophen 1000 mg	1 tab	1 tab	1 tab

DAYS 10–14 · MAINTENANCE

MEDICATION	MORNING	AFTERNOON	EVENING
Meloxicam 7.5 mg	1 tab	—	1 tab
Methocarbamol 750 mg	1 tab	1 tab	1 tab
Acetaminophen 1000 mg	1 tab	1 tab	1 tab

Breakthrough oxycodone

You have been given a prescription for **10 oxycodone 5 mg tablets** for breakthrough pain. The scheduled regimen above is designed to keep your pain manageable without opioids, and many patients do not need any oxycodone at all. If your pain rises above a 4 despite the scheduled medications, you may take 1 tablet. Take only as much as you need, for as short a time as possible.

DRIVING AND OPERATING MACHINERY

Three medications in this regimen — **gabapentin** (days 1–9), **methocarbamol** (days 1–14), and **oxycodone** if taken for breakthrough pain — can cause drowsiness, dizziness, or impaired coordination. While taking any of these, do not drive, operate heavy machinery, or make important financial, legal, or major life decisions. Plan to have someone else drive for at least the first week, and do not drive until you have stopped gabapentin, are off oxycodone, and feel the methocarbamol is no longer affecting your alertness.

Journavx (suzetrigine) — optional

Journavx is a non-opioid prescription medication FDA-approved in 2025 for moderate-to-severe acute pain after surgery.[6,7] It works by blocking pain signals in peripheral nerves before they reach the brain, so it carries no risk of addiction, no sedation, no respiratory depression, and does not impair driving. Clinical trials show it provides pain relief comparable to hydrocodone with acetaminophen. Most published evidence is in non-orthopedic surgery; direct trials in knee and shoulder surgery are ongoing. For patients who want to avoid the breakthrough oxycodone entirely, Journavx is a reasonable evidence-supported alternative.

Journavx is optional and not part of the standard regimen above. If you are interested, ask the office and a prescription will be sent to your pharmacy. Practical considerations:

- **Cost.** Often not covered by insurance. Out-of-pocket cost is approximately $15 per pill. Many patients reasonably decide the standard regimen is sufficient.
- **How to take it.** One 100 mg loading dose, then 50 mg every 12 hours. The first dose must be taken on an empty stomach — at least 1 hour before food or 2 hours after. Subsequent doses can be taken with or without food. Do not chew or crush the tablets.
- **No grapefruit.** Avoid grapefruit and grapefruit juice entirely during treatment.
- **Side effects.** Most common are itching, muscle spasms, and rash. Tell the office if you have liver disease before starting.
- **Hormonal contraception.** If you take a hormonal contraceptive containing a progestin other than levonorgestrel or norethindrone, use a backup non-hormonal method during treatment and for 28 days after stopping.

DRUG INTERACTIONS — READ BEFORE REQUESTING A PRESCRIPTION

Do not take Journavx if you take any of the following:

- **Antifungals:** ketoconazole, itraconazole (Sporanox), voriconazole (Vfend), posaconazole (Noxafil)
- **Antibiotic:** clarithromycin (Biaxin)
- **HIV or hepatitis C medications** containing ritonavir or cobicistat — including Paxlovid, Norvir, Kaletra, Stribild, Genvoya, Symtuza, Evotaz, Prezcobix
- **Antidepressant:** nefazodone
- **Seizure or tuberculosis medications:** carbamazepine (Tegretol), phenytoin (Dilantin), phenobarbital, rifampin, rifabutin
- **Herbal supplement:** St. John's wort

Contact your prescribing physician before taking Journavx if you take any of the following — a dose adjustment on your existing medication may be needed:

- **Antifungal:** fluconazole (Diflucan)
- **Antibiotics:** erythromycin, ciprofloxacin (Cipro)
- **Heart or blood pressure medications:** diltiazem (Cardizem, Tiazac), verapamil (Calan, Verelan)
- **Antidepressant:** fluvoxamine (Luvox)
- **HIV medication:** efavirenz (Sustiva)

Blood clot prevention

Lower-extremity surgery combined with reduced activity on crutches slightly increases your risk of a blood clot in the leg. To reduce this risk, take **one 81 mg aspirin (a "baby aspirin") once daily for as long as you are using crutches.** Stop once you are walking comfortably without crutches.

DO NOT START ASPIRIN IF ANY OF THE FOLLOWING APPLY — CALL THE OFFICE FIRST

- You are allergic to aspirin
- You have an active stomach ulcer or recent gastrointestinal bleeding
- You are already taking another blood thinner (warfarin, Eliquis, Xarelto, Pradaxa, Plavix, etc.) or have a known bleeding disorder

If you already take 81 mg aspirin daily for heart or vascular reasons, simply continue your normal dose — do not add a second tablet.

Brace

The brace is to be worn at all times — day and night — locked in **full extension** for the first week. Remove only for showering, exercises, and the motion machine. The brace will be unlocked by Dr. Roth, his PA or his NP at your post-op visit.

Activity and weight bearing

Use crutches at all times during the first week. It is essential that the knee gets fully straight after surgery. **Do not place pillows behind the knee.** Place pillows under the ankle and foot instead — this forces the knee into full extension. It will be uncomfortable but will not damage the repair.

You may return to sedentary work or school **3–4 days after surgery** if swelling and pain are tolerable and you are not taking opioids.

Weight bearing by graft type

- **Autograft (your own tissue) — isolated ACL reconstruction:** Weight as tolerated through the operative leg, using crutches for support and balance. Wean from crutches as tolerated, guided by your physical therapist and based on your quadriceps control.
- **Allograft (donor tissue) — isolated ACL reconstruction:** Partial weight bearing — approximately 50% of body weight through the operative leg — for the first 2–4 weeks, then progress to weight as tolerated. Allograft tissue heals more slowly than your own tissue, and a slightly more conservative early phase reduces the risk of stretching the new ligament before it has integrated.

IF A MENISCUS REPAIR WAS PERFORMED

Your weight bearing is restricted to **50% of body weight** on the operative leg. **Do not bear weight while the knee is bent past 90°** — for example, rising from a low chair, deep squatting, or lunging. Passive bending of the knee during exercises or while sitting is fine. The meniscus is sewn together with very fine suture; loaded deep flexion can pull the repair apart.

Ice and cold therapy

Cold therapy reduces pain and swelling and is one of the most effective non-medication tools you have. Begin icing as soon as you arrive home.

- **Bagged ice or gel packs:** apply for **20 minutes at a time, no more than once per hour.** Always keep a thin cloth between the ice and your skin. Do not exceed 20 minutes — frostbite is a real risk, especially after a nerve block when you cannot feel the cold.
- **Cold-therapy devices (Game Ready, Polar Care, Breg, etc.):** use for **20–30 minutes at a time, up to 4 times per day,** with a thin cloth between the pad and your skin — or follow the specific instructions for your device if different.

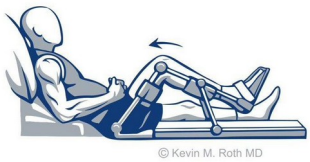
If you had a nerve block during surgery, the limb may be numb for 12–72 hours. Watch the clock carefully when icing during this period.

Exercises

Begin exercises 24 hours after surgery. Do them at least **3 times per day.** Try to perform 3 sets of 10 repetitions initially; you may increase to 15 repetitions if tolerated. The knee will feel painful and stiff — that is normal. Your goal at the first post-op visit is full extension and 90° of flexion. Formal physical therapy starts after that visit. Do ankle pumps throughout the day to minimize the risk of blood clots.

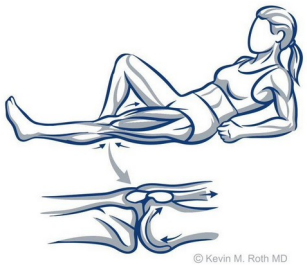
Continuous passive motion (CPM)

If a motion machine (CPM) was prescribed, use it approximately 4 hours per day. It is fine to sleep in the CPM. Remove the brace before getting in. Start at 30° and advance 10° per day; once you reach 100°, you may return the unit. When not in the CPM, elevate the leg to chest level whenever possible to reduce swelling.



Quadriceps sets

Lie down or sit with your leg fully extended. Tighten and hold the muscle on the front of your thigh to flatten the knee against the bed or floor. The kneecap should slide upward toward the thigh. If you are doing it correctly, the knee will flatten and the kneecap will slide up.



Heel props

Lie on your back with your heel propped on a rolled towel or the armrest of a couch. Leave nothing behind the back of your knee and let the knee relax and straighten. If you cannot get full extension, place a 2–5 lb weight on the thigh just above the kneecap.

Prone heel hangs

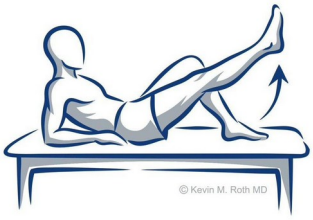
Lie on your stomach on a bed or table and slide down so your knee is at the edge and your foot hangs off. Let gravity straighten the knee. A 2–5 lb weight can be hung from the heel if needed.

Heel slides

Sitting or lying down, gently slide your heel along the floor toward your thigh, bending the knee. Hold a few seconds, then slowly straighten. A towel wrapped around the foot can help pull the knee into more flexion.

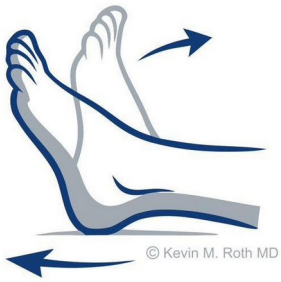
Straight leg raises

Master the quadriceps set first — if the knee bends during this exercise you are not ready. Tighten the quad as hard as you can, lift your heel 4–6 inches off the floor keeping the knee completely straight, then lower slowly while keeping the quad tight.



Ankle pumps

Move your foot up and down like pressing a gas pedal — 20–30 repetitions, every few hours. This circulates blood through the leg and reduces blood clot risk.



No tobacco or nicotine

Do not use tobacco or nicotine products for at least 3 months after surgery — cigarettes, cigars, vapes, smokeless tobacco, dip, chew, or nicotine patches and gum. Nicotine constricts the small blood vessels that bring oxygen and healing factors to your surgical site, significantly increasing the risk of infection, wound healing problems, and failure of the repair. For help quitting, call **1-800-QUIT-NOW**.

BLOOD CLOT WARNING SIGNS

Lower extremity surgery combined with reduced activity increases the risk of a blood clot forming in the leg. Know these warning signs:

Signs of a blood clot in the leg (DVT):

- Swelling in the calf or thigh — can occur on either the operative or non-operative side
- Pain or tenderness in the calf, especially behind the knee
- Redness, warmth, or bluish discoloration of the leg

Signs of a blood clot in the lung (pulmonary embolism — a medical emergency):

- Sudden shortness of breath
- Sharp chest pain, especially with deep breathing
- Rapid heart rate
- Unexplained cough, sometimes with blood-tinged mucus

If you have any DVT symptoms, call the office at **(650) 853-2943** or go to the nearest emergency room. **If you have any PE symptoms, call 911 immediately.**

When to call

Call the office at **(650) 853-2943** for any concern, day or night. This number reaches Dr. Roth or a covering physician after hours.

- Pain not controlled by the regimen above, or getting worse rather than better
- Numbness lasting more than 24 hours after surgery, or longer than expected from your nerve block
- Fever above 101 °F (a low-grade temperature is normal in the first few days)
- Increasing redness, warmth, or tenderness around the incisions
- Persistent or increasing drainage or bleeding from the incision
- Calf pain or swelling
- Color change in the operative limb

- Blistering of the skin
- Any other concern

GO TO THE NEAREST EMERGENCY ROOM IMMEDIATELY FOR

- Difficulty breathing
- Severe chest pain
- Loss of consciousness
- Pain that is completely uncontrollable

Follow-up

If you do not already have a follow-up appointment, call **(650) 853-2943** to schedule. Most follow-up visits are 5–10 days after surgery.

REFERENCES

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6. Bertoch T, D'Aunno D, McCoun J, et al. Suzetrigine, a nonopioid NaV1.8 inhibitor for treatment of moderate-to-severe acute pain: two phase 3 randomized clinical trials. *Anesthesiology.* 2025;142(6):1085–1099.
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Dr. Roth completed his orthopaedic surgery residency at Harvard Medical School and his sports medicine fellowship at the Kerlan-Jobe Orthopaedic Clinic in Los Angeles. In practice since 2013, he specializes in advanced arthroscopic techniques and sports medicine procedures, and sees patients at Palo Alto Medical Foundation's Palo Alto and Dublin offices.

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