



AFFIX PATIENT DETAIL STICKER  
HERE

Forename.....

Surname.....

Hospital Number.....

D.O.B...../...../.....

NHS Organisation.....

Responsible surgeon.....

Job Title.....

No special requirements

**OPERATION: ..... Anterior Cruciate Ligament (ACL)  
Reconstruction (arthroscopic) – using  
autograft**

**PROCEDURE:** The Anterior cruciate is a ligament that runs inside the knee from the thigh bone to the shin bone giving stability to the knee joint. Loss or damage of the ligament can make the knee more prone to ‘giving way’. Your ACL has torn (ruptured).

You may have come to a joint decision with your surgeon to attempt a reconstruction.

After the operation, you will more than likely be introduced to a rehabilitation (physio) program. It is very important you attend this strictly.

\*\*\*please be aware that a surgeon other than your consultant but with adequate training or supervision may perform the operation\*\*\*

**ALTERNATIVE PROCEDURE:** Some patients simply avoid activities that cause their knees to be unstable.

Physiotherapy and increasing strength of hamstrings and quadriceps may be able to compensate for the injury. The knee may still however be prone to ‘giving way’ and instability.

The decision to proceed to a reconstruction should be a joint one between yourself and the surgeon.

There are also alternative methods of reconstruction and numerous grafts that can be used. You should discuss the options with your surgeon before hand.



## RISKS

As with all procedures, this carries some risks and complications.

### COM MON (2-5%)

Pain: the knee will be painful after the procedure. Pain killers (Analgesics) will be given to prevent this including enough to go home with.

Numbness: the skin around the knee or shin may be temporarily or more permanently numb due to damage of small nerves.

Swelling/ Haemarthrosis: This is a collection of fluid or less commonly, blood in the knee joint. In most cases, the body will absorb the fluid itself. If the swelling becomes too large, the surgeon may feel an operation is necessary.

Stiffness: you may have difficulty in straightening your knee or squatting.

Persistent pain: pain may persist after the procedure. A repeat arthroscopy or other knee operation may be required.

Continued instability: weakness and instability may occur despite adequate surgery

### LESS COMMON (1-2%)

Infection: the wound sites may become red, painful and hot. There may also be a discharge. These are signs of infection and can usually be treated by antibiotics. The infection may spread to the knee joint itself (requiring a washout) and removal of the graft. Infection may also spread to the blood (sepsis) requiring intravenous antibiotics.

Graft rupture: (torn graft) this may occur after further trauma. Further surgery may be necessary.

DVT/ PE: These are blood clots in the calf/ leg and if they travel to the lungs may be fatal

### RARE (<1%)

Damage to structures within the knee: this is rare, but may cause further damage and symptoms. This may need further treatment including operation. These include fractured knee cap (patella) if a patellar tendon graft is used.

Damage to the skin under the tourniquet: this may require dressing, surgery or skin graft. There may also be numbness of the skin under the tourniquet, this is usually temporary.

Damaged instruments: these may break within the knee and require an opening of the joint to remove them.

Abnormal wound healing: the scar may become thick, red and painful (keloid scar). This is more common in Afro-Caribbeans. There may also be delayed wound healing for numerous reasons.

Compartment syndrome: this is a build up pressure within the lower leg and can cause nerve damage, blood vessel damage and muscle damage. If this occurs, an emergency operation will have to be performed to prevent death of tissue of the lower leg/ foot.

Osteoarthritis: this can be more common after joint operations.



**Confirmation of consent :**

I have read/ understand the procedure, risks and complications. I have asked questions and raised any immediate concerns I might have. I understand another surgeon other than my consultant may perform the operation.(although they will have adequate training/ supervision).

**I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure

**I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

Signature.....

Print name.....

Date...../.../20...

2<sup>nd</sup> Confirmation..... .Date...../.....20....

NAME of SURGEON (Capital letters).....

SIGNATURE of SURGEON.....

POSITION.....

DATE...../...../20.....

I also give consent for my notes, any data recorded during this operation and tissue discarded during the operation to be used for any current or future trials

Signature.....Date.....

If you have any complaints about your treatment or your care, you are always encouraged to discuss them with your surgical team.

However, if you wish to complain to the trust, each hospital will have a PALS or Patient Advise and Liaison Service. The head nurse on the ward or out patients' clinic can direct you to them. The PALS team will treat all complaints seriously.



**British  
Orthopaedic  
Association**