General Comments About Acute ACL Injuries - Julian Feller FRACS

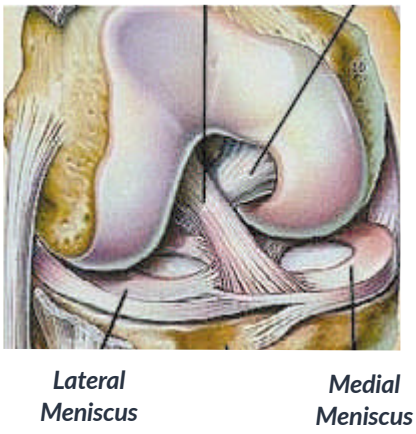
These notes have been prepared in response to the many emails and phone calls received by my office from people who have torn their anterior cruciate ligament (ACL) and are understandably concerned and seeking advice. It is important to note that this is general information only and is not specific advice for any individual. Appropriate assessment of your injury and situation is required to provide specific advice.
ACL ruptures (tears) and ACL reconstruction get a lot of publicity in the lay press, on the internet and in social media. There is a lot of information available to prospective patients and there can be conflicting messages.
From my perspective, there are some common themes that I keep coming back to. They are described below, but once again please note that these are general observations and do not constitute specific medical advice for an individual.

- Not every ACL rupture needs to be treated with surgery. The decision to perform a reconstruction is based on a combination of the individual's activities and the laxity (looseness) of the knee. A trial of non-surgical management may be of use and rarely puts the knee at risk of further injury.

- ACL reconstruction is rarely urgent. It is essentially an elective procedure. Occasionally there may be locking of the knee when a torn cartilage (meniscus) is jammed in the front of the knee and this may require early surgery, but this is uncommon with the initial injury. Difficulty extending (straightening) the knee is rarely due a mechanical block and is usually as a result of pain. This can be resolved with appropriate physiotherapy.

- Occasionally an ACL rupture is associated with a significant tear of other ligaments and in this situation early surgery may be preferable. However, most associated ligament injuries are of a lesser severity and will heal by themselves.

- Although people often feel they need urgent surgical attention, it is often better to let things settle down. Operating on a "calm" or "quiet" knee tends to give a more trouble-free and better recovery. Having good movement in the knee prior to surgery is very important. Time spent getting the knee settled down and mobile is time well spent and speeds up recovery after surgery. I think it is important to be able to lock the knee out as straight as the other knee and have enough bend to comfortably ride a stationary bike before one embarks on surgery. A not uncommon scenario is an associated medial ligament tear or sprain. This causes pain on the inside of the knee and makes it difficult to straighten the joint. This needs to be settled before surgery as operating before it is resolved may result in ongoing stiffness after surgery.



Anatomy of the knee joint showing the anterior cruciate ligament (ACL)

- People have often been supplied with a splint or a brace. While braces may be good for initial pain relief, they can mostly be discarded after a few days to allow work on restoration of normal movement of the joint. Braces that block extension (straightening) are not uncommonly prescribed when there is an associated medial ligament injury. This is probably only useful for the more severe and less common medial ligament injuries. Most medial ligament injuries will heal well without any kind of bracing and don't usually require a block to extension. This only makes it harder to regain extension prior to surgery.

- Unless there is a significant associated fracture (rare), it is usually possible to weightbear as tolerated. Patients are often alarmed by MRI reports of an associated fracture, but these are almost always undisplaced or minimally displaced "cracks" that are essentially more pronounced bone bruising. They will gradually resolve and settle over time without the need for restricted weightbearing.

FRACS Fellow of the Royal Australasian College of Surgeons

ORTHOSPORT VICTORIA
Epworth Richmond Level 5, 89 Bridge Road, Richmond VIC 3121
All Enquiries Tel: 03 9038 5200 Fax: 03 9038 5209 Web: www.osv.com.au