

Your ACL Reconstruction Surgery

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INTRODUCTION

Having seen me, or one of my team in clinic today you will have been introduced to the fact that you have sustained an injury to one of the major ligaments within your knee, the anterior cruciate ligament (ACL). This information leaflet is designed to inform you of this condition and the surgical treatment / reconstruction that I have recommended. It will also give you insight into the rehabilitation that will be required in order to achieve an excellent outcome and return to full sporting activity.

Anterior cruciate ligament surgery and rehabilitation have undergone dramatic changes over the past decade largely due to extensive clinical experience, improved surgical technique and better understanding of rehabilitation. Pre and post-operative rehabilitation is a major factor in the success of ACL reconstruction. Early restoration of full joint movement and weight-bearing are of paramount importance for successful rehabilitation.

My aim is to ensure you have a complete understanding of the basic principles of the ACL reconstruction, to restore the full range of motion, near normal strength and to prepare you for the operation and the accelerated rehabilitation.

The major goals of ACL surgery and rehabilitation are: to restore normal joint anatomy to provide static and dynamic knee stability to return to work and sport as soon as possible.

It is very important that you, the patient, takes an active part in the rehabilitation, both before and after the operation. My goal is to

guide you through the rehabilitation without unnecessary restrictions. Therefore, this is not a protocol or a strict regime, but an overall guide.

This program is based on accelerated rehabilitation principles and extensive experience of *Donald Shelbourne, MD* and *Mark De Carlo, MHA PT SCS ATC*, of the Methodist Sports Medicine Centre, Indianapolis, Indiana, USA.

ABOUT THE ANTERIOR CRUCIATE LIGAMENT

The knee is a complex joint, which has the ability to bend and rotate slightly. Knee ligaments help control motion by connecting bones and bracing the joint against abnormal types of motion. The ACL links the back of the **femur** (thighbone) to the centre of **tibia** (shinbone), stabilising the knee, mainly in the forwards and backwards direction.

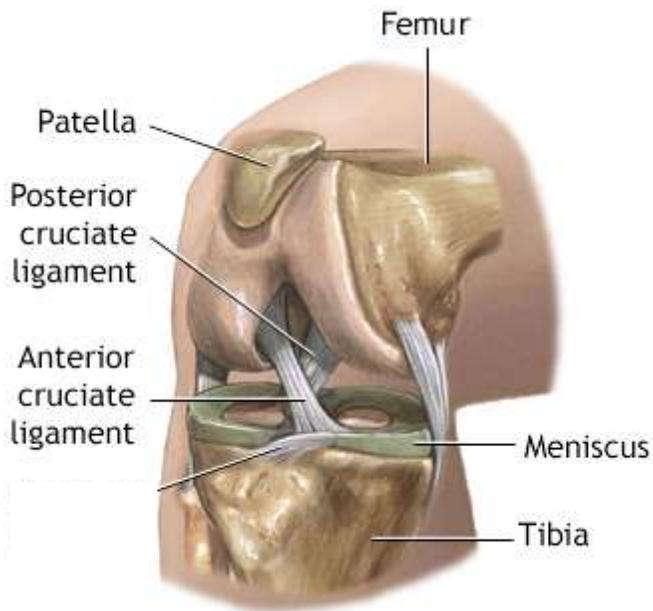
Probably more important than its mechanical restraining function, the ACL provides important neurological feedback that directly affects perception of joint position, and reflex muscular stabilisation of the joint (**proprioception**). Conscious and subconscious proprioception is essential for normal joint function in daily activities, occupational tasks and sports. Proprioception diminishes following ACL injury, but is significantly restored following surgical ACL reconstruction and rehabilitation.

The typical mechanism of an ACL injury is a non-contact twisting movement, usually due to stopping and/or changing direction. Side-stepping (cutting), pivoting and landing from a jump are examples of events that may cause an ACL tear. An audible pop or crack, pain and the knee giving way are typical initial signs, followed by almost immediate swelling, due to bleeding inside the joint. Associated damage to other important joint structures, such as meniscal cartilages, collateral ligaments and articular cartilage is very frequent.

A few patients will achieve satisfactory stability and function with non-operative treatment (rehabilitation and adjustments to daily activities and sports). However, chronic ACL deficiency results in gradual damage to the menisci and articular cartilage (joint lining) and consequent early joint wear.

A complete tear of the ACL has little ability to heal and often requires surgical reconstruction. Surgery is occasionally followed by an overnight stay in but often is performed as a day case procedure depending on the timing of the surgery. Then follows several months of intensive rehabilitation to restore normal range of motion, strength, flexibility and proprioception.

ACL reconstruction is not an emergency operation. Delaying surgery until a full range of motion is obtained significantly reduces the chance of having problems post-operatively. Delaying acute surgery also allows you to better prepare for surgery and gives you time to learn, fully understand and practise adequate exercise as well as building your quadriceps muscles.



PRE-OPERATIVE REHABILITATION

Pre-operative rehabilitation is extremely important for the successful

outcome of ACL reconstruction. Patients with an ACL deficiency, suitable for reconstructive surgery, should begin physical therapy as soon as the acute pain from the knee allows. They should also, if possible, visit a physiotherapist, prior to the operation. The early aims are to regain a full range of motion, maintain quadriceps strength and joint proprioception before the operation.

BEFORE THE OPERATION

- **Skin problems with your knee (wounds and cuts in any stage of healing) are not compatible with ACL surgery as they increase the infection risk.**
- **Please do not shave your legs before surgery as this may increase the risk of wound infection.**
- **Do not forget to tell us if you have any allergies or any relevant medical problems.**
- You should have a full range of knee movement and good leg muscles.
- You should be familiar with the full range of postoperative exercises.
- **On admission to the hospital:** bring your regular medication, relevant medical records and x-ray films.
- You are allowed to eat solid food **up to 6 hours** and drink clear fluids **up to 2 hours** before the operation. Details will be confirmed in the pre-assessment clinic.

THE OPERATION

ACL reconstruction involves replacing the torn ligament, either with a graft from the hamstrings muscles (semitendinosus-gracilis

autograft) or sometimes with the middle third of the patella tendon (bone-patella tendon-bone autograft). Fixing the graft into tunnels drilled in the bone with screws provides secure fixation which enables early accelerated progressive rehabilitation to take place. The procedure is performed using keyhole surgery and takes approximately one hour. You will have three scars over your knee following the procedure. Two puncture wounds either side of the kneecap and a 5cm wound over your tibia (shinbone). You will have dissolving stitches to close the wounds which need trimming but not removing. This will be done at about two weeks from your surgery. You may have a surgical drain which will be removed prior to going home.

AFTER THE OPERATION

Day 1

- **Knee is not braced or immobilised**, unless specifically required
- **Pre-emptive and postoperative pain management with tablets** (*Co-dydramol and Diclofenac*) will be supplied.
- **DVT prophylaxis:** early foot and leg exercises and mobilisation are encouraged. Blood thinning medication is only given if required.
- **Swelling control:** *Aircast Cryo/Cuff (cold pressure dressing)* may be applied in the operating theatre or on the ward. **Use cold packs most of the time**, when in bed **and** mobilising. Cold packs / Ice packs are very good at reducing swelling.
- When you return to your room from recovery unit, start moving your operated knee gently (*bending and straightening*).

·**Weight-bear as able**, aided with elbow crutches. Aim to progress to full weight bearing by the following day (once you have satisfactory quadriceps control, gait and knee extension).

·**Discharge from the hospital, if progressing well, is usually on evening of, or the morning after operation.**

2 to 14 days

·**Start with basic proprioceptive exercises as soon as you start weight-bearing:** Briefly shift weight on the operated leg and try to balance on one leg (*this may initially be painful and difficult!*) whilst supporting yourself.

·As you gain confidence try this when holding on to a solid object (*washbasin*) and progress when supervised to the same with eyes closed. You should be able to do this by the fifth day post-operatively.

·Reduce **dressings** to skin cover only (take down your bandage, but keep the adhesive dressings underneath), 48 hours post-operatively.

·**Progress to adapting your daily activities to one legged proprioceptive exercises** (balance on operated leg when brushing teeth, combing hair, using the phone) by 2 weeks.

·**Active knee bending** in side lying, or on sliding board.

·**Isometric quadriceps and hamstring co-contractions-** your physio will advise you on these exercises

·**Static quads** in full extension (*active extension from 40 to 0 degrees is contraindicated*).

·**Patella mobilisation / glides:** teach self-treatment exercises and how to relax quads when doing this.

- Discontinue any exercise that causes unexpected pain and discuss it with your physiotherapist or surgeon.**
- Static quads** in full extension (*active extension from 40 to 0 degrees is contraindicated*).
- Continue to **regain full extension** with **straight leg** and **closed kinetic chain exercises** (*always exercising with full weight through the leg*). **This is the most important target for now!**
- Flexion exercises:** wall and heel slides. Aim for 90 degrees by the end of second week post-operatively.
- Normalise gait:** walk in front of mirror.
- Discard crutches** once walking well and confident in activities of daily living.
- Contact your physiotherapist if you have problems with your knee or exercises.
- At 10 days to 2 weeks postoperatively I will plan to see you in the outpatient clinic for a review.**

PROPRIOCEPTIVE EXERCISES

Balance and proprioceptive training are very important components of this rehabilitation program. A quick and easy way of doing daily proprioception and balance exercises is to stand on one leg while brushing your teeth. This gives you regular opportunities to exercise proprioception for several minutes, a couple of times each day. Even if you have poor balance and proprioception initially, you can do your exercises whilst holding on to the sink with the opposite hand. As your skill level improves you can progress to “no hands” exercises. The next skill level involves the same exercise but with closed eyes, which may feel strange and will require some practice. Once these

exercises become too easy, try to lean in different directions (while standing on one leg and brushing teeth), and then stabilise yourself without losing balance. This will enable you not only to master the skill of standing in one spot, but also to fine-tune the ability to balance once the centre of gravity has moved.

2 to 6 weeks

- At 4-6 weeks: usually ready for driving and return to work.**
- Continue to progress according to your abilities.**
- Progress with closed kinetic chain exercises.**
- Progress** unilateral exercises: sitting to standing, dips, exercise bike and step machines.
- Progress with resisted hamstrings** exercises.
- Progress with** dynamic proprioceptive exercises.
- Carefully resume **pre-operative gym level** at week 4 -6
- Swimming:** straight leg kick only, and pool exercises.
- If you have patella problems** (clicking, grinding, pain) try taping patella medially. Pain at the front of the knee at this stage is very common and is due to your thigh muscles catching up with your level of activity. It will settle with time.
- You should have a full range of movement** (*symmetrical full hyperextension to full flexion*) **by the end of this period.**

Recommended exercises :

a) Squats

b) Seated toe drags

- c) Toe raises
- d) Treadmill walking
- e) Biking with toe clips
- f) Pilates
- h) Elliptical Trainer

DRIVING

Very little information exists in current literature about the ability of ACL injured or reconstructed knees to respond to situation-specific stimuli, such as braking quickly while driving a car. It is difficult to determine when it is safe to return to driving following surgery. A recent study from Australia seems to indicate that following a right ACL reconstruction patients should wait at least six weeks before driving again. However, this could take place at two weeks for patients with left ACL reconstruction (or when they are able to operate the clutch if they are driving a manual car). If in any doubt check with your insurance company before recommencing driving.

FLYING

There is no universal agreement as to when it is safe to travel by plane after an ACL reconstruction. It seems that most Orthopaedic Surgeons advise their patients not to fly for 4 to 6 weeks following the ACL reconstruction. Short flights do not seem to be a problem. However, long intercontinental flights are a potential problem as there is an increased incidence of spontaneous DVT (deep venous thrombosis), even in the young and healthy passengers. It is possible that sitting for long period of time, in a confined space could predispose to the development of deep venous blood clots, especially in people following recent knee surgery. If you have to travel by

plane, between 2 and 4 weeks after your ACL reconstruction, it would be wise to contact your airline's Medical Department and ask them for advice. Also, please discuss this issue with your GP, as you may have to take a blood thinner for several weeks.

6 to 12 weeks

- At 6 weeks: I will review you again in the outpatient clinic and assess the graft healing.**
- Usual milestones includes 0-130 degrees movement in the knee**
- Continue to progress:** increase gym workouts, step ups and step downs.
- Continue to improve your confidence, gait and proprioceptive aptitude**
- Swimming:** continue regularly (*no breaststroke*).
- Cycling** on normal cycle.
- Start jogging,** on the treadmill.

3 to 6 months

- Introduce sport specific exercises but no cutting activities.**
- Progression of strength work.
- Agility work:** catching a ball, sideways running, 2 leg jumping, skipping rope etc.

6 to 9 months

- Isokinetic testing (the involved quadriceps strength should be 80% of the non- involved, at six months).

·Participating in skill exercises as well as improving power and endurance.

·**Plyometric exercises**

·**Earliest return to competitive contact sports** is at nine months (provided: no swelling, no ligament laxity, full mobility, full muscle strength and proprioception, equal or better than the opposite leg).

·**Your outpatient review will be at 6 months . As long as your physiotherapist and I are happy with your outcome you will be discharged at this stage to return to full contact sport within the next 3-4 months.**

POSTOPERATIVE PROBLEMS

Success of reconstructive ACL surgery depends upon many factors of which rehabilitation is of utmost importance. The most perfectly performed surgery can be quickly undone by too much rehabilitation but equally, insufficient rehabilitation can lead to joint stiffness, muscle wasting and a poor functional result.

COMPLICATIONS

These are uncommon, but may occur occasionally:

Calf and hamstring pain are common and will settle within a week or two

Bleeding (2 in 100 patients) into the knee joint may require draining in the immediate postoperative period.

Infection (1%) may result in redness / heat in the skin or knee joint.

DO NOT TREAT WITH ANTIBIOTICS until you have contacted your surgeon.

Bruising around your graft harvest site, in the thigh or even appearing at your ankle is common and not of great significance.

Patch of numbness just next to your scar is not serious and usually recovers.

Joint-line pain : Pain at the front of the knee during rehabilitation is almost universal and will settle with time and muscle building.

Proprioception loss may mean the knee does not feel right for a long time. Regular proprioceptive exercises and a simple **compressive knee sleeve** (elastic bandage, neoprene sleeve or double tubigrip) worn intermittently, is known to help with this problem by applying skin pressure, which indirectly makes the knee feel more secure.

Functional failure rate: The average (international) failure rate, which means an inability to return to pre-injury level of activities, with this particular graft and technique, is up to 15% (1 person in 7) in competitive and contact sports, and up to 5% (1 person in 20) in activities of daily living and fitness training.

QUESTIONS

If you have questions about your rehabilitation please contact your **physiotherapist**. If you have any problems, especially if you experience any excessive skin redness, persistent wound discharge, excessive swelling, or severe pain during or after exercise, call Mr Willis-Owens secretary to arrange to be seen promptly.

Call your **GP** if you develop calf pain and tightness, shortness of breath, or if you develop a fever and feel unwell.

This rehabilitation guide is based on combined experience from a number of sports injury clinics performing ACL reconstructions and

rehabilitation. It has been developed according to contemporary high standards of leading national and international ACL surgical and rehabilitation centres. The main aim of ACL rehabilitation programme is to follow carefully all patients preoperatively and postoperatively and advance the program to minimise postoperative complications, maintain ACL stability and allow a faster return to daily activities while progressing to full work ability and sporting activities.