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Holmquist, Brandan, "Conservative Treatment of Anterior Cruciate Ligament Deficiency" (2014). Thinking Matters Symposium Archive. 11.
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Conservative Treatment of Anterior Cruciate Ligament Deficiency

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Introduction

One of the most common knee injuries is a tear or sprain to the anterior cruciate ligament. The ACL is responsible for preventing forward translation of the tibia on the femur. It is one of the four major stabilizing ligaments of the knee. The ACL can be injured in pivoting sports such as soccer, when the foot is planted and the knee twists, or in basketball, when landing awkwardly from a jump. Female athletes are three to nine times more likely to sustain an ACL injury compared to males. Regardless of age and activity level, the initial treatment after an ACL injury is rest, ice and usually crutches. Unlike the medial collateral ligament and posterior cruciate ligament, tears of the ACL require surgical treatment. For individuals who choose not to have surgery, rehabilitation of the injured knee is frequently recommended to restore as much function as possible and help prevent instability. Rehabilitation focuses on strengthening the muscles around the knee in order to provide better support, control and stability. Some athletes may choose a non-surgical approach to finish a sports season and have reconstructive surgery at a later time. This is not recommended for most sports but can be successful in single plane sports that require minimal pivoting or side to side movements like sprinting athletes and designated hitters in baseball and softball.

Purpose

The purpose of this literature review is to present a simple protocol for the treatment of Anterior Cruciate Ligament deficiency for one plane athletes like track athletes and basketball players. The patient’s knee will still be usable but will have moments of the knee “giving out.” However, it is highly recommended that patients who suffer an ACL tear should get surgery as soon as possible. This is to prevent instability and further injury of the patient. Surgery also will allow a higher quality of life not only in the foreseeable future, but for the rest of the patient’s life.

Stage of rehabilitation

Stage 1 (Injury – 2 weeks)
- Controlling edema/swelling and pain
- Quadriceps control with Russian electrotherapy with straight leg raises
- Active knee flexion
- Unloaded cycling for AROM
- Cryotherapy

Stage 2 (1 – 2 weeks)
- Can only progress if girth measurements are decreasing and ROM is beyond 90° flexion without pain.
- Quadriceps control (Russian electrotherapy with straight leg raises)
- Hip flexion/extension (Hamstring curl)
- Unloaded cycling
- Cryotherapy

Stage 3 (3 weeks)
- Can only progress if girth measurements are decreasing and ROM is still beyond 90° flexion without pain.
- Squats with 15 – 20% body weight
- Hip and knee extension
- Terminal knee extension
- Seated hamstring curls with cables
- Single leg balance / calf stretch
- Clamshells
- Cryotherapy

Stage 4 (4 – 5 weeks)
- Can only progress if girth measurements are decreasing and ROM is still increasing beyond 90° flexion without pain.
- Box squats / goblet squats
- Hip and knee extensions
- Terminal knee extensions
- Hip thrusters / single leg hip lift
- Supine hip extension curl
- Single leg squat rear foot elevated
- Reverse slide board lunge
- Single leg standing calf raise
- Mini band box for 1 – 2 minutes

Stage 5 (Addition of brace)
- Can only progress if girth measurements are decreasing and/ or normal and ROM is nearly equal bilaterally with no pain.
- Sport specific exercises
- Agility ladder
- Single plane running
- Box hops

References


Conclusion

In conclusion, conservative treatment for Anterior Cruciate Ligament deficiency can be effective in allowing athletes to finish seasons in very specific roles in certain sports. The patient’s knee will still be unstable and will have moments of the knee “giving out.”