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Treatment after anterior cruciate ligament injury: Panther Symposium ACL Treatment Consensus Group

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Abstract: Treatment strategies for anterior cruciate ligament (ACL) injuries continue to evolve. Evidence supporting best practice guidelines for the management of ACL injury is to a large extent based on studies with low-level evidence. An international consensus group of experts was convened to collaboratively advance towards consensus opinions regarding the best available evidence on operative versus non-operative treatment for ACL injury. The purpose of this study was to report the consensus statements on operative versus non-operative treatment of ACL injuries developed at the ACL Consensus Meeting Panther Symposium 2019. Sixty-six international experts on the management of ACL injuries, representing 18 countries, convened and participated in a process based on the Delphi method of achieving consensus. Proposed consensus statements were drafted by the Scientific Organising Committee and Session Chairs for the three working groups. Panel participants reviewed preliminary statements prior to the meeting and provided initial agreement and comments on the statement via online survey. During the meeting, discussion and debate occurred for each statement, after which a final vote was then held. Eighty per cent agreement was defined a priori as consensus. A total of 11 of 13 statements on operative versus non-operative treatment of ACL injury reached consensus during the symposium. Nine statements achieved unanimous support; two reached strong consensus; one did not achieve consensus; and one was removed due to redundancy in the information provided. In highly active patients engaged in jumping, cutting and pivoting sports, early anatomical anterior cruciate ligament reconstruction (ACLR) is recommended due to the high risk of secondary meniscus and cartilage injuries with delayed surgery, although a period of progressive rehabilitation to resolve impairments and improve neuromuscular function is recommended. For patients who seek to return to straight plane activities, non-operative treatment with structured, progressive rehabilitation is an acceptable treatment option. However, with persistent functional instability or when episodes of giving way occur, anatomical ACLR is indicated. The consensus statements derived from international leaders in the field will assist clinicians in deciding between operative and non-operative treatment with patients after an ACL injury. Level of evidence: V.

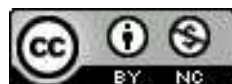
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Treatment after anterior cruciate ligament injury: Panther Symposium ACL Treatment Consensus Group

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ABSTRACT

Treatment strategies for anterior cruciate ligament (ACL) injuries continue to evolve. Evidence supporting best practice guidelines for the management of ACL injury is to a large extent based on studies with low-level evidence. An international consensus group of experts was convened to collaboratively advance towards consensus opinions regarding the best available evidence on operative versus non-operative treatment for ACL injury.

The purpose of this study was to report the consensus statements on operative versus non-operative treatment of ACL injuries developed at the ACL Consensus Meeting Panther Symposium 2019. Sixty-six international experts on the management of ACL injuries, representing 18 countries, convened and participated in a process based on the Delphi method of achieving consensus. Proposed consensus statements were drafted by the Scientific Organising Committee and Session Chairs for the three working groups. Panel participants reviewed preliminary statements prior to the meeting and provided initial agreement and comments on the statement via online survey. During the meeting, discussion and debate occurred for each statement, after which a final vote was then held. Eighty per cent agreement was defined a priori as consensus. A total of 11 of 13 statements on operative versus non-operative treatment of ACL injury reached consensus during the symposium. Nine statements achieved unanimous support; two reached strong consensus; one did not achieve consensus; and one was removed due to redundancy in the information provided.

In highly active patients engaged in jumping, cutting and pivoting sports, early anatomical anterior cruciate ligament reconstruction (ACLR) is recommended due to the high risk of secondary meniscus and cartilage injuries with delayed surgery, although a period of progressive rehabilitation to resolve impairments and improve neuromuscular function is recommended. For patients who seek to return to straight plane activities, non-operative treatment with structured, progressive rehabilitation is an acceptable treatment option. However, with persistent functional instability or when episodes of giving way occur, anatomical ACLR is indicated. The consensus statements derived from international leaders in the field will assist clinicians in deciding between operative and non-operative treatment with patients after an ACL injury.

Level of evidence: V

INTRODUCTION

Anterior cruciate ligament (ACL) injuries are one of the most common injuries of the knee, with an incidence of approximately 85 per 100 000 in patients aged between 16 and 39 years.¹⁻³ The ACL is the primary stabiliser of the knee limiting anterior tibial translation and internal rotation, with deficiency resulting in anterior and rotatory instability.^{4,5} The most common mode of injury is a non-contact mechanism during pivoting, cutting and jumping, with the knee slightly flexed and in a valgus position.^{6,7}

Both operative and non-operative treatments of an ACL injury continue to evolve.⁸⁻¹¹ Improved understanding of the structure and function of the native ACL has supported the development and adoption of anatomical ACLR techniques.³ In parallel, increased recognition of the resilience of the neuromuscular system in achieving dynamic, functional knee stability despite ACL deficiency has concurrently supported non-operative treatment as a viable strategy in some patients.^{12,13}

Successful outcomes following both operative and non-operative treatments necessitate progressive rehabilitation, which entails staged and phase-adjusted physical therapy with the aim to address impairments, achieve functional stability and safely return to sport.¹⁴ The acute phase after the injury or surgery focuses on the elimination of residual symptoms (effusion and pain) and impairments (range of motion, quadriceps activation and strength). Subsequently, neuromuscular and perturbation trainings are implemented to improve knee stabilisation.^{15,16} The last phase aims to further optimise muscular strength, return to pre-injury sports level through sport-specific exercises, and assess psychological readiness for the return to sport.¹⁷ Any discussion of non-operative treatment within this consensus document implies the completion of a progressive, staged rehabilitation protocol.

Similarly, any discussion of operative treatment implies anatomical ACLR (table 1), which intends to restore the ACL to its native dimensions, collagen orientation and insertion sites.¹⁸

Anatomical ACLR includes both single-bundle and double-bundle techniques, followed by a progressive rehabilitation programme that considers the natural healing cascade and ligamentisation of the graft.¹⁹ Following fixation during ACLR, a biological graft transitions from a tendon to a structure



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Table 1 Anatomical ACLR checklist based on 'evidence to support the interpretation and use of the Anatomical Anterior cruciate Ligament Reconstruction Checklist'⁹⁰

1	Individualisation of surgery for each patient
2	Use of 30 scopes
3	Use of an accessory medial portal
4	Direct visualisation of the femoral insertion site
5	Measuring the femoral insertion site dimensions
6	Visualising the lateral intercondylar ridge
7	Visualising the lateral bifurcate ridge
8	Placing the femoral tunnel(s) in the femoral ACL insertion site
9	Transportal drilling
10	Direct visualisation of the tibial insertion site
11	Measuring the tibial insertion site dimensions
12	Placing the tibial tunnels in the tibial ACL insertion site
13	Femoral fixation
14	Tibial fixation
15	Knee flexion angle during femoral tunnel drilling
16	Graft type
17	Graft tensioning

ACL, anterior cruciate ligament; ACLR, anterior cruciate ligament reconstruction.

with ultrastructural, biochemical and mechanical properties more similar to the native ACL.²⁰ These properties of the graft depend on the phase of ligamentisation, with the minimum graft strength occurring between 4 and 12 weeks postoperative.^{19 20} Comprehensive rehabilitation after operative ACLR is also paramount for clinical outcome and return to sports.

Whereas operative treatment aims to reduce laxity, non-operative treatments aim to reduce functional instability, and both thereby prevent further damage to the menisci and cartilage, which may contribute to post-traumatic osteoarthritis (PTOA).^{21 22} Functional bracing, intended to reduce the risk of ACL injury by decreasing peak ligament strain, has not yet been conclusively shown to achieve this goal, as the evidence is still limited.^{23 24}

There is still uncertainty as to which patients should undergo immediate surgery and which patients may be successfully treated non-operatively. Three different patient responses after ACL injury have been described: (1) a copers can return to the preinjury level without surgery and subjective instability; (2) an adapter reduces his/her level of activity to avoid subjective instability; (3) a non-coper cannot return to preinjury activity level due to subjective instability and episodes of giving way.²⁵ A screening tool to differentiate potential copers from non-copers was developed and included a combination of hop tests, questionnaires on general knee function and the frequency of giving-way episodes.^{26 27} Patients categorised as potential copers thereafter participated in structured progressive rehabilitation with additional perturbation training.^{15 16} Regardless of this three response concept, there is a strong historical view that the treatment approach should be determined through a shared decision-making process between the patient and the provider.²⁸ In particular, the physician should share information on the evidence-based treatment options while also considering the patient's expectations and goals. While the patient and provider are the primary stakeholders in the shared decision-making process, the potential influence of secondary stakeholders, such as family and coaches, should be anticipated so as to minimise interests potentially conflicting with the health of the patient.

Taken as a whole, the current body of evidence regarding the treatment of ACL injury is to a large extent based on low-level of evidence. Therefore, an international, multidisciplinary group of experts was assembled to develop expert-based and evidence-based consensus statements to assist clinicians in managing this difficult pathology. The purpose of this article was to report the results of the consensus group addressing the best available evidence on operative versus non-operative treatment of ACL injury that were developed at the 2019 Panther Symposium ACL Consensus Meeting.

METHODS

An international and multidisciplinary group of experts of ACL injury, including orthopaedic surgeons, sports medicine physicians, physical therapists and scientists, convened in a 1-year consensus-building effort, which culminated in the consensus meeting, at the University of Pittsburgh, Pennsylvania, USA (figure 1).

The symposium included experts from 18 countries, spanning six continents. Experts were assigned to one or more, of the three consensus groups defined by a specific subtopic within ACL injury. The operative versus non-operative treatment consensus group consisted of 34 participants. A modified Delphi method was used to develop the consensus statements.

The scientific organising committee and session chairs proposed a series of statements on the basis of a literature review. These were drafted with the aim of addressing areas of current controversy within the treatment of ACL injury, intended to assist clinicians in the management of this injury. Prior to the meeting, the proposed statements were presented to the panelists via web-based survey. Each panellist indicated the extent of agreement or disagreement with each statement and was asked to provide comments on each statement. On the third day of the 2019 Panther Symposium, after 2 days of presentations by symposium delegates on current knowledge, a consensus discussion was held.

A total of 13 statements on the operative versus non-operative treatment of ACL injury were discussed. The session was moderated by two experts (LE and ADL). Initial results and comments from the web-based survey were presented for each statement followed by discussion, debate and revision by the working group. Consensus was determined by show of hands. Satisfactory consensus was defined as 80% agreement. Opposing views were documented and discussed. Statements with less than 80% agreement were included in the consensus paper, noting the percentage of agreement. Statements felt to be irrelevant or redundant were excluded from this final paper.

This consensus group was assigned two liaisons (TD and BBR) who were responsible for amending each statement as requested over the course of the discussion. Liaisons transcribed the discussion and subsequently completed a literature review of MEDLINE for each finalised statement. To reduce the potential for bias in the data analysis and/or literature review, liaisons did not submit answers to the online questionnaire nor did they partake in the voting process.

RESULTS

Of the 13 statements discussed by this working group, 9 achieved unanimous consensus; 2 achieved non-unanimous consensus; 1 did not achieve consensus; and 1 was excluded due to redundancy in the information provided (table 2). The 12 finalised statements, with supporting literature, are as follows.

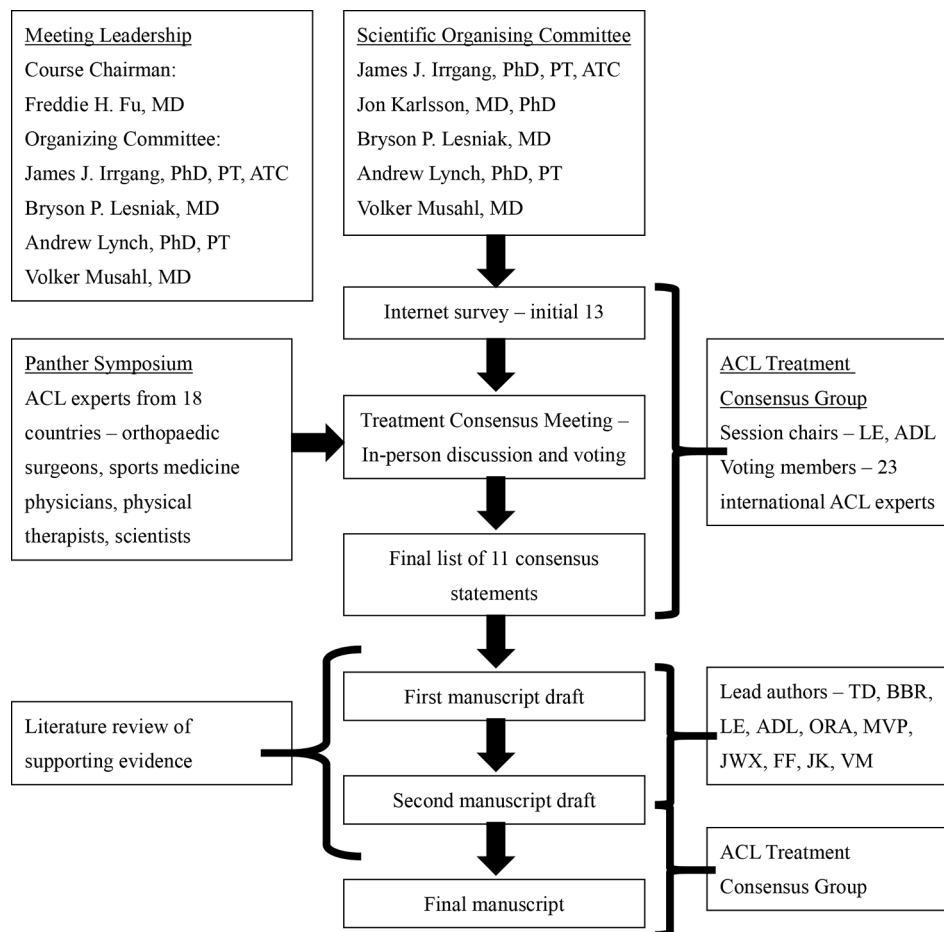


Figure 1 ACL Consensus Meeting Panther Symposium 2019. ACL, anterior cruciate ligament.

Table 2 Consensus statements on non-operative and operative treatment of ACL injury		
	Agreed statements	Agreement
1	Operative and non-operative treatments are both acceptable treatment options for ACL injury.	100%
2	Operative versus non-operative treatment should be reached via a shared decision-making process that considers the patient’s presentation, goals and expectations, as well as a balanced presentation of the available evidence-based literature.	82.6%
3	The (injury) status of other stabilising and supporting structures (eg, meniscus, other ligaments and cartilage) affects the decision to pursue operative or non-operative treatment.	100%
4	Individual anatomical differences (eg, tibial slope, femoral morphology and alignment) may affect the stability of the knee after ACL injury and should be considered in the decision-making process for operative versus non-operative treatment.	95.7%
5	After an ACL injury, patients may be offered a period of progressive rehabilitation to improve impairments and to improve overall function.	100%
6	Individuals presenting with instability in their desired activity despite optimal rehabilitation should be referred for operative treatment.	100%
7	Development of osteoarthritis after an ACL injury is multifactorial and evidence is inconclusive following operative or non-operative treatment.	100%
8	In active patients wishing to return to jumping, cutting and pivoting sports (eg, soccer, football, handball and basketball), operative treatment is the preferred option to maintain athletic participation in the medium to long term (1–5+ years after injury).	100%
9	In active patients wishing to return to jumping, cutting and pivoting sports (eg, soccer, football, handball and basketball), return to cutting and pivoting sports without surgery places the knee at risk of secondary injury (meniscus and cartilage).	100%
11	In active patients wishing to return to straight plane activities (eg, running, cycling, swimming and weightlifting), non-operative treatment is an option.	100%
12	In active patients wishing to return to straight plane activities (eg, running, cycling, swimming and weightlifting), in the case of persistent instability in daily life, operative treatment is appropriate for a return to non-rotational activities.	100%
	Not agreed statement	
10	In active patients wishing to return to cutting and pivoting sports (eg, soccer, football, handball and basketball), delayed operative treatment may be an option for temporary return to athletic participation following non-operative treatment accepting the risk of additional injury.	43.4%

ACL, anterior cruciate ligament.

Operative and non-operative treatments are both acceptable treatment options for ACL injury.

Agree 23/23, 100%

After ACL injury, some patients are able to regain good functional knee stability following non-operative treatment entailing progressive rehabilitation and are able to return to preinjury sports activity level without an ACLR (copers),^{29 30} but the identification of these patients has been challenging.³¹ In a prospective study, the combination of hop tests, muscle strength, subjective instability (episodes of giving way) and knee function was found to be a moderate predictive tool for identification of potential copers.^{10 26 27 30} A randomised controlled trial comparing operative and non-operative treatments in 121 young active, non-elite patients with isolated ACL tears demonstrated no superiority of either treatment with regard to patient-reported outcomes at follow-up of 2 and 5 years.^{8 9} However, almost 40% of the patients who were initially assigned to the non-operative treatment group required delayed ACLR, and 32% of the patients (29 menisci in 19 patients) had subsequent surgery for meniscal pathology during the 2-years follow-up period. In contrast, 34 patients (56%) who underwent early ACLR also had meniscus treatment (24 partial resection, 10 fixation) simultaneous with the ACLR, but only 10% (6 meniscal injuries in five patients) in the operatively treated group had meniscal injuries that required surgical treatment during follow-up.⁸ With regard to knee laxity, as measured by KT-1000 and pivot shift test, non-operative treatment resulted in a larger anterior tibial translation (9.0mm vs 6.6mm) and higher rate of rotatory laxity (positive pivot shift test: 78% vs 25%). A matched-paired study based on the Swedish National ACL registry comparing operative and non-operative treatments after ACL injury reported superior results for quality of life, knee function and symptoms at follow-up of 1, 2 and 5 years for ACLR compared with non-operative treatment.³² Another prospective trial with highly active patients included 832 patients at baseline with subacute ACL tear, whereas 345 patients were initially screened for possibility of non-operative treatment. Based on the results of various hop tests, subjective instability and general knee function, 146 patients were classified as potential copers, at final follow-up after 10 years, only 25 patients had not undergone ACLR.¹⁰

Conclusion: Operative and non-operative are both acceptable treatment options after ACL injury, and a decision based on concomitant injuries, risk factors, level of activity and patient's expectations and goals is recommended as demonstrated in the following statements.

Operative versus non-operative treatment should be reached via a shared decision-making process that considers the patient's presentation, goals and expectations, as well as a balanced presentation of the available evidence-based literature.

Agree 19/23, 82.6%

Before a particular treatment approach is pursued, the provider (physician and/or physical therapist) should present the evidence for operative and non-operative treatment options for an ACL injury to the patient. Based on the patient's activity level, goals and expectations, a decision should be made with the patient (and parents/guardians for minors) and provider as the primary stakeholders.²⁸ Physicians and physical therapists must be aware that personal and situational factors, such as level of competition, time in season, playing status and role in the team, could affect the injured athletes' treatment decision. Parents and coaches are often the first individuals from whom athletes seek support or advise.³³ However, the coach may be conflicted by the interests of the

team and the athlete's immediate and future health.^{34 35} For some athletes, reactions and comments of parents related to the athlete's injury were reported to negatively affect the athlete's treatment decision, with pressure to return to sport.³³ Due to the possible conflict of interest, secondary stakeholders such as family, coaches and agents, among others, should not be directly involved in the decision-making process, although their indirect involvement may be considered.

Conclusion: Shared decision-making of the treatment option should be based on the evidence for operative and non-operative treatments, patient's expectations and goals with the provider and patient as the primary stakeholders.

The (injury) status of other stabilising and supporting structures (eg, meniscus, other ligaments and cartilage) affects the decision to pursue operative or non-operative treatment.

Agree 23/23, 100%

ACL injuries often occur together with concomitant injury to other knee structures, with meniscal injuries reported in 23%–42%, cartilage lesions in 27%, and combined meniscal and chondral lesions in 15% of cases (figure 2).^{32 36 37}

However, most studies investigating non-operative ACL treatment or studies comparing non-operative and operative treatment are limited to isolated ACL tears.^{8–10} Based on clinical and biomechanical studies, an ACLR with concomitant meniscus repair may restore knee kinematics and results in improved patient-reported outcomes at short-term and long-term follow-ups.^{38–41} In contrast, simultaneously performed meniscectomy with ACLR is associated with poorer clinical outcome, inferior knee kinematics and a high rate (48%–100%) of osteoarthritis in the long-term follow-up.^{42–46} In case of delayed ACLR, a meniscectomy is more often performed than a meniscus repair.⁴⁷ The presence of concomitant knee injuries should therefore always be considered in the decision-making process, given the worse outcomes for meniscus injuries with delayed ACLR and higher rate of osteoarthritis in the long-term follow-up. In case of concomitant meniscus injury repair, anatomical ACLR with additional treatment of the meniscus injury is recommended.

In case of multiple ligament injuries involving the ACL and at least one other ligament, the literature has consistently demonstrated that operative management is superior to non-operative management.^{48–50} Based on a recent systematic review, early (within 3 weeks after injury) reconstruction in a multiple ligament-injured knee was superior to delayed reconstruction with regard

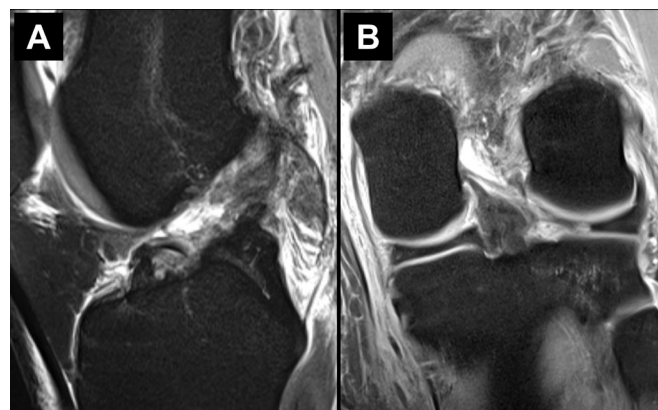


Figure 2 As seen in T2 MRI sequences, the patient sustained a (A) complete anterior cruciate ligament rupture and (B) associated lateral meniscus root tear.

to clinical outcome measurements (Lysholm score, 90 vs 82 out of 100 points) and resulted in higher rate of excellent/good International Knee Documentation Committee (IKDC) scores (47% vs 31%).⁴⁹ Although failure after ligament reconstruction is not consistently defined in the literature (ie, the need for revision vs objective laxity vs rerupture on imaging vs Knee injury and Osteoarthritis Outcome Score (KOOS) score < 44), the failure rate in a multiple ligament-injured knee is lower for reconstruction (6%–9%) compared with repair techniques (37%–40%).^{11 51}

Conclusion: The presence of a repairable meniscal lesion or a multiple ligament injury is an indication for an early anatomical ACLR with concomitant treatment of the other injured structures (meniscus repair and ligament repair/augmentation).

Individual anatomical differences (eg, tibial slope, femoral morphology and alignment) may affect the stability of the knee after ACL injury and should be considered in the decision-making process for operative versus non-operative treatment.

Agree 22/23, 95.7%

Bony morphology and soft tissue injury patterns have been demonstrated to influence knee joint laxity. An increased posterior tibial slope is associated with increased anterior tibial translation, as well as with increased rotatory instability (figure 3).^{52 53} In addition, an increased lateral femoral condyle ratio resulted in increased rotatory instability.^{54 55} Severe varus limb alignment (>5°) was demonstrated to increase the risk for more rapid degeneration of the medial compartment in the ACL-deficient knee and is also a risk factor for secondary failure after an ACLR.^{56 57} Whereas lateral meniscus tears and a complete lateral meniscectomy result in increased rotatory instability,^{58 59} a complete medial meniscectomy more strongly affects anterior tibial translation. However, general joint laxity (Beighton hypermobility score > 4) is not associated with increased rotatory laxity in the ACL-deficient knee.⁶⁰

Conclusion: Bony morphology features (increased posterior tibial slope and severe varus limb alignment) and concomitant injuries associated with increased or persistent knee instability should be considered in the decision-making process and are a relative indication for operative treatment.

After an ACL injury, patients may be offered a period of progressive rehabilitation to improve impairments and improve overall function.

Agree 23/23, 100%

Knee joint effusion, limited range of motion and decreased quadriceps strength in the injured leg are common impairments initially after an ACL injury.^{61 62} Effusion can limit quadriceps

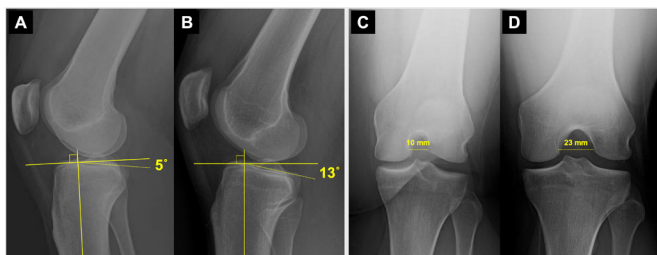


Figure 3 (A,B) Posterior tibial slope varies among patients, with greater slope increasing the risk of failure following ACLR. (C,D) Notch dimensions vary among patients, with small notch width dimensions constituting a relative contraindication for double-bundle ACLR. ACLR, anterior cruciate ligament reconstruction.

function and in turn affect knee joint mechanics.⁶³ Progressive rehabilitation is useful in treating these initial impairments.¹⁰ In patients with the possibility for non-operative treatment (absence of concomitant meniscus injuries or multiligament injuries requiring surgical treatment) before the evaluation of knee instability, a phase of rehabilitation is recommended to treat the initial impairments. Afterwards evaluation by hop tests, assessment of strength, overall knee function and subjective instability is recommended to quantify the patients' potential for non-operative treatment. If progressive rehabilitation does not provide a satisfactory outcome, then operative intervention needs to be pursued and the progressive rehabilitation will have enhanced the postsurgical outcome.⁶⁴ In a cohort study with 2187 patients after resolution of impairments, one group was treated with neuromuscular training (ie, strengthening and neuromuscular training) before ACLR and was compared with immediate ACLR. At 2 years of follow-up, preoperative progressive rehabilitation before ACLR resulted in better patient-reported outcome (KOOS and IKDC), compared with ACLR without preoperative rehabilitation.⁶⁴ Whereas 63% of the patients without preoperative rehabilitation returned to sport at 2 years of follow-up, which is similar to the reported rate (65%) in a meta-analysis from 2016, the rate increased to 72% in the group that completed preoperative rehabilitation.⁶⁴

Conclusion: Preoperative resolution of impairments and a period of rehabilitation is recommended for operative and non-operative treatments.

Individuals presenting with instability in their desired activity despite optimal rehabilitation should be referred for operative treatment.

Agree 23/23, 100%

Persistent instability is a risk factor for further damage to the meniscus and cartilage.⁶⁵ Although the definitions of recurrent instability and episodes of instability vary in current literature, a correlation between persistent and recurrent instability after ACL injury and meniscus and cartilage lesions has been demonstrated in several studies.^{66–68} In a cohort study of 62 patients with acute ACLRs, 37 with subacute ACLRs and 36 with chronic ACLRs, one episode of giving way was associated with a three-fold higher odds for lateral meniscus tears. Timing of surgery and episodes of instability influenced the incidence of lateral meniscus tears with 1.45 higher odds in subacute (6–12 weeks) ACLR and 2.82 higher odds in chronic (>12 weeks) ACLR.⁶⁷ Moreover, frequent episodes of instability are correlated with medial meniscus tears and chondral injuries.⁶⁸ Chondral defects and meniscectomy have been demonstrated as predictive factors for the development of osteoarthritis after ACLR.^{69 70}

A partial ACL injury progressed to a complete ACL tear in 39% of young active patients treated non-operatively, with half of the complete tears presenting with a concomitant meniscal lesion at the time of reconstruction. Age ≤ 20 years and participation in pivoting contact sports were identified as significant risk factors for progression to a complete tear.⁷¹

Conclusion: If patient-reported instability or severe episodes of giving way occur during the progressive rehabilitation, patients should be referred for anatomical ACLR.

Development of osteoarthritis after an ACL injury is multifactorial, and evidence is inconclusive following operative or non-operative treatment.

Agree 23/23, 100%

Osteoarthritis is the most common joint disease affecting not only the cartilage but also all other tissues of the joint as well.⁷² The pathomechanism of PTOA has not been fully elucidated, but based on current research, the process of development of osteoarthritis is multifactorial.⁷² Injuries, like ACL ruptures, can affect the joint biomechanics and cause chondral and meniscal lesions, and thereby reduce the sustainability of the joint. Matrix metalloproteases are responsible for cartilage destruction and synovial inflammation, and have been shown to be elevated following ACL injury and reconstruction.^{73,74} A meta-analysis of 24 observational studies found a fourfold increased risk for PTOA after knee injuries, although the definition of an injury was largely heterogeneous among the analysed studies.⁷⁵ After ACL injury, the prevalence of PTOA is increased after both operative and non-operative treatments as compared with those without injury.^{22,76–78} Based on a recent systematic review with 41 included studies, the rate of OA after ACLR varied between 1% and 80%, with meniscectomy as the consistent risk factor for the development of OA.⁷⁹ Although long-term outcome studies after ACLR are available, the technique has evolved in recent years, with a shift from non-anatomical ACLR to anatomical ACLR, limiting conclusions on the possible protective effect of anatomical ACLR.

Conclusion: Osteoarthritis after ACL injury is seen after both operative and non-operative treatments. Therefore, there is still a need for prospective, randomised controlled trials to evaluate the hypothesised preventative effect of anatomical ACLR on the development of PTOA.

In active patients wishing to return to jumping, cutting and pivoting sports (eg, soccer, football, handball and basketball), operative treatment is the preferred option to maintain athletic participation in the medium to long term (1–5+ years after injury).

Agree 23/23, 100%

In active patients wishing to return to pivoting and cutting sports, ACLR is the preferred treatment option to maintain participation in the medium to long term. However, overall, only 65% of patients return to their preinjury sports level after ACLR, and only 55% return to competitive level sport.⁸⁰ Although the exact reasons are still unknown, younger age, male gender, professional sports level and positive psychological response were demonstrated to be associated with a successful return to preinjury sports level after ACLR. In general, elite athletes return to their preinjury level of sports after ACLR more often than recreational athletes.^{81,82} For instance, over 90% of elite soccer players were reported to return to the preinjury level after ACLR.⁸¹ Similarly, in a recent systematic review, the return to sport rate in elite football and basketball players was 78% and 82%, respectively.⁸² In contrast only 12.8% of high-level athletes returned to the preinjury sports level with non-operative treatment, with a high rate of secondary meniscus and cartilage damage; after 20 years, 95% of the patients underwent meniscectomy, during which 68% of patients were found to have chondral lesions.^{26,83} Overall, athletes returned to their preinjury sports level between 6 and 13 months after ACLR.⁸²

Conclusion: In active patients, anatomical ACLR is the preferred treatment due to the higher rate of return to preinjury sports level.

In active patients wishing to return to jumping, cutting and pivoting sports (eg, soccer, football, handball and basketball), return to cutting and pivoting sports without surgery places the knee at risk of secondary injury (meniscus and cartilage).

Agree 23/23, 100%

In a prospective randomised controlled trial, patients with high activity level (median Tegner activity score of 9) with isolated ACL tears received early operative treatment or non-operative treatment with the option of delayed ACLR. Although no differences were evident for patient-reported outcomes, at 2-year follow-up, patients in the ‘optional’ operative treatment group had more self-reported and clinical laxity of the involved knee and more meniscal surgery over a 5-year follow-up period.⁸ In a separate cohort, the risk for sustaining at least one additional intra-articular injury increased by 0.6%, with each month of delay in operative treatment.⁸⁴ The odds of secondary cartilage lesions increased by nearly 1% for each month of delay.⁸⁵ A delay in ACLR of at least 12 months almost doubled the risk for meniscal tears.^{84,86} Increased risk of secondary injury is especially noted in young (<12 years) and skeletally immature patients.⁶⁷

Conclusion: Non-operative treatment increases the risk of secondary injuries if the patient wants to return to jumping, cutting and pivoting sports, due to the increased risk of further episodes of instability.

In active patients wishing to return to cutting and pivoting sports (eg, soccer, football, handball and basketball), delayed operative treatment may be an option for temporary return to athletic participation following non-operative treatment accepting the risk of additional injury.

Agree 10/23, 43.4%

No consensus was reached for this statement. Some professional athletes and active patients want to delay ACLR in order to temporarily return to athletic participation (competition). Based on current evidence, the risk of secondary damage to the knee (eg, meniscus and cartilage) is high, especially in high-demand sports with jumping, cutting and pivoting. In a recent cross-sectional study, 860 patients were included with 47.2% being professional athletes. With regard to prevalence of meniscus tears, medial, lateral and combined lesions were found more often with increasing time from injury (TFI) to surgery (medial meniscus tear prevalence at TFI of 0–36 weeks was 48.2% and that of >61 weeks was 59.3%). Not only did the prevalence of injury increase with time but also the rate of meniscectomy increased (medial meniscectomy at TFI of 0–36 weeks was 7.5% and that at TFI of >61 weeks was 12.8%).⁸⁷

Conclusion: Delayed ACLR in active patients may be a treatment option, but the provider, as well as the patient, must be aware of the risk of secondary injuries with worse long-term outcomes.

In active patients wishing to return to straight plane activities (eg, running, cycling, swimming and weightlifting), non-operative treatment is an option.

Agree 23/23, 100%

Straight plane activities are less demanding on the ligamentous stabilisers of the knee and therefore are amenable to non-operative treatment. The anteroposterior stability during straight plane activities might be maintained by muscular control, but coronal and rotational stability could not be compensated.⁸⁸ With specific neuromuscular training (perturbation training) additional to standard rehabilitation unphysiological muscular co-contractions during walking can be minimised and normalise the knee kinematics in the ACL deficient knee.¹⁵ In a matched paired study non-operative treatment resulted in an earlier return (non-operative 3–4 months vs operative 6–12 months) and a higher return to level II sports (non-operative 88.9%

vs operative 77.8%) as compared with operative treatment.³⁰ Another study demonstrated a significantly higher number of non-operative treated patients returned to level II and level III sports compared with operative treatment.²⁹

Conclusion: For return to straight plane activities, non-operative treatment is an option.

In active patients wishing to return to straight plane activities (eg, running, cycling, swimming and weight-lifting), in the case of persistent instability in daily life, operative treatment is appropriate for a return to non-rotational activities.
Agree 23/23, 100%

Straight plane activities are less demanding to the ligamentous stabilisers of the knee and are therefore amenable to non-operative treatment. If during the non-operative treatment, subjective instability persists or episodes of giving way occur, referral for consideration of anatomical ACLR is recommended.⁸⁻⁹ Moreover, current evidence for the efficacy of non-operative treatment is limited to isolated ACL tears.

Conclusion: Based on current evidence, persistent instability in activities of daily living is an indication for anatomical ACLR to restore knee laxity and prevent secondary injuries.

CONCLUSION

The expert panel at the ACL Consensus Meeting Panther Symposium 2019 reached consensus, defined as >80% agreement, on 11 of 12 statements in terms of operative versus non-operative treatment for ACL injuries. Consensus was reached that both treatment options may be acceptable, depending on patient characteristics, including the type of sporting demands and the presence of concomitant injuries. In highly active patients engaged in jumping, cutting and pivoting sports, early anatomical ACLR is recommended due to the high risk of secondary meniscus and cartilage injuries with delayed surgery, although a period of progressive rehabilitation to resolve impairments and improve neuromuscular function may be recommended. For patients who want to return to straight plane activities, non-operative treatment with structured, progressive rehabilitation is an acceptable treatment option. However, with persistent functional instability or when episodes of giving way occur, anatomical ACLR is indicated.

Despite strong consensus by experts, there is a need for larger randomised trials with longer-term follow-up in which early surgery (followed by rehabilitation) is compared with a strategy of early rehabilitation and delayed surgery. There are insufficient data to guide treatment in instances when there are concomitant meniscal and collateral ligament injuries. Data on long-term clinical outcomes are needed to better understand the effect of ACL treatment of injuries, subsequent injuries to meniscus and cartilage, and the development of osteoarthritis.

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REFERENCES

- Lynch TS, Parker RD, Patel RM, *et al*. The impact of the multicenter orthopaedic outcomes network (moon) research on anterior cruciate ligament reconstruction and orthopaedic practice. *J Am Acad Orthop Surg* 2015;23:154–63.
- Kaeding CC, Léger-St-Jean B, Magnussen RA. Epidemiology and diagnosis of anterior cruciate ligament injuries. *Clin Sports Med* 2017;36:1–8.
- Granan L-P, Bahr R, Steindal K, *et al*. Development of a national cruciate ligament surgery registry: the Norwegian national knee ligament registry. *Am J Sports Med* 2008;36:308–15.
- Zantop T, Herbort M, Raschke MJ, *et al*. The role of the anteromedial and posterolateral bundles of the anterior cruciate ligament in anterior tibial translation and internal rotation. *Am J Sports Med* 2007;35:223–7.
- Musahl V, Kopf S, Rabuck S, *et al*. Rotatory knee laxity tests and the pivot shift as tools for ACL treatment algorithm. *Knee Surg Sports Traumatol Arthrosc* 2012;20:793–800.
- Boden BP, Dean GS, Feagin JA, *et al*. Mechanisms of anterior cruciate ligament injury. *Orthopedics* 2000;23:573–8.
- Alentorn-Geli E, Myer GD, Silvers HJ, *et al*. Prevention of non-contact anterior cruciate ligament injuries in soccer players. Part 1: mechanisms of injury and underlying risk factors. *Knee Surg Sports Traumatol Arthrosc* 2009;17:705–29.
- Frobell RB, Roos EM, Roos HP, *et al*. A randomized trial of treatment for acute anterior cruciate ligament tears. *N Engl J Med* 2010;363:331–42.
- Frobell RB, Roos HP, Roos EM, *et al*. Treatment for acute anterior cruciate ligament tear: five year outcome of randomised trial. *BMJ* 2013;346:f232.
- Hurd WJ, Axe MJ, Snyder-Mackler L. A 10-year prospective trial of a patient management algorithm and screening examination for highly active individuals with anterior cruciate ligament injury: Part 2, determinants of dynamic knee stability. *Am J Sports Med* 2008;36:48–56.
- Stannard JP, Brown SL, Farris RC, *et al*. The posterolateral corner of the knee: repair versus reconstruction. *Am J Sports Med* 2005;33:881–8.

- 12 Fu FH, van Eck CF, Tashman S, et al. Anatomic anterior cruciate ligament reconstruction: a changing paradigm. *Knee Surg Sports Traumatol Arthrosc* 2015;23:640–8.
- 13 Eitzen I, Moksnes H, Snyder-Mackler L, et al. A progressive 5-week exercise therapy program leads to significant improvement in knee function early after anterior cruciate ligament injury. *J Orthop Sports Phys Ther* 2010;40:705–21.
- 14 Paterno MV. Non-Operative care of the patient with an ACL-Deficient knee. *Curr Rev Musculoskelet Med* 2017;10:322–7.
- 15 Chmielewski TL, Hurd WJ, Rudolph KS, et al. Perturbation training improves knee kinematics and reduces muscle co-contraction after complete unilateral anterior cruciate ligament rupture. *Phys Ther* 2005;85:740–9.
- 16 Fitzgerald GK, Axe MJ, Snyder-Mackler L. The efficacy of perturbation training in nonoperative anterior cruciate ligament rehabilitation programs for physical active individuals. *Phys Ther* 2000;80:128–40.
- 17 Ardern CL, Österberg A, Tagesson S, et al. The impact of psychological readiness to return to sport and recreational activities after anterior cruciate ligament reconstruction. *Br J Sports Med* 2014;48:1613–9.
- 18 van Eck CF, Lesniak BP, Schreiber VM, et al. Anatomic single- and double-bundle anterior cruciate ligament reconstruction flowchart. *Arthroscopy* 2010;26:258–68.
- 19 Pauzenberger L, Syré S, Schurz M. "Ligamentization" in hamstring tendon grafts after anterior cruciate ligament reconstruction: a systematic review of the literature and a glimpse into the future. *Arthroscopy* 2013;29:1712–21.
- 20 Scheffler SU, Unterhauser FN, Weiler A. Graft remodeling and ligamentization after cruciate ligament reconstruction. *Knee Surgery, Sports Traumatology, Arthroscopy* 2008;16:834–42.
- 21 van Yperen DT, Reijman M, van Es EM, et al. Twenty-Year follow-up study comparing operative versus Nonoperative treatment of anterior cruciate ligament ruptures in high-level athletes. *Am J Sports Med* 2018;46:1129–36.
- 22 Neuman P, Englund M, Kostogiannis I, et al. Prevalence of tibiofemoral osteoarthritis 15 years after nonoperative treatment of anterior cruciate ligament injury: a prospective cohort study. *Am J Sports Med* 2008;36:1717–25.
- 23 Hangalur G, Brenneman E, Nicholls M, et al. Can a knee brace reduce the strain in the anterior cruciate ligament? A study using combined in vivo/in vitro method. *Prosthet Orthot Int* 2016;40:394–9.
- 24 Sittler M, Ryan J, Hopkinson W, et al. The efficacy of a prophylactic knee brace to reduce knee injuries in football. A prospective, randomized study at West point. *Am J Sports Med* 1990;18:310–5.
- 25 Noyes FR, Matthews DS, Moor PA, et al. The symptomatic anterior cruciate-deficient knee. Part II: the results of rehabilitation, activity modification, and counseling on functional disability. *J Bone Joint Surg Am* 1983;65:163–74.
- 26 Fitzgerald GK, Axe MJ, Snyder-Mackler L. A decision-making scheme for returning patients to high-level activity with nonoperative treatment after anterior cruciate ligament rupture. *Knee Surg Sports Traumatol Arthrosc* 2000;8:76–82.
- 27 Noyes FR, Barber SD, Mangine RE. Abnormal lower limb symmetry determined by function hop tests after anterior cruciate ligament rupture. *Am J Sports Med* 1991;19:513–8.
- 28 Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). *Soc Sci Med* 1997;44:681–92.
- 29 Grindem H, Eitzen I, Engebretsen L, et al. Nonsurgical or surgical treatment of ACL injuries: knee function, sports participation, and knee Reinjury: the Delaware-Oslo ACL cohort study. *J Bone Joint Surg Am* 2014;96:1233–41.
- 30 Grindem H, Eitzen I, Moksnes H, et al. A pair-matched comparison of return to pivoting sports at 1 year in anterior cruciate ligament-injured patients after a nonoperative versus an operative treatment course. *Am J Sports Med* 2012;40:2509–16.
- 31 Thoma LM, Grindem H, Løgerstedt D, et al. Coper classification early after anterior cruciate ligament rupture changes with progressive neuromuscular and strength training and is associated with 2-year success: the Delaware-Oslo ACL cohort study. *Am J Sports Med* 2019;47:807–14.
- 32 Kvist J, Kartus J, Karlsson J, et al. Results from the Swedish national anterior cruciate ligament register. *Arthroscopy* 2014;30:803–10.
- 33 Nippert AH, Smith AM. Psychology stress related to injury and impact on sport performance. *Phys Med Rehabil Clin N Am* 2008;19:399–418.
- 34 Flint FA, Weiss MR. Returning injured athletes to competition: a role and ethical dilemma. *Can J Sport Sci* 1992;17:34–40.
- 35 Vergeer I, Hogg JM. Coaches' Decision Policies about the Participation of Injured Athletes in Competition. *Sport Psychol* 1999;13:42–56.
- 36 Cimino PM. The incidence of meniscal tears associated with acute anterior cruciate ligament disruption secondary to snow skiing accidents. *Arthroscopy* 1994;10:198–200.
- 37 Borchers JR, Kaeding CC, Pedroza AD, et al. Intra-Articular findings in primary and revision anterior cruciate ligament reconstruction surgery: a comparison of the moon and MARS study groups. *Am J Sports Med* 2011;39:1889–93.
- 38 Sarraj M, Coughlin RP, Solow M, et al. Anterior cruciate ligament reconstruction with concomitant meniscal surgery: a systematic review and meta-analysis of outcomes. *Knee Surg Sports Traumatol Arthrosc* 2019;27:3441–52.
- 39 Phillips M, Rönnblad E, Lopez-Rengsting L, et al. Meniscus repair with simultaneous ACL reconstruction demonstrated similar clinical outcomes as isolated ACL repair: a result not seen with meniscus resection. *Knee Surg Sports Traumatol Arthrosc* 2018;26:2270–7.
- 40 Lorbach O, Kiehl M, Domnick C, et al. Biomechanical evaluation of knee kinematics after anatomic single- and anatomic double-bundle ACL reconstructions with medial meniscal repair. *Knee Surg Sports Traumatol Arthrosc* 2015;23:2734–41.
- 41 Zaffagnini S, Signorelli C, Grassi A, et al. Anatomic anterior cruciate ligament reconstruction using hamstring tendons restores quantitative pivot shift. *Orthop J Sports Med* 2018;6:232596711881236.
- 42 Cohen M, Amaro JT, Ejinisman B, et al. Anterior cruciate ligament reconstruction after 10 to 15 years: association between meniscectomy and osteoarthritis. *Arthroscopy* 2007;23:629–34.
- 43 Magnussen R, Mansour A, Carey J, et al. Meniscus Status at Anterior Cruciate Ligament Reconstruction Associated with Radiographic Signs of Osteoarthritis at 5- to 10-Year Follow-Up – A Systematic Review. *J Knee Surg* 2009;22:347–57.
- 44 Wu WH, Hackett T, Richmond JC. Effects of meniscal and articular surface status on knee stability, function, and symptoms after anterior cruciate ligament reconstruction: a long-term prospective study. *Am J Sports Med* 2002;30:845–50.
- 45 Musahl V, Citak M, O'Loughlin PF, et al. The effect of medial versus lateral meniscectomy on the stability of the anterior cruciate ligament-deficient knee. *Am J Sports Med* 2010;38:1591–7.
- 46 Hertel P, Behrend H, Cierpinski T, et al. Acl reconstruction using bone-patellar tendon-bone press-fit fixation: 10-year clinical results. *Knee Surg Sports Traumatol Arthrosc* 2005;13:248–55.
- 47 Krutsch W, Zellner J, Baumann F, et al. Timing of anterior cruciate ligament reconstruction within the first year after trauma and its influence on treatment of cartilage and meniscus pathology. *Knee Surg Sports Traumatol Arthrosc* 2017;25:418–25.
- 48 Peskun CJ, Whelan DB. Outcomes of operative and nonoperative treatment of multiligament knee injuries: an evidence-based review. *Sports Med Arthrosc Rev* 2011;19:167–73.
- 49 Levy BA, Dajani KA, Whelan DB, et al. Decision making in the multiligament-injured knee: an evidence-based systematic review. *Arthroscopy* 2009;25:430–8.
- 50 Richter M, Bosch U, Wipperfurth B, et al. Comparison of surgical repair or reconstruction of the cruciate ligaments versus nonsurgical treatment in patients with traumatic knee dislocations. *Am J Sports Med* 2002;30:718–27.
- 51 Levy BA, Dajani KA, Morgan JA, et al. Repair versus reconstruction of the fibular collateral ligament and posterolateral corner in the multiligament-injured knee. *Am J Sports Med* 2010;38:804–9.
- 52 Rahnama-Azar AA, Abebe ES, Johnson P, et al. Increased lateral tibial slope predicts high-grade rotatory knee laxity pre-operatively in ACL reconstruction. *Knee Surg Sports Traumatol Arthrosc* 2017;25:1170–6.
- 53 Voos JE, Suero EM, Citak M, et al. Effect of tibial slope on the stability of the anterior cruciate ligament-deficient knee. *Knee Surg Sports Traumatol Arthrosc* 2012;20:1626–31.
- 54 Pfeiffer TR, Burnham JM, Hughes JD, et al. An increased lateral femoral condyle ratio is a risk factor for anterior cruciate ligament injury. *J Bone Joint Surg Am* 2018;100:857–64.
- 55 Pfeiffer TR, Burnham JM, Kanakamedala AC, et al. Distal femur morphology affects rotatory knee instability in patients with anterior cruciate ligament ruptures. *Knee Surg Sports Traumatol Arthrosc* 2019;27:1514–1519.
- 56 Noyes FR, Schipplein OD, Andriacchi TP, et al. The anterior cruciate ligament-deficient knee with varus alignment. An analysis of gait adaptations and dynamic joint loadings. *Am J Sports Med* 1992;20:707–16.
- 57 van de Pol GJ, Arnold MP, Verdonchot N, et al. Varus alignment leads to increased forces in the anterior cruciate ligament. *Am J Sports Med* 2009;37:481–7.
- 58 Musahl V, Rahnama-Azar AA, Costello J, et al. The influence of meniscal and anterolateral capsular injury on knee laxity in patients with anterior cruciate ligament injuries. *Am J Sports Med* 2016;44:3126–31.
- 59 Hoshino Y, Miyaji N, Nishida K, et al. The concomitant lateral meniscus injury increased the pivot shift in the anterior cruciate ligament-injured knee. *Knee Surg Sports Traumatol Arthrosc* 2019;27:646–651.
- 60 Sundemo D, Blom A, Hoshino Y, et al. Correlation between quantitative pivot shift and generalized joint laxity: a prospective multicenter study of ACL ruptures. *Knee Surg Sports Traumatol Arthrosc* 2018;26:2362–70.
- 61 Chmielewski TL, Stackhouse S, Axe MJ, et al. A prospective analysis of incidence and severity of quadriceps inhibition in a consecutive sample of 100 patients with complete acute anterior cruciate ligament rupture. *J Orthop Res* 2004;22:925–30.
- 62 Lynch AD, Løgerstedt DS, Axe MJ, et al. Quadriceps activation failure after anterior cruciate ligament rupture is not mediated by knee joint effusion. *J Orthop Sports Phys Ther* 2012;42:502–10.
- 63 Palmieri-Smith RM, Kreinbrink J, Ashton-Miller JA, et al. Quadriceps inhibition induced by an experimental knee joint effusion affects knee joint mechanics during a single-legged drop landing. *Am J Sports Med* 2007;35:1269–75.
- 64 Failla MJ, Løgerstedt DS, Grindem H, et al. Does extended preoperative rehabilitation influence outcomes 2 years after ACL reconstruction? A comparative effectiveness study between the moon and Delaware-Oslo ACL cohorts. *Am J Sports Med* 2016;44:2608–14.

- 65 Jonsson H, Riklund-Åhlström K, Lind J. Positive pivot shift after ACL reconstruction predicts later osteoarthritis in 63 patients followed 5–9 years after surgery. *Acta Orthop Scand* 2004;75:594–9.
- 66 Sommerfeldt M, Raheem A, Whittaker J, et al. Recurrent instability episodes and meniscal or cartilage damage after anterior cruciate ligament injury: a systematic review. *Orthop J Sports Med* 2018;6:232596711878650.
- 67 Anderson AF, Anderson CN. Correlation of meniscal and articular cartilage injuries in children and adolescents with timing of anterior cruciate ligament reconstruction. *Am J Sports Med* 2015;43:275–81.
- 68 Kluczynski MA, Marzo JM, Bisson LJ. Factors associated with meniscal tears and chondral lesions in patients undergoing anterior cruciate ligament reconstruction: a prospective study. *Am J Sports Med* 2013;41:2759–65.
- 69 Fairbank TJ. Knee joint changes after meniscectomy. *J Bone Joint Surg Br* 1948;30-B:664–70.
- 70 Keays SL, Newcombe PA, Bullock-Saxton JE, et al. Factors involved in the development of osteoarthritis after anterior cruciate ligament surgery. *Am J Sports Med* 2010;38:455–63.
- 71 Fayard J-M, Sonnery-Cottet B, Vrgoc G, et al. Incidence and risk factors for a partial anterior cruciate ligament tear progressing to a complete tear after Nonoperative treatment in patients younger than 30 years. *Orthop J Sports Med* 2019;7:232596711985662.
- 72 Glyn-Jones S, Palmer AJR, Agricola R, et al. Osteoarthritis. *The Lancet* 2015;386:376–87.
- 73 Vincent TL. Targeting mechanotransduction pathways in osteoarthritis: a focus on the pericellular matrix. *Curr Opin Pharmacol* 2013;13:449–54.
- 74 Troeberg L, Nagase H. Proteases involved in cartilage matrix degradation in osteoarthritis. *Biochim Biophys Acta* 2012;1824:133–45.
- 75 Muthuri SG, McWilliams DF, Doherty M, et al. History of knee injuries and knee osteoarthritis: a meta-analysis of observational studies. *Osteoarthritis Cartilage* 2011;19:1286–93.
- 76 Meuffels DE, Favejee MM, Vissers MM, et al. Ten year follow-up study comparing conservative versus operative treatment of anterior cruciate ligament ruptures. A matched-pair analysis of high level athletes. *Br J Sports Med* 2009;43:347–51.
- 77 Sanders TL, Kremers HM, Bryan AJ, et al. Is anterior cruciate ligament reconstruction effective in preventing secondary meniscal tears and osteoarthritis? *Am J Sports Med* 2016;44:1699–707.
- 78 Fithian DC, Paxton EW, Stone ML, et al. Prospective trial of a treatment algorithm for the management of the anterior cruciate ligament-injured knee. *Am J Sports Med* 2005;33:335–46.
- 79 Lie MM, Risberg MA, Storheim K, et al. What's the rate of knee osteoarthritis 10 years after anterior cruciate ligament injury? an updated systematic review. *Br J Sports Med* 2019;53:1162–7.
- 80 Ardern CL, Taylor NF, Feller JA, et al. Fifty-five per cent return to competitive sport following anterior cruciate ligament reconstruction surgery: an updated systematic review and meta-analysis including aspects of physical functioning and contextual factors. *Br J Sports Med* 2014;48:1543–52.
- 81 Waldén M, Hägglund M, Magnusson H, et al. Anterior cruciate ligament injury in elite football: a prospective three-cohort study. *Knee Surg Sports Traumatol Arthrosc* 2011;19:11–19.
- 82 Lai CCH, Ardern CL, Feller JA, et al. Eighty-three per cent of elite athletes return to preinjury sport after anterior cruciate ligament reconstruction: a systematic review with meta-analysis of return to sport rates, graft rupture rates and performance outcomes. *Br J Sports Med* 2018;52:128.
- 83 Nebelung W, Wuschech H. Thirty-Five years of follow-up of anterior cruciate ligament-deficient knees in high-level athletes. *Arthroscopy* 2005;21:696–702.
- 84 Brambilla L, Pulici L, Carimati G, et al. Prevalence of associated lesions in anterior cruciate ligament reconstruction: correlation with surgical timing and with patient age, sex, and body mass index. *Am J Sports Med* 2015;43:2966–73.
- 85 Granan L-P, Bahr R, Lie SA, et al. Timing of anterior cruciate ligament reconstructive surgery and risk of cartilage lesions and meniscal tears: a cohort study based on the Norwegian national knee ligament registry. *Am J Sports Med* 2009;37:955–61.
- 86 Lawrence JTR, Argawal N, Ganley TJ. Degeneration of the knee joint in skeletally immature patients with a diagnosis of an anterior cruciate ligament tear: is there harm in delay of treatment? *Am J Sports Med* 2011;39:2582–7.
- 87 Sommerfeldt M, Goodine T, Raheem A, et al. Relationship between time to ACL reconstruction and presence of adverse changes in the knee at the time of reconstruction. *Orthop J Sports Med* 2018;6:232596711881391.
- 88 Waite JC, Beard DJ, Dodd CAF, et al. In vivo kinematics of the ACL-deficient limb during running and cutting. *Knee Surg Sports Traumatol Arthrosc* 2005;13:377–84.
- 89 Meunier A, Odensten M, Good L. Long-Term results after primary repair or non-surgical treatment of anterior cruciate ligament rupture: a randomized study with a 15-year follow-up. *Scand J Med Sci Sports*:061120070736040
- 90 van Eck CF, Gravare-Silbernagel K, Samuelsson K, et al. Evidence to support the interpretation and use of the anatomic anterior cruciate ligament reconstruction checklist. *J Bone Joint Surg Am* 2013;95:e153.