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MANAGING ACL RUPTURES IN PROFESSIONAL FOOTBALLERS, FROM INJURY TO RETURN TO SPORT

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Introduction

This patient group will test your clinical, surgical, and communication/psychology skills to the limit. Is there a secret- no! Just be on top form all the time- do the standard things, but do them perfectly, and do the 'right thing'. Anterior Cruciate Ligament (ACL) ruptures in established elite footballers are relatively rare, but much more common in elite youth players- to some extent this is natural selection in action. Unfortunately whilst young players do well after ACL Reconstruction (ACLR) they rarely get a contract- probably because they fall behind their year-group and never catch up. Making the diagnosis: always think the worst: e.g. partial tears almost never exist; graft re-ruptures do. So be careful- don't just read Magnetic Resonance Imaging (MRI) reports, read the MRI yourself.

The First Consultation

This is a very emotional event- the player may not yet accept/believe what has happened. They will be sad, frightened and suspicious. You must show empathy- it IS the end of the World for a footballer even though for the general population not so bad, and you must show you realise this. You need to evoke confidence- with poise, but also honesty and not shy from unpleasant truths eg timescales, or significant chondral damage which may greatly harm the prognosis. Ensure you have already planned operation opportunities so you can answer the question: 'When?'

Treatment Options

Non-operative treatment is NOT appropriate here. Don't forget that these gifted individuals are still human and rules regarding timing of ACLR apply to them – only operate, despite the pressure to 'beat nature' when the knee is 'quiet' and there is full active extension. Although surgeons use a variety of grafts for footballers –patellar tendon has a much lower re-tear rate than hamstrings. Allograft has an unacceptable re-rupture rate. Lateral tenodeses may have an increasing role in 'at risk' cases e.g .with hyperextension excess or marked varus. Do not try out 'new things' e.g. double bundle techniques- do what works!

Rehabilitation

You must engage with a team of trusted colleagues- sports physician, physiotherapists, strength and conditioning experts etc.. Adopt the 'traffic-light' approach as promoted by Isokinetic- the patient can only progress if certain goals / criteria are achieved rather than the time milestone approaches as Return To Play (RTP) times vary greatly between individuals. Do not try to 'beat nature'- whilst some players can get back at 6 months graft re-rupture is much more common around this time. Many footballers need 9 months and all players take 18 months to be at their peak. Go long from the outside – it is much easier to speed up later than to slow down. Ensure you communicate with all parties whenever you review the player.

RTP Criteria

A dry knee. Player's confidence. Aerobic fitness or will fatigue. 'Symmetry': muscle bulk, functional tests e.g. hop height/distance, single leg balance/control in squat, symmetry in undertaking training drills, isokinetic testing. Ideally all testing should be equivalent both sides but a 10% side to side difference is probably OK.

RTP Strategy

Need gradual re-introduction to play- parts of games and build. Always respect swelling – may need to be pulled out for a period.

Re-ruptures

This will happen approx. 5%. Deal with the disappointment including yours- you may need support too: don't forget they broke their original one. If it was not your primary ACLR do not rejoice/gloat. In revision an extra-articular tenodesis is usually needed.

Oddities

Deal with the media by never inviting their attention, never comment (unless a player asks which is rare) if they call your office, be discrete, ensure hospital staff 'hide' the player. Whilst a name check in the Newspaper is attractive it is often a breach of confidentiality.
Agents often try to control treatment. If the treatment is obviously wrong you have a duty to say, but if the treatment/surgeon is standard/good and the player wants to be elsewhere for treatment then they must go- never persuade a player to have treatment with you if they wish to go somewhere else.

Summary

Treat these players how you treat normal patients- but with the greatest attention, empathy, accuracy, and as a team.