

2018 International Olympic Committee Consensus Statement on Prevention, Diagnosis, and Management of Pediatric Anterior Cruciate Ligament Injuries

International Olympic Committee Pediatric ACL Injury Consensus Group*†

In October 2017, the International Olympic Committee hosted an international expert group of physical therapists and orthopaedic surgeons who specialize in treating and researching pediatric anterior cruciate ligament (ACL) injuries. The purpose of this meeting was to provide a comprehensive, evidence-informed summary to support the clinician and help children with ACL injury and their parents/guardians make the best possible decisions. Representatives from the following societies attended: American Orthopaedic Society for Sports Medicine; European Paediatric Orthopaedic Society; European Society for Sports Traumatology, Knee Surgery, and Arthroscopy; International Society of Arthroscopy, Knee Surgery and Orthopaedic Sports Medicine; Pediatric Orthopaedic Society of North America; and Sociedad Latinoamericana de Artroscopia, Rodilla, y Deporte. Physical therapists and orthopaedic surgeons with clinical and research experience in the field and an ethics expert with substantial experience in the area of sports injuries also participated. This consensus statement addresses 6 fundamental clinical questions regarding the prevention, diagnosis, and management of pediatric ACL injuries. Injury management is challenging in the current landscape of clinical uncertainty and limited scientific knowledge. Injury management decisions also occur against the backdrop of the complexity of shared decision making with children and the potential long-term ramifications of the injury.

Keywords: pediatric; injury prevention; knee; child; evidence based practice

The number of anterior cruciate ligament (ACL) injuries in children is rising.^{112,133} ACL injuries in children create a level of concern that is more significant than in any other population with ACL injury. Do children who rupture their ACL mature similarly to their uninjured peers? Do they continue with sport? Do they prioritize their education and other interests over sport? Does an ACL injury and treatment change their lives? These young individuals have to live with their knee problem for the rest of their lives, which may compromise their quality of life and increase the risk for further injury, meniscal tears, and early-onset osteoarthritis.¹³⁴ Compounding the problem is that there is very little high-quality evidence to guide decision making in the management of pediatric ACL injuries.⁹¹

Progress on these issues can be made only on the basis of long-term follow-up in multicenter collaborations. Achieving progress requires a long-term commitment from those who have children's interests close at heart. Therefore, in October 2017, the International Olympic Committee (IOC) hosted an international expert group of physical therapists and orthopaedic surgeons who specialize in treating and researching pediatric ACL injuries. Representatives from the following societies

attended: American Orthopaedic Society for Sports Medicine (AOSSM); European Paediatric Orthopaedic Society; European Society for Sports Traumatology, Knee Surgery, and Arthroscopy (ESSKA); International Society of Arthroscopy, Knee Surgery and Orthopaedic Sports Medicine (ISAKOS); Pediatric Orthopaedic Society of North America; and Sociedad Latinoamericana de Artroscopia, Rodilla, y Deporte (SLARD).

Clinicians are charged with the responsibility of providing accurate information and effective treatment to this vulnerable population. Sharing information about the potential consequences of ACL injury and treatment in childhood to long-term knee health should be a central part of the shared decision-making process. Adult patients with ACL injury may develop symptoms and signs of osteoarthritis within 10 years of the index injury.⁶⁰ Therefore, the clinical concern is that a child who is injured at the age of 10 years could have symptomatic osteoarthritis by the age of 20 years. A quintessential question is, therefore, What is the long-term prognosis after ACL injury in childhood? Having a definitive, evidence-based answer to this question will strengthen our confidence in clinical decision making. Clearly, the answer to this question is not straightforward and depends on many factors, but an important point is that long-term outcomes after ACL injury in childhood, including the development of osteoarthritis, have not been studied.

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TABLE 1
Fundamental Clinical Questions and
Relevant Consensus Statement Topics^a

Section: Question	Relevant Consensus Statement Topics
1: How can the clinician prevent ACL injuries in children?	Injury prevention
2: How does the clinician diagnose ACL injuries in children?	Diagnosis, clinical tests, and imaging
3: What are the treatment options for the child with an ACL injury?	High-quality rehabilitation Surgical techniques The pediatric ACL graft
4: What are the most important considerations when making treatment decisions?	Skeletal age assessment The decision for ACL reconstruction Risks associated with ACL reconstruction Management of associated injuries
5: How does the clinician measure outcomes that are relevant to the child with an ACL injury?	Pediatric patient-reported outcome measures
6: What are the clinician's roles and responsibilities?	Ethical considerations

^aACL, anterior cruciate ligament.

Injury management is challenging in the current landscape of clinical uncertainty and limited scientific knowledge. Injury management decisions also occur against the backdrop of the complexity of shared decision making with children and the potential long-term ramifications of the injury. This consensus statement addresses 6 fundamental clinical questions regarding the prevention, diagnosis, and management of pediatric ACL injuries (Table 1). By framing each topic around clinical questions, the aim of this consensus statement was to provide a comprehensive, evidence-informed summary to support the clinician and help children with ACL injury and their parents/guardians make the best possible decisions.

CONSENSUS METHODS

A modified Delphi consensus process^{32,37,127} was used to identify the topics to be addressed in this consensus statement. Experts were contacted by email in June 2016 and

invited to respond to an electronic survey. A mix of open and closed questions was used to gather expert opinion regarding the key issues in the field. These responses were summarized and formed the basis of 18 statements regarding injury prevention, diagnosis, prognosis, surgical techniques, treatment decision making, management, and outcome measurement (see Appendix Table A1).

A 2-round consensus process was conducted, involving 19 content experts. Respondents rated the importance of the 18 predefined statements on an 11-point scale ranging from "not important at all" to "of utmost importance." Consensus was defined as a mean ranking of at least 8 points for each statement. After the first voting round, statements reaching consensus were removed so that only statements that failed to reach consensus went through to the second voting round. The statements that finally reached consensus formed the topics that were discussed at the consensus meeting.

The IOC convened a consensus meeting of 21 experts in Lausanne, Switzerland, in October 2017. The experts were identified by the IOC through the AOSSM, ESSKA, ISAKOS, and SLARD member societies and from physical therapists and orthopaedic surgeons with clinical and research experience in the field. An ethics expert with substantial experience in the area of sports injuries also participated.

SECTION 1: INJURY PREVENTION

This section addresses the fundamental clinical question, How can the clinician prevent ACL injuries in children? Prevention of ACL injury is important because of the potential for serious long-term consequences in those who sustain the injury and because of the increased risk of reinjury to either knee.¹⁰⁰ Therefore, it is paramount that the principles of injury prevention be incorporated in the treatment of the child with an ACL injury.

Substantial advances have been made in the development and application of ACL injury prevention programs across numerous pivoting sports. There is compelling evidence that ACL injury prevention programs work in skeletally mature patients: they reduce the number of athletes who sustain a primary ACL injury and lower the number of new ACL injuries among athletes who return to sport after primary ACL injury.^{86,95,115,117,120,130}

The athlete's biomechanical movement patterns are a key modifiable risk factor for injury. Injury prevention programs

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Figure 1. Injury prevention exercises incorporated into team training.

target movement patterns by incorporating strength, plyometrics, and sports-specific agility training.^{36,80} Coach and athlete education on cutting/landing techniques (eg, wide foot position when cutting, flexed knee when landing) that avoid high-risk knee positions is also fundamental. Injury prevention programs are straightforward to implement because they require little to no equipment and are performed as part of regular team training or physical education 2 to 3 times per week (Figure 1).

FIFA 11+ for Kids

Injury prevention programs should also be implemented early in the athlete's developmental process. This will give the athlete the best opportunity to develop strong and favorable movement strategies. One well-established injury prevention program,¹²⁶ the Fédération Internationale de Football Association (FIFA) 11+, was recently modified to suit the pediatric population: FIFA 11+ for Kids (eg, adding falling techniques, making partner-based exercises more play oriented). Completing the program can reduce football-related lower extremity injuries by over half.¹⁰⁷ Children who complete the program also have improved motor control, balance tests, and agility as compared with those who do not complete the program.¹⁰⁶

Factors That Might Affect Injury Prevention Effectiveness

Well-designed injury prevention programs have the lowest injury rates and injury time loss,^{12,126} but the effect of a well-designed injury prevention program is strongly influenced by how frequently athletes perform the training.^{52,118,119} Therefore, consistent implementation, utilization, and adherence across all levels of competitive play are one of the biggest challenges facing the clinician. Those involved in youth sports and clinicians who treat pediatric athletes with ACL injury have a responsibility to actively advocate for injury prevention in a primary setting and for children who return to sport after an injury.

SECTION 2: DIAGNOSIS, CLINICAL TESTS, AND IMAGING

This section addresses the fundamental clinical question, How does the clinician diagnose ACL injuries in children? High-quality injury prevention programs are the first-line defense against the potential negative short- and long-term consequences of ACL injury. However, if injury prevention efforts fail, timely and accurate diagnosis is important, since diagnosis is the starting point for effective management planning and shared decision making. The clinician combines information from the patient's history, examination, clinical tests, and imaging to build the clinical picture that will inform diagnosis and treatment. Typically, a thorough history and clinical examination will enable the clinician to make an accurate diagnosis.

Clinical Pearl 1: Hemarthrosis (acute swelling in the knee within 24 hours after a trauma, attributed to intra-articular bleeding) following acute knee injury is an important clue suggesting structural knee injury.

Clinical Pearl 2: Diagnosis can be more challenging in children than adults because children may be poor historians and have greater physiologic joint laxity (be sure to examine both knees) and because magnetic resonance imaging (MRI) interpretation is more difficult given developmental variants in children.^{62,124}

Clinical Pearl 3: Because of the immature skeleton, children may sustain different knee injuries than adults (eg, sleeve fracture of the patella, epiphysiolysis).

Consider starting the assessment by ordering plain knee radiographs for all pediatric patients with a hemarthrosis or suspected acute knee injury. The reason is that tibial eminence fractures and an ACL tear can present with similar histories and physical examination findings. It is also important to rule out other pediatric fractures (eg, epiphyseal fracture, sleeve fracture of the patella). Perform an MRI to confirm the diagnosis of ACL injury and evaluate other soft tissue structures.⁶⁵ In children with an ACL injury, MRI may yield additional information to identify meniscal tears, other ligament injury, or osteochondral

TABLE 2
Diagnostic Accuracy of Clinical Examination and MRI in Intra-articular Knee Disorders^a

Diagnosis	Sensitivity, %			Specificity, %			Positive Predictive Value, %		Negative Predictive Value, %	
	Clinical	MRI	<i>P</i> Value	Clinical	MRI	<i>P</i> Value	Clinical	MRI	Clinical	MRI
ACL tear	81.3	75.0	.55	90.6	94.1	.39	49.0	58.6	97.8	97.1
Medial meniscus tear	62.1	79.3	.15	80.7	92.0	.03 ^b	14.5	34.3	97.6	98.8
Lateral meniscus tear	50.0	66.7	.24	89.2	82.8	.21	34.0	30.1	94.1	95.7

^aAdapted from Kocher et al.⁶⁵ Clinical examination included patient history, physical examination, and radiographs performed by a pediatric orthopaedic sports medicine specialist or a postresidency pediatric sports medicine fellow. ACL, anterior cruciate ligament; MRI, magnetic resonance imaging.

^b*P* < .05.

injury. In children with a locked knee, acute MRI is warranted to assess the presence of a displaced bucket-handle meniscal tear or an osteochondral injury that may need prompt surgical treatment.

Measurement Properties for Clinical Examination and MRI

No single question, test, or image can accurately identify an ACL injury every time. The measurement tools available to the clinician are not perfect, but they do yield valuable information in the clinical context. Knowledge of the measurement properties of clinical tools helps the clinician balance the information gained from these tools. The negative predictive values of clinical examination and MRI for ACL tear and meniscal pathology are greater than the positive predictive values (Table 2). This means that if clinical examination or MRI is negative for injury, the chance of the patient's having an injury is low. However, if the tests are positive, it *does not* mean that the clinician can always reliably rule the diagnosis *in*.

SECTION 3: TREATMENT OF ACL INJURIES IN CHILDREN

This section addresses the fundamental clinical question, What are the treatment options for the child with ACL injury? Once the clinician is certain of the injury diagnosis, he or she first needs to know the available treatment options and discuss these options with the child and the child's parents/guardians so that a shared decision can be made about how best to manage the knee injury.

The goals of treatment for the child with ACL injury are as follows:

- To restore a stable, well-functioning knee that enables a healthy active lifestyle across the life span
- To reduce the impact of existing, or the risk of further, meniscal or chondral pathology, degenerative joint changes, and need for future surgical intervention
- To minimize the risk of growth arrest and femur and tibia deformity

Two treatment options can help the child with an ACL injury (with or without associated knee injuries) achieve

these goals: high-quality rehabilitation alone (nonsurgical treatment) and ACL reconstruction plus high-quality rehabilitation. This section describes the key components of high-quality rehabilitation for the child with an ACL injury and the options for the ACL reconstruction surgical technique. Section 4 outlines potential treatment decision modifiers.

High-Quality Rehabilitation

High-quality rehabilitation is a critical component in the management of ACL injury, and the principles of rehabilitation are the same, irrespective of whether the child has had an ACL reconstruction or has elected for nonsurgical treatment. Guidance for pediatric rehabilitation is extrapolated from clinical experience and research in adults, although it is uncertain whether adult principles apply to children.¹³⁸ Pediatric rehabilitation must be performed in close collaboration with the child's parents/guardians. Exercises and functional goals must be modified and not simply copied from the adult-oriented rehabilitation protocols that may be more familiar to many clinicians. The reason is that children are not small adults—they cannot be expected to perform unsupervised training independently, with perfect technique. Qualified rehabilitation clinicians must supervise rehabilitation for the child with an ACL injury.

Rehabilitation Focus

Dynamic, multijoint neuromuscular control is the primary focus of ACL rehabilitation in children. For the youngest patients (with markedly open physes, age <12 years), there is less emphasis on the development of muscular strength and hypertrophy. During maturation and throughout the onset of puberty, rehabilitation strategies that more closely resemble those used with adult patients are appropriate given the increase in androgenic hormones.¹⁵ These strategies must include heavier and externally loaded strength training.

Rehabilitation must be thorough and individualized to the child's physiologic and psychological maturity to achieve successful outcomes: emphasize exercises that facilitate dynamic lower limb alignment and biomechanically sound movement patterns. Although this has been successfully implemented in the rehabilitation programs of adolescents and adults, it has not yet been documented

TABLE 3
Recommended Functional Tests and Return-to-Sport Criteria for the Child and Adolescent With ACL Injury^a

For patients who choose ACL reconstruction	
Prehabilitation	<ul style="list-style-type: none"> • Full active extension and at least 120° of active knee flexion • Little to no effusion • Ability to hold terminal knee extension during single-leg standing (Figure 2) • For adolescents: 90% limb symmetry on muscle strength tests
For patients who choose ACL reconstruction OR nonsurgical treatment	
Phase 1 to phase 2	<ul style="list-style-type: none"> • Full active knee extension and 120° of active knee flexion • Little to no effusion • Ability to hold terminal knee extension during single-leg standing
Phase 2 to phase 3	<ul style="list-style-type: none"> • Full knee range of motion • 80% limb symmetry on single-leg hop tests with adequate landing strategies • Ability to jog for 10 min with good form and no subsequent effusion • For adolescents: 80% limb symmetry on muscle strength tests
Phase 3 to phase 4: sport participation (return-to-sport criteria) and continued injury prevention	<ul style="list-style-type: none"> • Single-leg hop tests >90% of the contralateral limb (with adequate strategy and movement quality) • Gradual increase in sport-specific training without pain and effusion • Confidence in knee function • Knowledge of high-injury risk knee positioning and ability to maintain low-risk knee positioning in advanced sport-specific actions • Mentally ready to return to sport • For adolescents: 90% limb symmetry on muscle strength tests

^aMuscle strength testing should be performed with isokinetic dynamometry or handheld dynamometry/1-repetition maximum. The type of test and experience of the tester are highly likely to influence the results. If using handheld dynamometry/1-repetition maximum, consider increasing the limb symmetry criterion cutoff by 10% (ie, 90% limb symmetry becomes 100% limb symmetry). Clinicians who do not have access to appropriate strength assessment equipment should consider referring the patient elsewhere for strength evaluation. ACL, anterior cruciate ligament.

as extensively in children. The exercises are gradually progressed through phases 2 and 3 of the pediatric ACL rehabilitation protocol (Table 3 and Appendix Table A2) as part of sport-specific rehabilitation. Appendix Table A2 provides examples of exercises to consider in each rehabilitation phase. Reinjury anxiety and the patient's confidence in his or her injured knee affect outcomes after ACL rehabilitation among adults.^{8,9} These psychological factors are also likely to be important in the pediatric population but currently are insufficiently studied.

Following surgical treatment, the graft type used for ACL reconstruction and associated injury or surgery to other ligaments, menisci, or articular cartilage necessitates specific adjustments to the rehabilitation program. Rehabilitation programs should be designed to allow the child to participate in his or her team practice sessions to maintain the social benefits of staying within the team. Parents or guardians should be active participants in the daily rehabilitation.¹⁰¹ This may include assisting the child in technical and functional exercises during team practice (eg, short passes in soccer).

Rehabilitation Phases

Rehabilitation for the child with an ACL injury is organized into 4 phases, with an additional prehabilitation phase for those who choose ACL reconstruction (Table 3 and Appendix Table A2). Specific clinical and functional milestones should be met before progressing from one phase to the next.¹²⁸ Throughout the first 2 phases, the child should

be guarded from cutting and pivoting activities during sport, free play, and physical education classes in school.

Rehabilitation Progression

The framework for progression through functional milestones is similar for ACL reconstruction and nonsurgical treatment. However, there are different expectations for progression and time to return to full participation in sport. For all patients, rehabilitation progression must be guided by clinical and functional milestones, and return to full participation⁷ is dependent on successfully achieving the return-to-sport criteria (Table 3). Nonsurgical treatment should last for at least 3 to 6 months.⁴⁹ Postoperative rehabilitation should last for a minimum of 9 months before return to full participation in preferred physical activities.⁵⁰

Data from international registries suggest that young athletes are at high risk for a second ACL injury following an ACL reconstruction,⁷⁶ and the risk is greatest in the first 12 months postoperatively.^{28,50} Therefore, consider advising the child athlete not to return to pivoting sports until at least 12 months following ACL reconstruction. Rehabilitation is also an excellent opportunity to train the uninjured leg, which might be important considering the risk of contralateral injury.²⁸ Once the child returns to sport, a comprehensive injury prevention program emphasizing biomechanical alignment and landing/cutting technique should be integrated with usual training.



Figure 2. Child demonstrating how to hold terminal knee extension during single-limb stance. This is an important marker of quadriceps control in anterior cruciate ligament rehabilitation and prehabilitation.

Considerations When Designing Rehabilitation Programs for the Prepubescent Child

Children who are close to skeletal maturity may follow rehabilitation¹²⁸ and return-to-sports guidelines^{50,77} intended for adults. There are 5 important considerations for the prepubescent child:

1. Consider a home-based program with emphasis on playful exercises and variation (Figure 3) to discourage boredom.
2. Single-leg hop tests and isokinetic strength tests have larger measurement errors in the prepubescent population, so use these tests with caution.⁵⁹



Figure 3. One example of an exercise that could be incorporated into a home-based anterior cruciate ligament rehabilitation program.

3. Focus on evaluating the quality of movements during single-leg hop testing instead of the leg symmetry index measures.
4. Tests and criteria to assess movement quality are yet to be validated, so the responsible clinician needs to have skills and experience in this area.
5. Return-to-sport criteria were designed and scientifically tested in the skeletally mature patient and are recommended for the child who is close to maturity.^{50,125} The validity of these criteria in the prepubescent child is unknown.

Bracing

Many clinicians involved in nonsurgical treatment of skeletally immature children recommend that the child wears a protective brace during strenuous physical activities.⁹³ The child who has had surgical treatment typically wears a brace during the prehabilitation phase until ACL reconstruction is performed. Following surgery, it is recommended that the child wear a protective knee brace through the successful completion of the functional milestones in rehabilitation phase 1 (usually 2 to 6 weeks postoperatively, depending on concomitant surgical procedures). However, the effectiveness of bracing following ACL injuries or reconstruction in pediatric patients is unknown. Other considerations related to the use of a brace might be to prevent knee hyperextension or knee valgus/varus, to enhance the child's awareness of his or her injury, and as a protective signal to others whom the child might encounter (eg, at school).

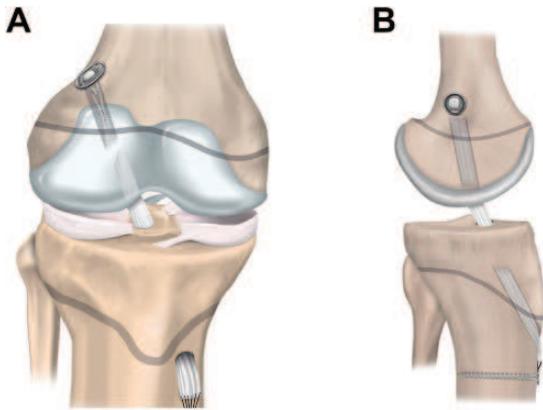


Figure 4. Transphyseal anterior cruciate ligament reconstruction: (A) anterior and (B) lateral views.

Surgical Techniques

The general principles of ACL reconstruction in adults apply to the pediatric patient: use a well-positioned (soft tissue) autograft of adequate size, with adequate fixation to allow functional rehabilitation. Physeal damage should be minimized to avoid growth disturbance. Bone plugs and fixation devices should not cross the physis.^{41,68,111}

Key Indications for ACL Reconstruction

There are 3 indications for pediatric ACL reconstruction:

1. The child has repairable associated injuries that require surgery (eg, bucket-handle meniscus tear, repairable meniscal lesion, or osteochondral defect).
2. The child has recurrent symptomatic knee giving way after completing high-quality rehabilitation.
3. The child experiences unacceptable participation restrictions (ie, an unacceptable modification of activity level to avoid knee giving way).

ACL Reconstruction Techniques

There are 3 possible techniques for pediatric ACL reconstruction.

Transphyseal ACL Reconstruction. The transphyseal technique in the child is similar to the technique that the surgeon would use for ACL reconstruction in adults. Single-bundle transphyseal ACL reconstruction with a quadrupled hamstring graft is the most common (Figure 4).^{21,25,38,55,71,114} Therefore, because the surgeon is more likely to be familiar with the key elements of the procedure, it may reduce the risk of intraoperative complications. Ensure that the diameter of the bone tunnels is as small as possible (<9 mm) to accommodate an appropriately sized graft.⁵⁸ Similarly, to minimize physeal damage, orient the tibial tunnel as vertically and centrally as possible while maintaining the anatomic position of the graft. On the femoral side, the surgeon should take care

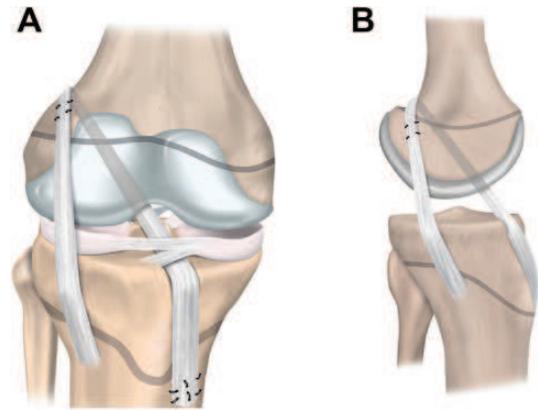


Figure 5. Physeal-sparing anterior cruciate ligament reconstruction with an over-the-top technique and iliotibial band: (A) anterior and (B) lateral views.

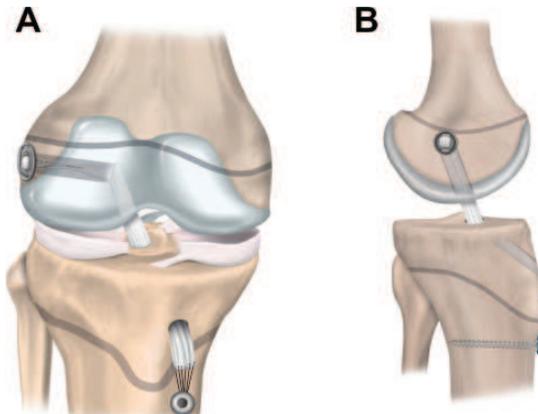


Figure 6. Physeal-sparing anterior cruciate ligament reconstruction with an all-epiphyseal technique: (A) anterior and (B) lateral views.

to avoid the perichondral ring. Drilling via the anteromedial portal can result in a tunnel that has an elliptical trajectory through the physis. Consider a slightly more vertical orientation than what might be used for an ACL reconstruction in an adult patient, or choose a different drilling approach.

Physeal-Sparing ACL Reconstruction. Physeal-sparing techniques avoid physeal damage in patients with markedly open physes. The techniques include an over-the-top technique with a strip of the iliotibial band (Figure 5)⁶⁷ and an all-epiphyseal procedure (Figure 6).³ In the all-epiphyseal procedures, use of fluoroscopic visualization is recommended to reduce the risk of physeal damage. With the over-the-top technique, avoid femoral rasping to minimize the risk for damage to the perichondral ring.

Partial Transphyseal ACL Reconstruction. The partial transphyseal technique (Figure 7) combines a transphyseal tibial tunnel with a physeal-sparing technique on the femoral side.^{5,53,82}

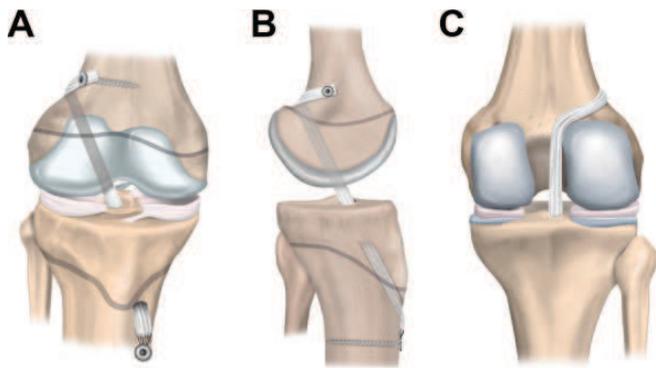


Figure 7. Partial transphyseal anterior cruciate ligament reconstruction: (A) anterior, (B) lateral, and (C) posterior views.

TABLE 4
Three Options for Femoral Tunnel Trajectories^a

Tunnel Option	Considerations
A: Vertical transphyseal	
Advantage	Minimizes physeal volume affected
Disadvantage	Less-than-ideal coverage of ACL footprint
B: Oblique transphyseal	
Advantage	Anatomic graft position covering the ACL footprint
Disadvantage	Greater volume of physis negatively affected
C: Horizontal all epiphyseal	
Advantage	Appropriate placement at ACL footprint; no drilling through the physis
Disadvantage	Requires precise tunnel placement to reduce the risk for physeal damage

^aACL, anterior cruciate ligament.

Surgical Principles and Techniques for Growth Disturbance Risk Reduction

Drill-hole trajectory and location influence the degree of risk to the physes (Table 4 and Figure 8). Knowledge of 3 key principles will help the surgeon minimize the risk to the physes during transphyseal ACL reconstruction:

1. Drilling at the periphery of the physis and the perichondral ring increases the risk of growth disturbance. Drill holes may be placed in an all-epiphyseal manner to allow for drilling at the native ACL footprint while avoiding the physis. Precise tunnel placement is required when performing this technique to avoid damage to the undulating distal femoral physis.
2. Bone tunnel drill holes should be as vertical as possible (while still maintaining anatomic graft position) and as central as possible. This is especially important when

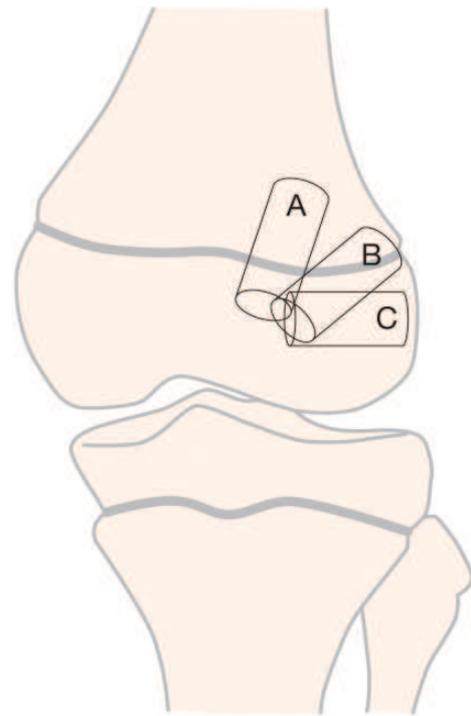


Figure 8. Three options for femoral tunnel trajectories: A, vertical transphyseal; B, oblique transphyseal; and C, horizontal all-epiphyseal.

drilling through the anteromedial portal. Drilling an oblique tunnel rather than a more vertical tunnel increases the amount of physis removed and increases the risk for growth disturbance.

3. Do not cross the epiphysis with hardware, implants, or bone blocks. Fill bone tunnels with soft tissue rather than leaving the tunnels open.

Graft Choice and Fixation

Only soft tissue grafts (not allografts) should be used for ACL reconstruction in pediatric patients with open physes. The quadrupled hamstring graft is most common.^{25,38,55,71,114} A quadriceps tendon graft may be used.⁵³ The patellar tendon *should not* be harvested in pediatric patients with open physes, to avoid damage to the tibial tubercle apophysis. Allografts are not indicated in pediatric patients in most cases, since the use of allografts in pediatric ACL reconstruction has shown poor clinical outcomes.^{61,108,123} A novel technique involving the use of living-donor hamstring tendon allograft was reported^{47,55} to avoid the varied sterilization techniques used in cadaveric soft tissue allografts and to preserve the neuromuscular unit of the growing patient.^{139,140} However, long-term clinical outcomes are yet to be assessed.

Extracortical fixation of soft tissue grafts may be performed with a cortical button, suture, post, or staple. Aperture fixation may be performed with interference screws, provided that the screws do not cross the physis.

Graft Incorporation

Data regarding ACL graft incorporation in children are scarce. Pediatric soft tissues have a greater biological growth potential as compared with adults,^{40,94} and cell migration and proliferation of ACL fibroblasts slow as a person grows older.⁸³ The clinical relevance of the growth potential to pediatric ACL reconstruction is still unclear,¹⁰² although there is rationale from animal models that the pediatric ACL graft may remodel faster than the adult ACL graft.⁸⁹

Adaptations and Remodeling in the Growing Child

The ACL graft must adapt as the child grows. The graft may increase in length as the bone grows, and the bone tunnels may reduce in relative size.^{16,73} It is uncertain whether the diameter of the intra-articular part of the graft becomes longer and thinner¹¹ or not¹⁶ as the child grows. The graft does not increase in diameter as the child grows but may increase in length.¹⁰

The graft may become more vertically oriented with longitudinal bone growth after transphyseal ACL reconstruction. This observation might be explained by the movement of the femoral fixation site with physeal growth or because the tibial tunnel aperture becomes relatively more posterior owing to greater anterior growth of the proximal tibia. Other changes occurring as the child grows are secondary intercondylar notch narrowing, distal migration of the tibial and/or proximal migration of the femoral extracortical fixations, and verticalization of the Blumensaat line.¹¹⁰ However, the long-term clinical significance of these growth-related changes is unclear.

SECTION 4: TREATMENT DECISION MODIFIERS

This section addresses the fundamental clinical question, What are the most important considerations when making treatment decisions? The key issues addressed relate to assessment of skeletal maturity, the decision for surgery, the management of injuries to other knee structures, and the potential adverse events following treatment. These issues may alter the ACL injury management decision depending on the risk tolerance of the decision-making team (which should include clinicians, the child, and the child's parent/guardian).

Skeletal Age Assessment

Assessing and documenting the child's skeletal age, in addition to his or her chronological age, is necessary for individualizing treatment of ACL injuries. The main goal with respect to skeletal age assessment is to define remaining knee growth. Protecting the physis and perichondral ring from damage during ACL reconstruction is an important consideration¹¹¹; insult to a growth area that is near completion of growth can result in premature closure.

Estimating skeletal age and remaining growth are key considerations for treatment decision making. These estimates will guide choice of treatment, timing of surgery, and

TABLE 5
Considerations for Skeletal Age Assessment

1. Understand the difference between skeletal age and chronological age.
2. Use imaging of the knee to determine whether the femoral and tibial physes and the tibial tubercle apophysis are open. If the growth areas are closed, then, independent of chronological age, the child can be treated as an adult.
3. None of the specific methods for skeletal age determination in isolation are sufficient to accurately determine skeletal age.
4. Use a multifaceted clinical approach to determining skeletal age that includes whether the child has had an adolescent growth spurt, the relative heights of the child's parents, and Tanner staging.¹²²
5. The most common method of skeletal age assessment is via posterior-anterior radiograph of the left hand and wrist. This can be compared with a skeletal atlas (eg, Gilsanz and Ratib⁴⁶ or Greulich and Pyle⁴⁸) or via a smart-phone application (eg, the Bone Age app for iPhone).

surgical method. Open physes in the child are vulnerable at surgery, and none of the current recommended surgical treatments for the child with an ACL injury can be guaranteed to protect the physis and avoid the potential complication of growth arrest or deformity (Table 5). The clinician might also consider long-leg radiographs (hips to ankles) after injury to establish a baseline for assessing the potential development of angular deformity and leg-length discrepancy. Assessing skeletal age is also relevant in research and may be beneficial for medicolegal reasons. If overgrowth, growth arrest, or deformity occurs, presurgical documentation of skeletal age may be important.

Treating the Child With ACL Injury: To Operate or Not to Operate?

Children who have repairable additional injuries at ACL injury diagnosis (eg, displaced bucket-handle meniscal tear) should be treated with early ACL reconstruction and meniscal repair.⁷⁵ For those without additional injuries warranting surgery, there are conflicting opinions regarding the best treatment approach. These approaches range from early ACL reconstruction for all children to primary nonsurgical management (high-quality rehabilitation alone) with the option of late ACL reconstruction (1) if the child has recurrent instability problems despite high-quality rehabilitation or (2) if he or she sustains secondary intra-articular injuries.

A well-performed ACL reconstruction and preservation of the meniscus can restore knee stability.⁶⁶ However, if the child receives inadequate (or no) rehabilitation, the chances of recovering high-level function to safely participate in all aspects of life (including pivoting sports), for the rest of his or her life, might be slim. Similarly, high-quality rehabilitation will not salvage poor surgical treatment (eg, graft malposition).

Children who undergo ACL reconstruction after failed nonsurgical management may have a greater number of

meniscal and chondral injuries at the time of ACL reconstruction as compared with those who undergo early ACL reconstruction.^{4,81,97} The number of instability episodes prior to surgery appears to be a more important factor than the length of time between injury and surgery.⁴² This consideration is the background for early surgery decisions. However, there is a lack of high-quality prospective studies investigating the outcomes of surgical and nonsurgical treatment for pediatric ACL tears.⁹¹

Nonsurgical treatment is a viable and safe treatment option for skeletally immature patients who do not have associated injuries or major instability problems.⁹⁰ High-quality rehabilitation alone may stabilize the knee dynamically without compromising the physes and is a focused training program supervised by a qualified rehabilitation clinician (see section 3 for the key principles of high-quality rehabilitation). Nonsurgical treatment can be (1) a permanent treatment option for those who do not develop functional instability or (2) a short-term option to delay ACL reconstruction until the child has reached skeletal maturity. Abandoning nonsurgical treatment in favor of ACL reconstruction is an option if the child has recurrent instability problems despite completing active rehabilitation or if the child has a secondary intra-articular injury. Therefore, clinicians must work together to closely and frequently monitor the child with repeated MRI and clinical examination as appropriate, being alert to instability episodes and secondary injuries that require prompt assessment and treatment.⁴²

Risks Associated With ACL Reconstruction

Irrespective of the technique, surgical treatment of the ACL has inherent risks. Different ACL reconstruction techniques have different considerations to help avoid risk to the physes, articular surface, and soft tissue structures of the knee. Here we describe 5 key risks associated with surgical treatment for ACL injury of which clinicians, patients, and parents/guardians must be aware.

Risk 1: Growth Disturbance

Growth disturbances are a rare (approximately 2%)⁴¹ but serious risk of ACL reconstruction. Growth disturbances may be a result of hardware, bone plugs at the physis, extra-articular tenodesis, or use of over-the-top femoral position. Most of the growth in the child's lower extremities occurs from the physes of the distal femur and proximal tibia. Any surgical procedures where tunnels are drilled through or near the physis are associated with a risk of growth arrest and associated angular deformity and/or leg-length discrepancy. Transphyseal techniques have a higher rate of graft rupture and a lower rate of lower limb deformity or axis deviation. Physeal-sparing techniques have a lower rate of graft rupture and a higher rate of lower limb deformity or axis deviation.

Highly tensioned soft tissue grafts placed across femoral physes have been associated with limb-length discrepancy and angular deformity.³⁴ Metaphyseal fixation techniques may pose an increased risk of femoral angulation and

rotation relative to other techniques. Epiphyseal techniques may increase the risk of rotational deformity and decrease the risk of angular deformity.²³ Excessive growth may also be a problem, including symmetrical and asymmetrical overgrowth.²²

Most patients with ACL rupture requiring surgical treatment are approaching skeletal maturity and do not have substantial growth remaining. This means that angular deformities and limb-length discrepancies are likely of relatively low clinical significance. Therefore, it may be reasonable to perform transphyseal procedures when the child has minimal growth remaining.

Regularly Monitor the Patient Until Skeletal Maturity. Routine clinical and radiologic follow-up within the first 12 months postoperatively can help the surgeon detect early clinical and radiographic evidence of leg-length discrepancy, angular deformity, or physeal injury. For the child with markedly open physes, appropriate follow-up evaluation of leg-length discrepancy might include annual clinical assessment and knee radiographs with long-leg alignment views until skeletal maturity and physeal closure. Height should be monitored, and if growth exceeds 6 cm in 6 months or if clinical findings warrant, the annual assessment should be brought forward.

Classifying Growth Disturbances. Growth disturbances can occur in several forms (Figure 9). The growth arrest may be due to

- Localized physis injury resulting in a bone bridge leading to growth arrest and possible malalignment (type A)
- Overgrowth process potentially caused by hypervascularization (type B)
- Undergrowth process arising from a graft traversing a physis under tension during growth and leading to a tethering effect (type C)

Risk 2: Secondary ACL Rupture

Young age, returning to pivoting sport, and receiving an allograft are important predictors of new ACL injury after index ACL reconstruction.^{2,61} One in 4 patients <25 years old who returned to pivoting sports after ACL reconstruction can be expected to sustain a new ACL injury (the pooled ipsilateral reinjury rate is approximately 10%; the pooled contralateral reinjury rate is approximately 12%).¹³⁵

High rates of reinjury among young people with ACL reconstruction are concerning, although data regarding reinjuries among children with ACL reconstruction are sparse in comparison with data from skeletally mature patients. The best available evidence suggests a graft rupture rate of 13% in children and adolescents (age range, 6-19 years) and a contralateral ACL injury rate of 14%.⁶³ It is reasonable to hypothesize that high-quality rehabilitation with high adherence is likely an important step in reducing reinjury risk. The principles of rehabilitation for the skeletally immature patient are addressed in section 3. The ACL graft is also affected by the status of the other ligaments, menisci, cartilage surfaces, limb alignment, rotation, and the dynamic muscle control of these structures—all factors that must be considered during treatment decision making.

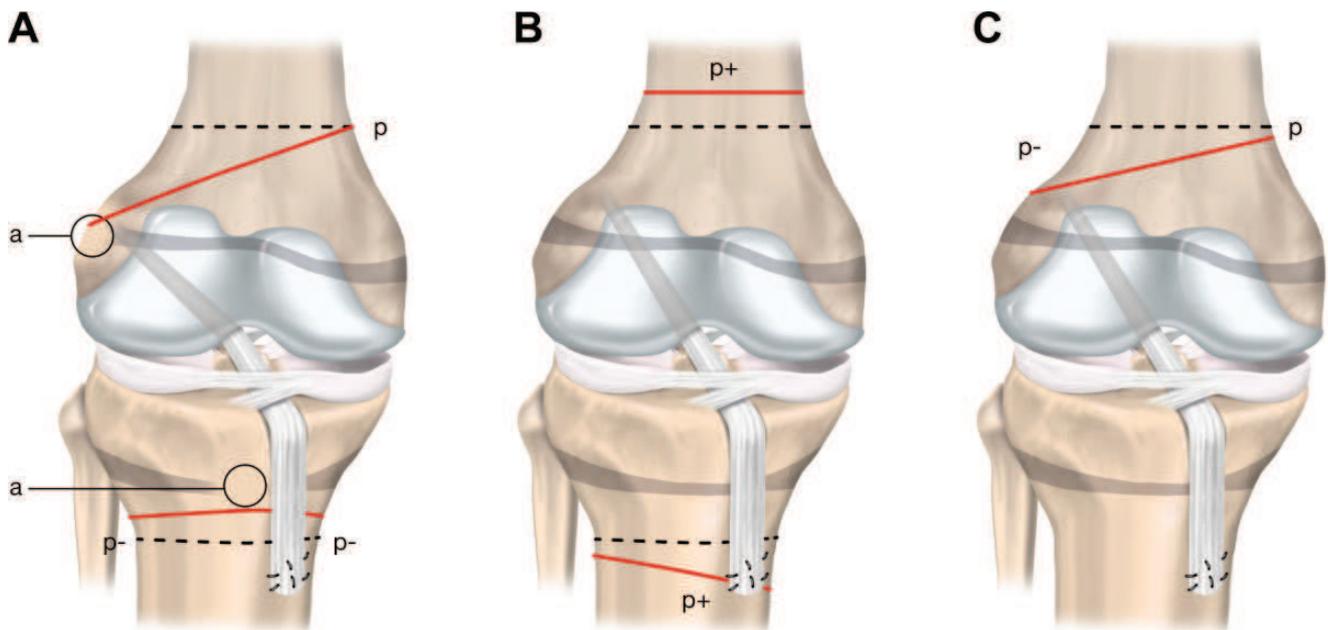


Figure 9. Three growth disturbances that may occur following anterior cruciate ligament (ACL) reconstruction. *p* represents the physiological growth process; dashed lines represent the physiological growth arrest lines; continuous lines represent the observed pathological growth arrest line. (A) Type A (arrest): growth arrest process (*a*) occurs due to a localized injury of the physis and results in a bone bridge across the physis. The amount of deformity is proportional to the location and size of the initial physeal injury. (B) Type B (boost): overgrowth process (*p*+) is probably caused by local hypervascularization, stimulating the open physis. This growth disturbance is temporary and usually becomes apparent in a limited period of 2 years following ACL reconstruction. It primarily leads to leg-length discrepancy. (C) Type C (decelerate): undergrowth process (*p*-) due to a tenoepiphyseodesis effect. The graft tension across the open physis causes the deformity. Adapted from Chotel et al.²²

Risk 3: Poor Long-term Knee Health

Meniscectomy is associated with an increased risk for osteoarthritis.^{24,103,137} Therefore, whenever possible, treatment of ACL injuries must emphasize preservation of the meniscus. Prior meniscectomy at the time of ACL reconstruction is associated with greater likelihood of chondral lesions, while prior meniscal repair is not.¹⁹ Because of the technical nature of performing ACL and concurrent meniscal surgery in smaller, younger patients with open physes, patients in whom meniscus repair is indicated should be treated by surgeons who (1) are experienced in treating patients with open physes and (2) perform a high volume of meniscal repairs.

Risk 4: Knee Stiffness

Knee stiffness may be due to the degree of injury to the ACL, disruption of the joint capsule, and injury to structures other than the ACL. Knee stiffness may also be related to surgical interventions or inadequate rehabilitation. Knee stiffness is rare in children aged ≤ 13 years and is less common in males and in those having surgery with an iliotibial band or hamstring autograft.⁹⁸ Patients who have knee stiffness following ACL injury should aim for full active knee extension range of motion prior to undergoing ACL reconstruction. If the knee extension deficit persists beyond 3 months postoperatively, MRI may be warranted

to assess for anterior impingement (cyclops lesion) and subsequent arthroscopy (should the deficit continue to be unresolved despite focused rehabilitation attention).

Risk 5: Infection

Data related to infection risks for pediatric patients are extrapolated from literature that combines pediatric and adult patients. Infection rates for adult patients are generally low for ACL reconstruction. The rate of deep infections after ACL reconstruction with autograft is 0.19%.¹³

Management of Associated Injuries

This section addresses the key issues for managing cartilage and meniscal injuries in combination with ACL rupture and the multiligament-injured knee.

Associated Meniscus and Cartilage Injuries in Children With ACL Injuries

The degree of vascular penetration of the menisci declines with age to between 10% and 30% of the menisci receiving vascular inflow in adults.¹⁰⁴ The more robust vascular distribution in the pediatric menisci is reflected by increased intrameniscal signal intensity on MRI. Globular and intrameniscal signal may be observed in children and may



Figure 10. Appearance of the highly vascular pediatric meniscus on magnetic resonance imaging: 10-year-old boy (Signa HDxt 3.0T; GE Medical Systems).

appear to be an intrasubstance meniscal tear. However, these findings are benign and usually reflect the abundant vascularity of the pediatric menisci (Figure 10).²⁶

It is important to evaluate the MRI characteristics of the pediatric menisci to rule out meniscal injuries. In cases where the diagnosis is difficult, diagnostic arthroscopy may be performed to clarify the diagnosis and ascertain the state of the meniscus. The clinician should also assess for a posterior medial meniscocapsular tear (ramp lesion). Ramp lesions may be present in 1 in 6 adult patients with ACL injury, and the prevalence of ramp lesions in children with an ACL injury is similar.⁸⁴ The surgeon should be vigilant to verify the presence or absence of a medial meniscal ramp tear by visualizing the posteromedial compartment. Use a posteromedial knee arthroscopic portal, if necessary, to probe the posteromedial meniscocapsular junction. Ramp lesions may place more stress on an ACL reconstruction if the lesion is not concurrently repaired.³⁰

Meniscal repair should be performed whenever possible in the pediatric patient because of the deleterious effects of meniscectomy and the positive outcomes of meniscal repair (ie, the improved healing potential of the meniscus).^{4,74,113} This is especially important for bucket-handle, root, and radial meniscal tears and ramp lesions. If the surgeon does not have the skills or equipment to repair the meniscus tear, he or she should consider referring to a surgeon who has the expertise and equipment. Early diagnosis and appropriate treatment of ACL injuries and meniscus tears are needed to provide the best chance of preserving meniscal tissue.

Articular cartilage injuries in combination with ACL injury are less common than meniscal tears.⁴ However, the clinician should have a higher degree of suspicion of articular cartilage injury in patients with combined ACL and meniscal injuries.³³ The medial femoral condyle may be particularly vulnerable.³³ Factors that may be associated with more severe chondral lesions are recurrent

instability episodes and increased time between ACL injury and reconstruction.^{33,51,81} It is unclear whether nonsurgical management of ACL injuries is associated with greater incidence of new chondral and meniscal lesions than ACL reconstruction.⁹²

Associated Ligament Injuries in Children With ACL Injuries

There is limited research on multiligament knee injuries and treatment in pediatric patients, and these injuries are less common in children than in adults.⁸⁷ Therefore, consider referral to a specialist center.

Specific Surgical Treatment Considerations

Combined ACL and Fibular Collateral Ligament Injuries. Use fluoroscopy prior to placing suture anchors for a repair or for tunnel reaming for a concurrent ligament reconstruction to evaluate tunnel position in relation to the physes.¹³⁶

Combined ACL and Posterior Cruciate Ligament Injuries. Nonsurgical treatment may be appropriate for partial posterior cruciate ligament (PCL) tears or nondisplaced avulsion injuries. PCL reconstruction is a relatively safe and viable treatment option for patients with multiligament injuries.⁶⁹ Using a tibial inlay technique with a modified femoral tunnel location avoids transphyseal drilling.¹³² However, there are no high-quality studies of this technique in children.

True Knee Dislocation. Perform a reduction by manipulating the tibia relative to the femur. Avoid forceful hyperextension or rotation to minimize the risk for damage to cartilaginous and/or neurovascular structures. Following reduction, a dynamic knee brace can be applied (for at least 12 weeks) to prevent further intra-articular damage and to help hold the knee in a reduced position⁷⁹ while further treatment is planned. Ultimately, reconstruction of the ACL and PCL in combination with repair/reconstruction of additional ligaments (as needed) is the appropriate treatment.

SECTION 5: PEDIATRIC PATIENT-REPORTED OUTCOME MEASURES

This section addresses the fundamental clinical question, How does the clinician measure outcomes that are relevant to the child with an ACL injury? Assessing patient-reported outcome measures (PROMs) provides insight into aspects of the patient's function that cannot be evaluated with clinical tests or imaging.²⁷ Because of this, evaluating PROMs is important when managing the child with an ACL injury and when conducting research in this field.

Valid outcome instruments must have appropriate measurement properties, including reliability, validity (content, criterion, and construct), and responsiveness. Instruments that were developed for adults may not be valid for children and adolescents. Pediatric patients have different levels of comprehension (this age group includes a spectrum of comprehension abilities from younger children

TABLE 6
Appropriate PROMs for the Child With ACL Injury^a

Type of Instrument	Scale
Health-related quality of life	Child Health Questionnaire ⁵⁶ PedsQL ¹²⁹
Condition or region specific	Pediatric PROMIS ⁵⁷
	Pedi-IKDC ⁷⁰
Activity-level assessment	KOOS-Child ⁹⁹ Pediatric Functional Activity Brief Scale ³⁹

^aACL, anterior cruciate ligament; IKDC, International Knee Documentation Committee; KOOS, Knee injury and Osteoarthritis Outcome Score; PedsQL, Pediatric Quality of Life inventory; PROMs, patient-reported outcome measures; PROMIS, patient-reported outcomes measurement information system.

to older adolescents) and interpretation of instruments. Most important, pediatric patients may value different outcomes when evaluating their knee function, and instruments must reflect the issues that are important to children and adolescents.

Pediatric PROMs should be either developed or specifically validated in this population. The process of validation should include an assessment of comprehensibility, reliability, validity, and responsiveness. Child-reported outcome assessment is typically valid for older children and adolescents (≥ 10 years).¹¹⁶ For younger children (< 10 years), parent proxy-reported outcome assessment may be more appropriate. However, there is potential for bias with proxy-reported outcomes.¹⁰⁹

Pediatric PROMs (Table 6) must be valid for children and adolescents with ACL injury. However, a pediatric-derived PROM is not currently available. Such an instrument would ensure that the items covered issues that matter most to children and adolescents. The Pediatric International Knee Documentation Committee (Pedi-IKDC) and Knee-injury and Osteoarthritis Outcome Score for Children (KOOS-Child) were adapted from adult PROMs designed to assess self-reported knee function. The Pedi-IKDC has been correlated with the IKDC subjective knee form, providing preliminary evidence of construct validity.^{10,11} Given that patients with a history of ACL injury may develop symptoms and signs of osteoarthritis within 10 years of the index injury⁶⁰ and given the relationship between symptomatic osteoarthritis and poor quality of life,¹³⁴ assessing quality of life and long-term knee function outcomes with valid PROMs may also be important.

Recommendations for using PROMs in clinical practice with pediatric patients include the following:

- A generic measure of health-related quality of life
- Either the Pedi-IKDC or KOOS-Child to assess self-reported knee function
- The Pediatric Functional Activity Brief Scale to assess self-reported activity level

In research, it may be appropriate to include other PROMs depending on the research question. Researchers

need to make decisions about the most appropriate outcomes when planning their study.

SECTION 6: ETHICAL CONSIDERATIONS

This section addresses the fundamental clinical question, What are the clinician's roles and responsibilities? Treatment decisions that involve children are among the most difficult decisions that the clinician faces, especially when scientific knowledge is limited. Striking a balance among ethical principles can be especially challenging when there is a conflict of opinion. In this section, we outline the relevant ethical considerations for the clinician who treats children with ACL injuries.

It is impossible to provide specific ethical guidance that applies to all sporting injuries in adolescents and children, given the varying individual circumstances. However, it is incontrovertible that it is in the best interests of all children not to have knee and associated injuries. Therefore, injury prevention programs are fundamental to the best interests of the child. Clinicians have an obligation to support policies and practices that encourage coaches, teams/clubs, and national and international federations to prioritize injury prevention. All parties should be committed to protecting the long-term welfare of the growing child. Nevertheless, there may be exceptional cases where parents/guardians may, with the approval of their child, rationally prioritize short-term goals. One example could be that, despite inherent risks for reinjury, an early return to sport might be a high priority for a child who has exceptional talent in a given sport.

Protecting the integrity of the knee should be the clinician's primary focus. Decisions regarding how to protect the integrity of the child's knee must be shared among the child, parent/guardian (surrogate decision maker), and clinician.¹⁸ Parents have an obligation to care for their children and bring them up to live good lives.¹⁷ Nevertheless, parents have different perceptions of what constitutes "good living."²⁰ Most ethicists agree that parental influence is a positive thing.¹⁴ However, in high-performance children's sport, parents and coaches can pressure the child and clinician to focus on short-term athletic goals at the expense of long-term welfare.⁵⁴

Issues Related to Consent and Obtaining Consent for Treatment

Children are a vulnerable population.^{6,44} In the context of treatment of ACL injury, the child is doubly vulnerable given his or her developing but uncertain life plans⁷⁸ and developmental stage. We can never be certain of all the risks to the normal development of the individual child.⁸⁵ It is difficult to gain legally legitimate informed consent from children in the treatment decision-making process. Therefore, the clinician needs to act as a fiduciary on behalf of the child, while parents give consent.⁸⁸

The clinician and/or parents are obliged to serve the interests of the child above all other interests.^{88,121} This is what is meant by having a fiduciary duty to the patient.

The clinician must talk with the child and the surrogate decision makers in ways that are respectful of and comprehensible by everyone involved.¹ In addition to avoiding conflicts of interest, the clinician must always seek the approval or assent of the child, irrespective of the wishes of the parent/guardian, at a communication level that matches the child's competence.⁴³ The child should be present in all discussions concerning him or her, to respect his or her (emerging) autonomy.¹³¹

Arriving at a Shared Decision

There should be consensus among all parties when arriving at a decision. This consensus should be based on realistic assessments of risks and benefits and a proper consideration of the goals of the child and parent. The clinician's responsibility is to guide this discussion with accurate information from the best-quality research. Several ethical standards can help the clinician, child, and parents navigate the decision-making process and arrive at ethically justified treatment decisions.

Pediatric ethical standards are not identical: some aim at higher thresholds, while others accept a lower threshold of justification. Six standards can be helpful in different clinical scenarios in pediatric ACL injury:

*Best interests*⁷²: Widely used, but it is difficult to predict what is in the best long-term interests of a child

*Harm principle*³¹: A threshold below which the clinician should not acquiesce to parent-led decision so that the child is not harmed

Parental discretion^{45,64}: Parent preference is accepted because it is not sufficiently harmful to the child for the clinician to dissent from the parent's choice

*Costs/benefits*²⁹: Involves risk assessment, but its application to the child means that the clinician may need to compare very different kinds of futures that may or may not eventuate

*Not unreasonable*¹⁰⁵: Focuses only on the appropriateness of decisions and decision makers

*Reasonable choice*⁹⁶: A decision method that attempts to incorporate the previous 5 standards into a single model or intervention

The clinician has an important role in treatment decision making because he or she typically has superior knowledge of treatment options, risk, and benefits than do children and parents. To best guide the child and his or her parents, the clinician must have a clear idea of the range of interventions that are optimal, acceptable, and not desirable, and he or she must be able to justify this with reference to the best-quality research and clinical experience. In many health care settings, parents take responsibility for the ACL treatment decision, commensurate with the child's assent. Where there is a lack of consensus in the decision-making process (eg, the parent decides in favor of something that is not recommended by the clinician), the clinician may also consider whether he or she can defend a treatment recommendation based on 1 of the 6 ethical standards.

SECTION 7: FUTURE RESEARCH

Management of pediatric ACL injuries is highly debated. Reflecting some of the concern and controversy is a high ratio of clinical commentaries and narrative reviews to original articles on this topic. The problem for the clinician is that high-quality evidence is scarce to help him or her best manage pediatric ACL injuries. The scientific literature is inconsistent and limited by inferior methods that carry a high risk of bias.^{35,91} There are no randomized trials comparing different treatment approaches or surgical techniques. Most publications have only short-term follow-up—none beyond 10 years. Therefore, long-term knee health (including osteoarthritis) and quality of life are unknown.

Methodological Considerations

Future studies must address 5 key issues:

1. Most clinical studies on pediatric ACL injury are of cross-sectional or retrospective design, and the study populations are often at high risk of selection bias and include small samples. This means that there is a high risk that existing research does not reflect the typical pediatric patient with an ACL injury.
2. Many studies do not provide adequate descriptions of the treatments that the patients have received, and patient adherence has not been reported. A meaningful interpretation of study outcomes is possible only with a detailed description of the surgical technique, rehabilitation, brace usage, return-to-sport clearance, and recommendations of activity modification.
3. Many studies fail to assess the skeletal age of included participants, and few report the remaining growth of participants. Chronological age alone is an unreliable indicator of skeletal maturity. Because of this, it is difficult to know to which skeletal age group these research results apply.
4. Patients aged up to 18 years are often included in pediatric studies. This is a problem because it is likely that the patient population is a mix of skeletally mature and immature patients. Therefore, the literature may be biased toward the older patients. Having mixed populations also complicates pooling or comparing results from skeletally immature patients across studies.
5. Knowledge of preinjury and posttreatment activity level gives important insight into a key risk factor for injury. The greater exposure that a child has to potentially injurious situations (eg, playing pivoting sports), the greater the chance of injury (or reinjury). Activity level is a key confounding factor that is rarely accounted for in statistical analyses. This means that there is a risk that estimates of secondary injury incidence may be over- or underestimated in comparisons among studies or patient groups.

Research Priorities

There are 4 research priority areas to improve prevention and outcomes of pediatric ACL injury:

1. Prospective injury surveillance studies to identify injury mechanisms and modifiable risk factors for ACL injury, combined injuries, and knee reinjuries.
2. Prospective research on outcomes after surgical and nonsurgical treatment (active rehabilitation alone). Long-term follow-up (beyond 10 years) is essential to answer key questions of how an ACL injury in childhood affects physical activity, future knee health, and quality of life.
3. Research on the efficacy of different surgical techniques and characteristics (eg, timing of surgery, graft types) and active rehabilitation programs, knee brace use, and activity modification after injury and surgery.
4. Multicenter and registry studies should be prioritized. Because of smaller numbers of ACL injuries in pediatric patients than in skeletally mature patients, specialist treatment centers, expert clinicians, and researchers must prioritize collaboration.

IN MEMORY OF DR ALLEN ANDERSON

An excellent clinician-scientist and a keen coworker in this project, Allen F. Anderson, MD, died in a farming accident on Sunday, November 12, 2017. This tragedy occurred shortly after he had been an active participant in this IOC consensus meeting on the topic of his lifelong clinical and research passion: pediatric ACL injuries. Born on November 16, 1949, Dr Anderson was a graduate of the University of Tennessee College of Medicine. He completed a residency in orthopaedics at Vanderbilt University and was board certified by the American Board of Orthopaedic Surgery in general orthopaedics, with a certificate of added qualification for sports medicine. Dr Anderson was a sports medicine specialist with an interest in knee injury and ligament reconstruction and with special interest in children's injuries. He published >100 peer-reviewed journal articles and 26 book chapters and received a patent for the invention of a pediatric ACL reconstruction system. Among numerous awards are 3 standouts: being recognized as one of America's Top Physicians (2004-2012) from the Consumers' Research Council, being elected to Best Doctors in America by his peers (2007-2008), and being Nashville Business Journal Top Doctor (2016-2017).

Dr Anderson had many prestigious positions through his life. He served as president of the AOSSM from 2015 to 2016 and as an associate editor of *The Orthopaedic Journal of Sports Medicine* and *The American Journal of Sports Medicine*. Above all, he was a true friend and colleague to whom you could go with problems and challenges, not the least among our youngest patients. Allen will be greatly missed by us all.

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APPENDIX

TABLE A1
Delphi Consensus Process Statements

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1. Diagnostic tests and imaging
 2. Methods for skeletal age assessment
 3. Surgical techniques (transphyseal vs physeal-sparing)
 4. Indications for surgical treatment
 5. Risks associated with surgical treatment (eg, growth disturbance, joint angulation)
 6. Uncertainties and limitations regarding the pediatric anterior cruciate ligament (ACL) graft
 7. Rationale for nonsurgical treatment
 8. Disadvantages/risks associated with nonsurgical treatment (eg, secondary meniscal injury)
 9. Management of associated injuries (eg, meniscus, articular cartilage)
 10. Rehabilitation guidelines
 11. Functional tests for treatment decision making and clearance to return to unrestricted activity
 12. ACL injury prevention
 13. Managing reinjury risk
 14. Pediatric patient-reported outcomes
 15. Guidelines for long-term follow-up
 16. Development of posttraumatic osteoarthritis
 17. Influence of treatment approach on development of posttraumatic osteoarthritis
 18. Development of a pediatric ACL treatment outcome registry
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TABLE A2
Exercise Examples for Each Phase of Pediatric Anterior Cruciate Ligament Rehabilitation

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|---------|--|
| Phase 1 | <ul style="list-style-type: none"> • Stationary bike • Active extension (unloaded) • Quads setting • Squat variants with and without support • Single-limb standing (control of isometric terminal knee extension) • Closed-chain hip and pelvis control exercises |
| Phase 2 | <ul style="list-style-type: none"> • Single-limb standing control of dynamic terminal knee extension • Single-leg squats • Bridging • Squats on BOSU ball • Step-ups (front and lateral) • Lunge onto BOSU ball |
| Phase 3 | <ul style="list-style-type: none"> • Bulgarian split squats (progress by adding hand weights—dumbbells or kettlebells) • Stair jumps (double- and single-leg) • Split squat jumps on BOSU ball • Hopping and landing emphasizing shock absorption and avoiding dynamic knee valgus • Lateral, frontal, and backward agility exercises • Running direction change exercises (progress from wide turn to tight turn/tight cut, from around a stationary object to an opponent) • Leg press • Quads strength with leg extension machine |
| Phase 4 | Injury prevention (refer to Section 1 of the consensus statement, and FIFA 11+ for Kids manual ¹ for guidance) |
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