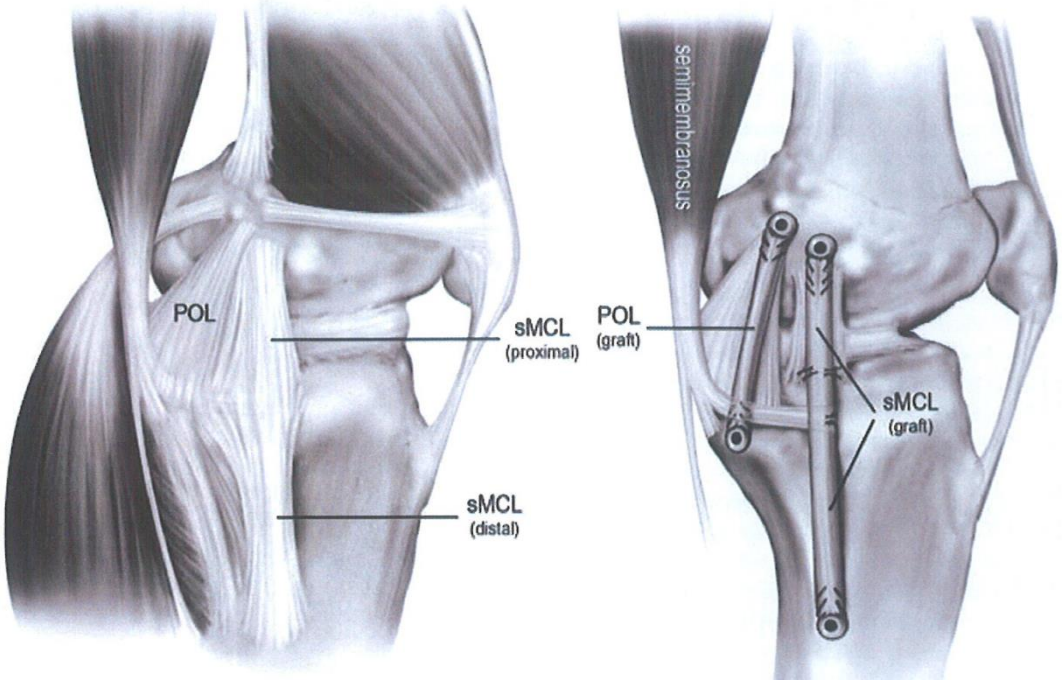
INFORMATION ON MCL INJURIES AND MANAGEMENT



The medial, or inside, aspect of the knee has a number of thickenings, in the wall, of the knee joint. These “thickenings” are called ligaments and are responsible for the stability of the inside of the knee, preventing the knee from buckling into a “knock-knee” position.

They also provide some stability, preventing the knee from rotating abnormally with certain movements.

In most cases, injuries to these ligaments can be treated non-operatively, with, or without, a brace. In a smaller amount of cases, a reconstruction/repair has to be carried out.

From the above picture, on the right, one can see that there are 2 main aspects to the ligament complex on the medial side of the knee:

1. The MEDIAL COLLATERAL LIGAMENT – this consists of a deep and a superficial part (sMCL) – it is the sMCL that is mainly responsible for preventing opening of the knee, when the knee is bent to about 20-30deg, such as when one goes into a tackle, or twists when getting up from a chair, etc
2. The POSTERIOR OBLIQUE LIGAMENT – this ligament is responsible for stability in full extension (knee straight), and also prevents “popping out” of the knee when the knee rotates.

If the point has been reached where a repair/reconstruction has become necessary, the picture on the right shows what we would want to do.

It involves reconstructing the 2 main parts of the ligament and hopefully restoring the stability to that side of the knee.
It may also involve other ligament/cartilage work, as these injuries are often associated with other ligament and cartilage damage. This will have been discussed with you already.

The choices of graft are:

1. Your own tissue – hamstring tendons, either from the same side, or the other leg, are the best options
2. Synthetic ligament (you can google “LARS ligament” – this is the synthetic graft that I occasionally use, when someone has run out of their own tissue, such as when there are multiple ligaments injured.
3. Allograft – from a dead person (such as a heart/kidney transplant). In South Africa we do not have decent allografts at our disposal, due to the higher level of HIV in this country. I generally avoid these grafts.

Usually the hospital stay is for 24 hours, but it also depends on whether any other operation was carried out at the same time.

You would be admitted on the same day as the operation and the operation would be carried out under general anaesthetic. Local nerve blocks may be given, as well, depending on the anaesthetists preferences.

After the operation you will be placed in a hinged brace which will be locked and you will be advised on what to do with it during your post-operative rehabilitation.

Pain killers and anti-inflammatories will be given to you on your departure from the hospital.
One must realise that we cannot re-establish the ligaments as tight and stable as they were before the injury, and there is often a little play in the joint, despite our best efforts.

What can go wrong after an operation of this kind?

There is no surgical procedure in existence that is without possible complications! However, serious complications are infrequent.

Complications include:

1. Bleeding after the operation – an unlikely scenario in a pure MCL reconstruction

2. Swelling of the knee – some swelling is inevitable after the operation, especially if other surgery has been carried out to the knee..

3. Venous thrombosis ("clots in the veins"). Every attempt is made to minimise this complication. TED stockings(white long stockings) are used on both legs which compress the calf muscles and prevent DVT. Anti-inflammatory medications also play a role in thinning the blood slightly and contributing to prevention of DVT. We mobilize patients very quickly after surgery thus reducing the risk further.

   IT IS RECOMMENDED THAT YOU DO NOT UNDERTAKE ANY AIR TRAVEL FOR 4 WEEKS AFTER YOUR SURGERY. PLEASE DISCUSS ANY TRAVEL PLANS WITH ME PRIOR TO YOUR SURGERY.

4. Infection – a rare but serious complication.

The expected time of return to activities:

The knee has to be protected for 3-6 months following this procedure. If a cruciate ligament reconstruction has been carried out at the same time, then the period of protection will continue for up to 1 year. The finer detail of the rehabilitation will be discussed with you prior to your surgery.
If the MCL is reconstructed alone, then you will use crutches for 6weeks, non weight-bearing, and a further 6 weeks partial weight-bearing.
The brace will be wron for sleeping, walking and standing, but it can be removed in a controlled situation, such as when you are at physio, or doing exercises at home.

I hope this explains the most important aspects of the MCL reconstruction, but I can answer any further questions before the time, on email, or on the day of your surgery

Glen Vardi
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