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GP NEWS

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medial collateral ligament injury

tips for best management

1. valgus force is the mechanism of injury

Medial Collateral Ligament (MCL) is one of the most commonly injured ligaments of the knee. Typically they result from a valgus force from direct contact or strong cutting/change of direction movement.[1]

Prognosis is excellent for full recovery with isolated injuries treated non-operatively. Surgery may be considered if multiple structures are involved including the ACL or meniscus.[2,3]

2. objective signs for diagnosis[1]

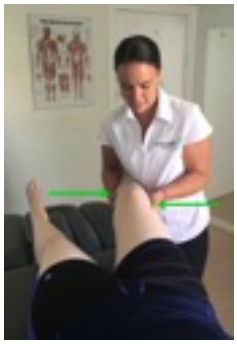
- **palpation**: localised knee swelling and medial tenderness over the MCL proximal from the joint line. The presence of a significant joint effusion can indicate a combined injury with other knee structures.

- **valgus stress testing**: ligament laxity on valgus stress test at 30º knee flexion can determine the grading of the injury:

grade I: pain without laxity on valgus stress testing indicating micro-tearing of the MCL

grade II: increased laxity on valgus stress testing, but with an end feel indicating partial tear of the MCL

grade III: no end feel to valgus stress testing at 30º knee flexion indicating complete rupture (if positive on valgus testing in 0º knee flexion, this can indicate a combined injury with ACL involvement)



3. non-operative management for all isolated MCL injuries is recommended:[1,3]

- A *ROM brace* is essential in early management of grade II & III injuries to limit valgus forces & potential for chronic laxity.
- *RICE* (Rest, Ice Compression & Elevation) principles should also be applied within the first 72 hours to limit excessive inflammation.
- *Protective ambulation* with crutches is also often required early until pain reduces in walking.
- *Physiotherapy* can commence from day1 post-injury to ensure quadriceps atrophy is minimised, oedema is limited & range of movement is maintained within non-stressful MCL range.

We keep knee R.O.M. braces in stock to fit with a priority booking if

ocean view physiotherapy

4339 2275

newsletter produced by Rebecca McRae - Physiotherapist
at ocean view physiotherapy
86 ocean view drive wamberal 2260

Rebecca has recently joined ocean view physiotherapy.

Rebecca graduated from the University of Canberra in 2011. Having worked in musculoskeletal and sport injury clinics in Canberra for over 4 years Rebecca has moved to the Central Coast in 2016. In Canberra she worked with many elite sporting teams including the Canberra Capitals WNBL team, ACT Netball, Cricket ACT and local AFL, hockey and triathlon clubs.

Rebecca enjoys the challenge of diagnosing the cause of her patient's injuries and has extensive experience with the Connect Therapy Integrated Systems Model, dry needling and visceral manipulation.

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telephone: 4339 2275 email: info@oceanviewphysio.com.au

references:

1. *Bhatia, S & Verma NN. (2015) Best Practice Guidelines Medial Collateral Ligament. BMJ http:// bestpractice.bmj.com/best-practice/mybp/monograph-pdf/828.pdf*

2. *Chen L, Kim PD, Ahmad CS & Levine WN. Medial collateral ligament injuries of the knee: current treatment concepts. Curr Rev Musculoskelt Med 2008; 1:108-113*

3. *Wijdicks CA, Griffith CJ, Johansen S, et al. Injuries to the medial collateral ligament and associated medial structures of the knee. J Bone Joint Surg Am. 2010;92:1266-1280.*