Background: An 18 year old male collegiate football player complained of right knee pain after participating in a football game two days prior. The athlete could not recall his mechanism of injury, but was able to finish the game with mild knee pain and did not seek immediate treatment. Past medical history reported an MCL knee sprain and a quadriceps strain during his high school years. The patient had an obvious antalgic gait and was point tender just proximal to the superior border of the right patella running proximally to the distal 1/3 portion of the right anterolateral thigh. Severe edema and ecchymosis was located from the middle thigh running distally to the distal tibiofibular joint. The athlete’s range of motion (ROM) had a significant decrease in knee flexion lacking 53° when compared to the non-injured side. Girth measurements included 4 inches distal a 3.5cm increase, inferior pole a 5.5cm increase, midpatella a 7.5cm increase, superior pole a 7cm increase, and at 4 inches proximal a 2 cm increase. Manual muscle testing revealed weakness in the quadriceps (4/5) and hamstrings (4/5). Special Tests revealed a positive sweep test implicating knee effusion. No neurovascular abnormalities were discovered.

Differential Diagnosis: Quadriceps contusion, prepatellar bursitis, suprapatellar bursitis, quadriceps strain, deep vein thrombosis (DVT), synovitis.

Treatment: The team physician ordered an ultrasound to rule out DVT secondary to the severity of swelling, which tested negative. Physician’s clinical examination, without MRI, lead to the diagnosis of a Prepatellar Morel Lavallee Lesion (MLL) also known as closed internal degloving of the prepatellar bursae. The Physician attempted aspiration with little results and recommended a compression sleeve and rehab. After rehabilitation focusing on ROM, decreasing pain and edema, increasing hamstring and quadriceps strength, and proprioception, the athlete was progressed functionally. The treatment process for the athlete’s initial stage of injury included applying compression to the athlete’s leg using a compression wrap and crutches to decrease pressure on the area. After several days of rehab, the team chiropractor additionally applied a Spider Tech kinesiotaping to the injury to assist in decreasing edema for 2 consecutive days. Cryo/Intermittent compression, elevation, and electrical stimulation were used to control edema and decrease pain. At two weeks, the patient wore a compression sleeve with a donut pad and attempted progressive functional activities, but was unable to secondary to pain. The following week, the patient was pain free with football activities and participated in the next game wearing a compression sleeve and knee brace with the understanding that he could experience re-injury with direct contact. Following the game, the patient had increased edema and increased pain, but was able to finish. He stated that he landed directly on his injured knee during the last series of the game. He was withheld for another 2 weeks focusing on rehab to decrease swelling and increasing ROM. The patient was able to compete in the final game of the season without complications.

Uniqueness: Morel Lavallee Lesion is an injury that is commonly misdiagnosed as prepatellar bursitis. In this case, the athlete did not use compression on the injury until 2 days post injury and as a result, the athlete sought assistance when severe edema occurred which may have resulted in delayed...
absorption and return to play. **Conclusion:** Research shows that in high school and collegiate levels there are limited studies that show MLL as the diagnosed injury. Thus, it is important that athletic trainers consider MLL, treat immediately, and understand the possible long term complications. A thorough clinical exam, early detection, and appropriate treatment can save unnecessary diagnostic tests and a shorter return to play timeline.

**Word Count:** 599