Posteriolateral Knee Pain in a Collegiate Football Player
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**Background:** An 18 year old wide receiver was tackled and immediately reported right posteriolateral knee pain, paresthesia, and loss of function in the lower extremity. Initial examination revealed posteriolateral instability with an empty end feel with varus stress testing. His medical history is not significant for injuries to the involved knee or surrounding area. **Differential Diagnosis:** Fibular fracture, PCL tear, LCL tear, peroneal neuritis, lateral meniscal tear, and biceps femoris strain. **Treatment:** After the initial evaluation, he was iced, placed in a straight leg knee immobilizer, instructed to ambulate utilizing NWB crutch gait pattern, and referred to the team orthopedic surgeon for further evaluation. The physician diagnosed him with an LCL and posterolateral corner knee injury, with normal peroneal nerve functioning and ordered an MRI. MRI results indicated marked medial and lateral soft tissue edema. The LCL and biceps femoris tendon were torn at the attachment from the fibular head and retracted 15 mm. Discernible edema was present within the fibular head of the soleus, representing a partial tear. A small knee joint effusion and mild contusions were seen along the medial aspect of the tibial plateau and anterioomedial femoral condyle. The semimembranosus tendon was completely torn and retracted 5 cm from the tibial plateau. Edema deep and anteriorly to the MCL, representing low grade tearing of the deep fibers, was present. An LCL, biceps femoris, semimembranosus, and posterirolateral corner reconstruction was performed six days after incident. A postoperative rehabilitation program was initiated along with wound management of the surgical incision. Four weeks s/p, he presented with increased soreness secondary to rejection of the subcutaneous sutures by the body. Rehabilitation was reduced to the use of a stationary bike and sutures were removed as they surfaced. Six weeks s/p, the patient underwent an I+D for subcutaneous suture removal. Post I+D, re-evaluation examination revealed sutures in place, AROM 0-90° of knee flexion, and normal neurovascular function. He was instructed to cover the wound until suture removal in two weeks. Eight weeks s/p, I+D incision was healed and he was able to complete 0-135° of knee AROM. 12 weeks s/p, he complained of increased swelling, pain, and decreased ROM resulting from an infection. An additional I+D was performed and he was seen by an infectious disease specialist. The patient was placed on a second round of Keflex® and was cleared to continue with rehabilitation. 24 weeks s/p, he was fitted for a custom functional hinged knee brace and progressed to performing sport specific activities. The patient was cleared by the team physician and fully returned to athletic activities approximately 11 months post surgery. His return to activity did not elicit any pain or apprehension. **Uniqueness:** Posterolateral corner injuries are infrequent in athletics. Specifically, in this case, the combination of a grade III LCL sprain and avulsion fractures of the fibula and tibia from the biceps femoris and semimembranosus tendons is rare. This injury was difficult to diagnose on evaluation because the reported symptoms were diffuse and the pathology and subsequent surgical interventions forced the rehabilitation program to follow a strict progressive protocol to reduce the pulls of the biceps femoris and semimembranosus tendons.
Also, it is uncommon for the vicryl used during the surgery to be rejected. Finally, the two additional surgeries did not substantially hinder the rehabilitation, as the patient was able to progress well throughout the remainder of the program. **Conclusion:** Prompt recognition and treatment of posteriorlateral reconstruction is critical to reduce the incident of graft failure. The literature reports that reconstruction occurring within 2 weeks demonstrates better outcomes then when surgery is performed after two weeks. **Word Count:** 600