Osteochondral Lesion in the Knee of a Division 1 Baseball Pitcher
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Background: This case report observes an OCD lesion in a male, 20 year old, D1 collegiate athlete, who is a right-handed pitcher. He previously played basketball on many teams throughout high school but had reported no previous knee injuries. He reported to the athletic training room in October 2012, complaining of progressive, unremitting right knee pain for 3 weeks and was unable to finish team lift that morning. The athlete felt sharp pain along with clicking while doing everyday activities, but the pain seemed to migrate locations around the knee. During observation, it was noticed that edema was present and there was a lack of full extension during gait. He was non-complaint during follow up evaluations and rehabilitation treatments, but the pain and edema decreased. Upon initial evaluation, the clinical impression presented a meniscal injury. An appointment with the team MD was scheduled in November 2012. Differential Diagnosis: Patello-Femoral Pain Syndrome, Chonromalacia patella, Meniscal Injury. When the pain did not remit upon follow up visit with MD, an MRI was ordered where it revealed a possible OCD lesion. Treatment: An MRI-arthrogram was ordered to confirm MRI results, which identified an unstable Osteochondral Lesion present in the anterior-lateral femoral condyle with a loose body. Various options were discussed to manage the injury and the MD recommended arthroscopic evaluation with possible repair of the lesion. The athlete decided that the surgical option seemed most appropriate. In December 2012, surgery was performed where the loose body was removed and the lesion was recessed. Any unstable cartilage around the rim was removed and the MD proceeded with a micro-fracture technique. In January 2013, there was a follow up visit and the athlete was allowed to begin AROM. Later in January/February 2013, his immobilizer brace was removed, and he was allowed to start gentle strengthening from full flexion to about 70 degrees and 0 degrees to 30 degrees. During this time the athlete still complained of some catching on the rise of his squats and minor pain. He had been jogging but was urged not to continue by team MD. His rehabilitation was split into two parts; strength days and cardio/proprrioception days. The athlete was gradually returned into practice with light pitching drills at less than 50% that progressed to full team drills. End of February 2013, the athlete was allowed to start gradual bullpen work and continued to progress with strengthening. In March 2013, the athlete returned to game play in starting pitcher position. Almost a year later, the athlete is doing well and only complains of soreness due to inactivity over Summer 2013. Uniqueness: Due to requirements of the lower extremity during the pitching motion, less stress to the right leg allowed athlete to return sooner as compared to this injury at other player positions. Additionally, the lesion could have been career-ending if it were a different location on the femur. In conjunction with the two prior points, the surgical procedure also allowed the athlete to return to play sooner. Conclusions: This case report indicates the importance of athletic trainer evaluation and compliance of athlete in order to obtain the correct diagnosis and return to activity sooner. Research shows that MRI-arthrogram is the gold standard for diagnosing OCD lesions. This case also indicates that further research is needed about the incidence of this type of injury in athletes, the success rate of previous return to play level given location of OCD as well as, its prevalence in different sport activities. Word Count: 596