A Triple-Strand Anatomic Medial Collateral Ligament Reconstruction Restores Knee Stability More Completely Than a Double-Strand Reconstruction

A Biomechanical Study In Vitro

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Background: There are many descriptions of medial collateral ligament (MCL) reconstruction, but they may not reproduce the anatomic structures and there is little evidence of their biomechanical performance.

Purpose: To investigate the ability of “anatomic” MCL reconstruction to restore native stability after grade III MCL plus posteromedial capsule/posterior oblique ligament injuries in vitro.

Study Design: Controlled laboratory study.

Methods: Twelve cadaveric knees were mounted in a kinematic testing rig to impose tibial displacing loads while the knee was flexed-extended: 88-N anteroposterior translation, 5-N/crad internal-external rotation, 8-N/crad valgus-varus, and combined anterior translation plus external rotation (anteromedial rotatory instability). Joint motion was measured via optical trackers with the knee intact; after superficial MCL (sMCL), deep MCL (dMCL), and posterior oblique ligament transection; and then after MCL double- and triple-strand reconstructions. Double strands reproduced the sMCL and posterior oblique ligament and triple-strands the sMCL, dMCL, and posterior oblique ligament. The sMCL was placed 5 mm posterior to the epicondyle in the double-strand technique and at the epicondyle in the triple-strand technique. Kinematic changes were examined by repeated measures 2-way analysis of variance with posttesting.

Results: Transection of the sMCL, dMCL, and posterior oblique ligament increased valgus rotation (5° mean) and external rotation (9° mean). The double-strand reconstruction controlled valgus in extension but allowed 5° excess valgus in flexion and did not restore external rotation (7° excess). The triple-strand reconstruction restored both external rotation and valgus throughout flexion.

Conclusion: In a cadaveric model, a triple-strand reconstruction including a dMCL graft restored native external rotation, while a double-strand reconstruction without a dMCL graft did not. A reconstruction with the sMCL graft placed isometrically on the medial epicondyle restored valgus rotation across the arc of knee flexion, whereas a reconstruction with a more posteriorly placed sMCL graft slackened with knee flexion.

Clinical Relevance: An MCL injury may rupture the anteromedial capsule and dMCL, causing anteromedial rotatory instability. Persistent MCL instability increases the likelihood of ACL graft failure after combined injury. A reconstruction with an anteromedial dMCL graft restored native external rotation, which may help to unload/protect an ACL graft. It is important to locate the sMCL graft isometrically at the femoral epicondyle to restore valgus across flexion.

Keywords: medial collateral ligament; anatomic reconstruction; biomechanics; anteromedial rotatory instability

The medial collateral ligament (MCL) is the most frequently injured ligament of the knee:3 it is injured in up to 40% of all knee injuries4 and in 8% of knee injuries in athletes.27 The anterior cruciate ligament (ACL) is injured in 95% of knees with multiligament injuries12; combined ACL + MCL injuries are the most common of these11 and are associated with anteromedial rotatory instability (AMRI).45 Even in knees with clinically isolated ACL tears, there is abnormality of the MCL on magnetic resonance
A joint laxity and not to subjective symptoms described by patients. It was hypothesized that native ER would not be restored without a dMCL graft and that native valgus rotation would not be restored across the arc of flexion without an isometric sMCL graft.

**METHODS**

After approval by the research ethics committee in Wales (12/ WA/0196, license ICHTB 12275, application R15092-1A), 12 knees were obtained from the MedCure tissue bank: 8 male, 4 female; age 52 ± 8 years (mean ± SD); body mass index, 23.3 ± 5.9. The fresh-frozen specimens were kept at −20°C and thawed for 24 hours at room temperature before use. The exclusion criteria were donor age >70 years, osteoarthritis, previous surgery, and abnormal laxity or misalignment; these were confirmed by gross inspection and manual examination by an orthopaedic surgeon (N.M.) during dissection. A power analysis (Version 3.1.9.7; G*Power) based on previously published dataPagination Error! indicated that a change of 2° of ER could be identified with 88% power and 95% confidence (alpha = .05) with 7 specimens.

**Specimen Preparation**

The skin and subcutaneous fat were removed, leaving other soft tissues intact. The femur and tibia were cut 17 cm above and below the joint line. The fibula was cut 12 cm below the joint line and fixed to the tibia in its anatomic position using a tricortical bone screw. Each knee was tested in 1 day and kept moist with occasional water spray during the testing.

Soft tissues were removed from the proximal femur and the distal tibia, and an intramedullary rod was cemented into the femur using polymethylmethacrylate. The distal tibia was cemented into a steel pot with a rod extending 0.5 m axially. The femoral intramedullary rod was clamped to the moving arm of a 6 degrees of freedom kinematics rig with the shaft of the femur at the anatomic 6° valgus offset so that the tibia hung vertically below it, with secondary motions uninhibited (Figure 1). The femoral epicondylar axis was aligned to the flexion-extension axis of the rig, and the knee was flexed from 0° to 100°.
To apply anteroposterior translation (draw) forces to the proximal tibia, a 5.5-mm Steinmann pin was drilled through it from medial to lateral, and 2 semicircular metal hoops were mounted on it. These hoops were used to apply 88-N of anterior or posterior translation force by string, pulley, and hanging weights without constraining internal rotation (IR)–ER. A 250 mm diameter polyethylene pulley was fixed to the distal tibial extending rod to allow the application of 5-N/C\textdegree IR or ER torque and 8-N/C\textdegree varus or valgus moment using a string, pulley, and weights system. These loads represent those imposed during clinical examination, as in previous studies.\textsuperscript{10,17,22,24} During pilot testing, the tibia was grossly unstable in IR-ER after the medial soft tissues were transected and a valgus moment was applied. To control this, a screw passing through a fixture on the tibial extending rod could be tightened to prevent rotation but not inhibit other degrees of freedom. When the knee was intact, the position of free neutral tibial rotation was marked on the fixture at 0° and 30° of flexion; then, valgus-varus tests and graft tensioning could be performed at the native neutral rotation.

An optical tracking system measured tibial motion relative to the femur.\textsuperscript{17,22,24} Triads of reflective markers (BrainLab) were secured to the femur and tibia with bicortical rods and tracked by a stereo infrared camera (Polaris Vega; Northern Digital Inc) with a root mean square translational accuracy of ±0.12 mm (Network Device Interface specification). Small metal bone screws were used as digitization points, these were placed 10 mm proximal to the medial and lateral epicondyles (to avoid interfering with graft tunnels), the proximal end of the femur, the most medial and lateral points of the tibial plateau, and the distal end of the tibia. These anatomic landmarks were digitized with an optical stylus (BrainLab) to define the femoral and tibial coordinate systems. Zero degrees of flexion was defined as when the tibial and femoral rods were parallel when viewed in the sagittal plane, and the 6 degrees of freedom tibiofemoral motions were measured from that datum.\textsuperscript{17,22,24}

**Surgical Procedures**

Reconstructions of the MCL + POL were performed after the sMCL, dMCL, and PMC/POL had been transected using a scalpel at the proximal rim of the meniscus. Double-strand (DS) suture tapes (Ultra Tape; Smith & Nephew Endoscopy) were used as grafts. The small-diameter bone tunnels for the sutures allowed DS and triple-strand (TS) reconstructions to be compared in each knee without bone tunnel conflict. The femoral tunnels of the DS technique were placed at the mean centers of the anatomic attachments as described in previous work.\textsuperscript{25} The sMCL was centered 5 mm posterior and 3 mm proximal from the medial epicondyle, and the POL was 11 mm posterior and 4 mm proximal from the medial epicondyle (Figure 2A).

The femoral tunnels of the TS technique reproduced the anatomic attachments defined in previous work.\textsuperscript{4} The sMCL was centered 1 mm proximal from the medial epicondyle, the dMCL 5 mm posterior and 6 mm distal from...
the medial epicondyle, and the POL 11 mm posterior and 4 mm proximal, as in the DS technique (Figure 2B).

The tibial sMCL tunnel was 60 mm below the joint line, at the center of the anteroposterior width of the native sMCL for the TS technique and at the posterior edge in the DS technique, as in the original article. To identify the tibial POL attachment, the fascia anterior to the semimembranosus tendon was incised and the tendon retracted distally. The POL attached at the posteromedial rim of the tibia near the direct arm of semimembranosus. Femoral and tibial POL tunnels were the same in both surgical techniques. By applying a slight flexion and ER load, the tight fibers of the dMCL could be clearly seen and the tibial attachment identified. The tibial dMCL tunnel was placed at the center of the width of the native dMCL 12 to 15 mm below the joint line, giving a graft oriented 25° to 30° anterodistal from the femoral tunnel in neutral rotation near knee extension.

To evaluate isometry, 2.4-mm eyelet pins were drilled into the centers of the attachments and sutures passed around them. In the TS technique, the sMCL and dMCL were isometric during the knee range of motion and the POL was anisometric: tight in extension with slackening in flexion. In the DS technique, the sMCL and POL were anisometric: tight in extension with slackening in flexion. The pins in the femur were overdruilled 25 mm deep with a cannulated 7-mm drill. The femoral tunnel entrances were reinforced with nylon tubes 12 mm long and a 2-mm bore so that the suture tapes did not cut into ("cheesewire") the edge of the bone tunnel entrance, ensuring that the suture tapes were located at the center of each tunnel. The tibial tunnels were overdrilled to 9 mm for 30-mm depth, filled with polyester resin paste (Ispon P38; U-POL), and redrilled with a cannulated 7-mm drill to 25-mm depth. This tunnel reinforcement was found to be necessary during pilot testing, owing to the soft bone in the knees.

The suture tape was looped through a cortical button (EndoButton; Smith & Nephew) for femoral lateral cortical fixation, and the 2 strands were pulled through the femur and nylon tube to the medial side. The suture tapes were pulled through the tibial bone tunnels to the lateral aspect. After initial tensioning, the knee was flexed-extended through the full range of motion 15 times. The final graft tensioning was with the tibia fixed in the neutral IR-ER of the unloaded knee. The kinematic data come measures were the ability of MCL reconstruction to reduce joint laxity below that of the MCL-injured state and the differences between the kinematics with each reconstruction method.

RESULTS

Anterior Translation

The mean anterior tibial translation (ATT) of the native knee in response to 88-N anterior translation force ranged from 1 to 3 mm across 0° to 100° of knee flexion (Figure 3). The ATT did not change significantly with MCL transection or reconstruction, all measurements being within 1 mm (P > .05).

Posterior Translation

The mean posterior tibial translation of the native knee in response to an 88-N posterior translation force ranged from 2 to 3 mm across 0° to 100° of knee flexion and, as with ATT, was not changed significantly by any stage of the experiment (P > .05).

External Rotation

The mean ER of the intact knee in response to 5-N-m torque ranged from 12° to 19° across 0° to 100° of flexion (Figure 4). Transection of the medial structures caused ER to
Figure 3. Anterior translation in response to an 88-N anterior translation force across 0° to 100° of knee flexion. Mean ± SD (n = 12). Grade 3 injury: sMCL + dMCL + PMC/POL transected. DS reconstruction: sMCL + POL grafts. TS reconstruction: sMCL + dMCL + POL grafts. dMCL, deep medial collateral ligament; DS, double strand; PMC, posteromedial capsule; POL, posterior oblique ligament; sMCL, superficial medial collateral ligament; TS, triple strand.

Figure 4. External rotation in response to 5-N·m external rotation torque across 0° to 100° of flexion. Mean ± SD (n = 12). Grade 3 injury: sMCL + dMCL + PMC/POL transected. DS reconstruction: sMCL + dMCL + POL grafts. TS reconstruction: sMCL + dMCL + POL grafts. For abbreviations, see Figure 3.

### Table 1

| Flexion, deg | ER Increase vs Native, deg | P Value | ER Increase vs Native, deg | P Value | Grade 3 | ER Increase vs Native, deg | P Value | Grade 3 | P Value, TS |
|--------------|---------------------------|---------|---------------------------|---------|---------|---------------------------|---------|---------|-------------|
| 0            | 3.9 .002                  |         | 1.1 .699                  | .08     |         | 4.0 .001                 | ≥.99    | .047    |
| 10           | 4.7 .001                  |         | 0.3 ≥.99                  | .003    |         | 4.4 .001                 | ≥.99    | .004    |
| 20           | 5.5 .002                  |         | 0.2 ≥.99                  | .001    |         | 5.0 .002                 | ≥.99    | .001    |
| 30           | 6.9 .001                  |         | 0.7 ≥.99                  | .001    |         | 6.1 .002                 | .084    | <.001   |
| 40           | 8.5 <.001                 |         | 1.0 ≥.99                  | <.001   |         | 7.4 .001                 | .009    | <.001   |
| 50           | 10.3 <.001                |         | 1.3 .547                  | <.001   |         | 8.9 <.001                | .017    | <.001   |
| 60           | 12.0 <.001                |         | 1.5 .251                  | <.001   |         | 10.3 <.001               | .022    | <.001   |
| 70           | 13.1 <.001                |         | 1.4 .30                   | <.001   |         | 11.1 <.001               | .04     | <.001   |
| 80           | 13.4 <.001                |         | 1.3 .461                  | <.001   |         | 11.4 <.001               | .128    | <.001   |
| 90           | 13.2 <.001                |         | 1.2 .728                  | <.001   |         | 11.5 <.001               | .297    | <.001   |

*Bold indicates significant difference. DS, double strand; ER, external rotation; TS, triple strand.*

increase by 9° ± 1° (mean ± SD; range, 4° ± 1° to 13° ± 2°; P < .001) across the arc of flexion (Table 1). The DS reconstruction did not reduce ER significantly as compared with transection, and the laxity remained 7° ± 1° (range, 4° ± 1° to 12° ± 2°; P < .001) higher than in the intact knee. After TS reconstruction, the ER was 0° to 2° larger than native ER and did not differ significantly (P > .25) from the native knee.

**Internal Rotation**

The mean IR in response to 5-N·m IR torque ranged from 9° to 19° across 0° to 100° of flexion (Figure 5). Transection of the medial structures caused a significant increase in IR of 7° ± 1° (range, 3° ± 1° to 11° ± 2°; P < .001) (Table 2) across the entire flexion cycle. Although the DS reconstruction significantly reduced the IR by 3° ± 1° to 7° ± 1° between 0° to 20° of flexion, it did not significantly reduce the IR above 20° of flexion. The IR with the DS reconstruction was significantly higher than that in the intact knee throughout the entire flexion cycle by 5° ± 1° (range, 3° ± 1° to 7° ± 1°). The TS reconstruction did not reduce the IR significantly, and it remained significantly higher than that in the intact knee throughout flexion by 6° ± 1° (range, 3° ± 1° to 8° ± 2°). The IR was not significantly different between the reconstruction methods at any angle of flexion examined (P ≥ .99).
Grade 3 Injury

| Flexion, deg | IR Increase vs Native, deg | P Value | IR Increase vs Native, deg | P Value | P Value, Grade 3 | IR Increase vs Native, deg | P Value | P Value, Grade 3 | P Value, TS |
|--------------|---------------------------|---------|---------------------------|---------|-----------------|---------------------------|---------|-----------------|------------|
| 0            | 10.1                      | .003    | 5.0                       | .009    | .117            | 3.4                       | .324    | .001           | ≥.99       |
| 10           | 10.8                      | <.001   | 6.7                       | .028    | .153            | 5.2                       | .009    | <.001          | ≥.99       |
| 20           | 10.3                      | <.001   | 7.6                       | .004    | .205            | 6.9                       | .001    | .008           | ≥.99       |
| 30           | 9.2                       | <.001   | 7.5                       | .002    | .31             | 7.4                       | <.001   | .119           | ≥.99       |
| 40           | 8.1                       | <.001   | 7.2                       | .001    | .583            | 7.0                       | .001    | .489           | ≥.99       |
| 50           | 6.9                       | .001    | 6.4                       | .001    | ≥.99            | 6.3                       | .001    | ≥.99           | ≥.99       |
| 60           | 5.7                       | .002    | 5.4                       | .003    | ≥.99            | 5.4                       | .004    | ≥.99           | ≥.99       |
| 70           | 4.6                       | .004    | 4.4                       | .005    | ≥.99            | 4.5                       | .009    | ≥.99           | ≥.99       |
| 80           | 3.9                       | .005    | 3.8                       | .005    | ≥.99            | 4.0                       | .006    | ≥.99           | ≥.99       |
| 90           | 3.6                       | .002    | 3.5                       | .002    | ≥.99            | 3.6                       | .003    | ≥.99           | ≥.99       |
| 100          | 3.3                       | .001    | 3.2                       | .001    | ≥.99            | 3.2                       | .001    | ≥.99           | ≥.99       |

*Bold indicates significant difference. DS, double strand; IR, internal rotation; TS, triple strand.

Figure 5. Internal rotation in response to 5-N·m internal rotation torque across 0° to 100° of flexion. Mean ± SD (n = 12). Grade 3 injury: sMCL + dMCL + PMC/POL transected. DS reconstruction: sMCL + POL grafts. TS reconstruction: sMCL + dMCL + POL grafts. For abbreviations, see Figure 3.

Valgus

The mean valgus rotation of the native knee ranged from 1° to 3° in response to an 8-N·m valgus moment across 0° to 100° of knee flexion (Figure 6). Transection of the sMCL + dMCL + PMC/POL increased valgus rotation by 5° ± 1° (range, 4° ± 1° to 6° ± 1°), a significant increase at all angles of flexion (Table 3). After DS reconstruction, the valgus rotations were not significantly different from the native at 0° to 30° flexion but became progressively more lax with knee flexion, reaching 5° excess rotation across 60° to 100° of flexion. The valgus rotation was not reduced significantly from that of the injured knee across 80° to 100° of flexion. Although the DS reconstruction resulted in a significant reduction of valgus rotation from the injured state across 40° to 70° of flexion, significantly increased rotations remained above 30° of flexion. After the TS reconstruction, valgus rotation was restored to the native state within 1° to 2° across 0° to 100° of knee flexion and did not differ significantly from the native knee throughout the flexion cycle.

Varus

The mean varus rotation of the native knee ranged from 2° to 3° in response to an 8-N·m varus moment across 0° to 100° flexion and was not changed significantly at any stage, with all mean values within ±0.5° of the native state.

Combined ATT + ER: AMRI Laxity

The mean ATT in response to combined 5-N·m ER torque + 88-N ATT force ranged from 0 to 4 mm across 0° to 100° of flexion (Figure 7). Transection of the medial structures caused a significant increase in ATT of 3 ± 1 mm to 4 ± 1 mm during the combined loading at flexion angles >50° (Table 4). After the DS reconstruction, the ATT was not significantly different from that of the injured knee at any angle of flexion. After the TS reconstruction with the combined loading, the ATT was significantly reduced by 3 ± 1 mm (range, 2 ± 1 to 4 ± 1 mm) at flexion angles >40° and did not differ significantly from the native knee at any angle of flexion examined.

The mean ER of the intact knee in response to 5-N·m ER torque + 88-N ATT force ranged from 11° to 18° across 0° to 100° of flexion (Figure 8). Cutting the medial structures caused an increase in ER of 4° ± 1° to 15° ± 2° across the flexion cycle as compared with the intact knee when under combined ATT + ER loads (significant increase >10° of flexion) (Table 5). The DS reconstruction did not reduce the ER significantly below that of the injured knee at any flexion angle. The TS reconstruction reduced the ER when under combined ATT + ER loads, by 3° ± 1° to 12° ± 1° across 0° to 100° of knee flexion (significant reduction >10° of flexion) (Table 5). After the TS reconstruction,
TABLE 3
Valgus Rotation: Comparison of Native State to Grade 3 Injury and TS and DS Reconstructions

| Flexion, deg | Rotation Increase vs Native, deg | Rotat. Increase vs Native, P Value, Grade 3 | P Value, DS Reconstruction | P Value, TS Reconstruction |
|-------------|---------------------------------|--------------------------------------------|---------------------------|---------------------------|
| 0           | 4.4 .004                         | 0.8 .568 <.001 1.2 .375 <.001              | 1.2 .49 <.001           | 2.0 .54 <.001 .734       |
| 10          | 5.0 .002                         | 1.0 .575 <.001 1.2 .167 <.001              | 2.0 .11 <.001 .057      |
| 20          | 5.8 <.001                        | 1.2 .123 <.001 1.2 .105 <.001              | 2.6 .11 <.001 .057      |
| 30          | 6.0 <.001                        | 1.2 .105 <.001 1.1 .214 <.001              | 3.3 .002 <.001 .004     |
| 40          | 6.0 <.001                        | 1.1 .166 <.001 1.1 .098 <.001              | 3.9 <.001 .002 <.001    |
| 50          | 6.2 <.001                        | 1.2 .098 <.001 1.2 .068 <.001              | 4.5 <.001 .003 <.001    |
| 60          | 6.2 <.001                        | 1.3 .068 <.001 1.4 .04 .001                 | 4.9 <.001 .003 <.001    |
| 70          | 5.8 <.001                        | 1.4 .04 .001 1.6 .018 <.001                 | 5.0 <.001 .057 <.001    |
| 80          | 5.4 <.001                        | 1.6 .018 <.001 1.6 .018 <.001               | 4.7 <.001 .076 <.001    |
| 90          | 5.1 <.001                        | 1.6 .018 <.001 1.6 .018 <.001               | 4.5 <.001 .84 <.001     |

aBold indicates significant difference. DS, double strand; TS, triple strand.

Figure 6. Valgus rotation in response to an 8-N-m abduction moment across 0° to 100° of flexion. Mean ± SD (n = 12). Grade 3 injury: sMCL + dMCL + PMC/POL transected. DS reconstruction: sMCL + POL grafts. TS reconstruction: sMCL + dMCL + POL grafts. For abbreviations, see Figure 3.

Figure 7. Anterior translation in response to combined 5-N-m external rotation torque + 88-N anterior tibial translation force across 0° to 100° of flexion. Mean ± SD (n = 12). Grade 3 injury: sMCL + dMCL + PMC/POL transected. DS reconstruction: sMCL + POL grafts. TS reconstruction: sMCL + dMCL + POL grafts. For abbreviations, see Figure 3.

DISCUSSION

This biomechanical study in vitro found that a knee with a grade III MCL lesion comprising lesions of the sMCL, dMCL, and PMC/POL had its ER/AMRI kinematics restored to native values by a TS medial reconstruction but not by a DS reconstruction. In addition, while the TS reconstruction restored native valgus rotation across the arc of flexion, the DS reconstruction did not in the flexed knee.

DS and TS reconstructions restored native valgus rotation laxity in the extended knee, the posture when the sMCL grafts were tensioned. The TS reconstruction restored native valgus rotation across the arc of knee flexion, but the DS reconstruction allowed excess valgus rotation with increasing flexion, reaching 5° of excess at 90° of flexion. The sMCL graft of the TS reconstruction was placed at the medial femoral epicondyle,4 which confers isometry.32 However, the DS graft was placed 5 mm posteriorly, the mean anatomic position of another study25 on which the original technique9 was based, so it slackened because of anisometry. Other studies show consistently that the sMCL attachment spreads over the epicondyle, so the anterior fibers tighten with knee flexion, maintaining control of valgus.4,35,40,43 This “winding up” mechanism was described by Muller in 1983.31

The ER was restored to the native state by the TS reconstruction, while the DS reconstruction did not reduce the...
injury-induced ER instability. Although this study did not include a formal assessment of the isolated effect of dMCL transection and reconstruction, the evidence available supports the idea that control of ER depends on an intact native or reconstructed dMCL. The earlier studies of the DS technique\(^9,29\) seemed to restore native ER, but the experimental model used left the native dMCL intact, while the present work transected the dMCL and found that ER was not restored by the DS technique. Given that (1) the POL graft was the same in DS and TS reconstructions, (2) the sMCL grafts were parallel and had the same material and tensioning protocol, (3) the dMCL is the largest medial restraint of ER near knee extension,\(^5\) and (4) dMCL transection causes pathologic ER,\(^8\) the clear implication of the lack of control of ER with the DS reconstruction is the importance of including a dMCL graft to address AMRI.

Neither reconstruction could fully restore IR near knee extension. That is unsurprising, noting the contrast between the narrow suture tapers and the width and complexity of the PMC/POL structure wrapping around the femoral condyle. This suggests that the POL reconstruction should be viewed only as a tensile support to protect the repair/reefing to tighten the posteromедial capsular tissues. A POL procedure may be indicated if there is postomedial instability, an injury that may occur in combination with posterior cruciate ligament injury but is relatively uncommon and thus unnecessary in most MCL reconstructions.

It is common practice with combined injuries of the MCL and ACL to first brace the knee after injury, to allow the medial ligament complex to heal, and then reconstruct the ACL. In the present study, the ACL was left intact to represent a perfect reconstruction, thus eliminating a surgical variable other than the medial procedures being investigated. Further work could measure ACL graft tension in combined reconstructions under AMRI loading. The ACL tension more than doubled with MCL deficiency, when ER and valgus loading were imposed in a cadaveric model. Further work could measure ACL graft tension in combined reconstructions under AMRI loading. The ACL tension more than doubled with MCL deficiency. Exposure of the ACL graft to excess load by persisting MCL laxities likely explains dramatic increases in ACL graft failure rates.\(^1,2,38\) Exposure of the ACL graft to excess load by persisting MCL laxities likely explains dramatic increases in ACL graft failure rates.\(^1,2,38\)

This study used synthetic tapes for the reconstructions. This graft choice was driven by a number of factors. The choice was partly due to the plan to study 2 reconstructions in each knee but to avoid the problems of repeated cycling of soft tissue grafts in cadaveric biomechanical studies (attrition by fixation and loading, progressive stretching, and variable size and quality of fixation in cadaveric bone). The consistency of synthetic tapes is advantageous for a comparative biomechanical study in vitro. Importantly, the tapes allowed small-enough graft tunnels to...
ensure that, with the 2 techniques, they did not communicate. Clinical MCL reconstructions often use autogenous hamstring tendon grafts, but they are active stabilizers against valgus near knee extension and resist ER; thus, their sacrifice for MCL reconstruction may be questioned.\textsuperscript{13,15,21} Allografts avoid the effect of reducing dynamic control of the medial knee,\textsuperscript{13} but in ACL reconstruction, at least, they have higher failure rates.\textsuperscript{28} Furthermore, there is no reason to suspect that the findings of this biomechanical study should not be applicable with autogenic or allogenic tendon grafts. Despite the harvest time, synthetic material may be a viable option, and 2 of the surgeon authors (S.V.B. and A.W.) use this method routinely.\textsuperscript{7} Our surgeon authors are not adverse to using soft tissue grafts, especially in severe injuries where the medial soft tissues may not be suitable for repair and augmentation with a synthetic graft. Nevertheless, the biomechanical findings of the study are as relevant to techniques using soft tissue grafts.

The TS technique used 3 tunnels each in the femur and tibia and hence 6 fixation implants, which is complex and expensive. It may be possible to obtain similar restraint with 1 femoral tunnel for the sMCL and dMCL grafts, for example, given that they are positioned 8.5 mm apart.\textsuperscript{4} In addition, POL reconstruction may not be required in cases of pure valgus instability and AMRI attributed to a combined MCL + ACL injury. Although the sMCL and dMCL are the main medial restraints to AMRI,\textsuperscript{5} it is necessary to confirm that an sMCL + dMCL reconstruction will be effective in such a situation.\textsuperscript{30} The POL needs consideration only in the relatively uncommon scenario of PMRI and/or excess hyperextension attributed to the MCL injury that also involves the posterior cruciate ligament and posterior capsule. Avoiding unnecessary surgery is desirable to save medical resources and reduce costs as well as morbidity. Similarly, it is logical to presume that a dMCL graft is unnecessary in PMRI (without concomitant AMRI) with POL/PMC. The case for simplification of the TS reconstruction further applies in multiligament surgery if allografts are unavailable.

This study focused on the biomechanics of MCL reconstruction to demonstrate the stabilizing performance of reconstructions that reproduced the transected anatomic structures. Based on this evidence, future work may move toward clinical application with simpler reconstructions, particularly relating to anteromedial instability in knees with combined ACL + MCL injuries.

\textbf{Limitations}

Cadaveric experiments can represent the situation only at time zero and with the low loads imposed by the
operative techniques. The limitations of working in vitro mean that care must be taken when reproducing common clinical procedures. Although the suture tapes were convenient and reproducible for this biomechanical demonstration in vitro, most clinical MCL reconstructions use autogenous tendon grafts. The limitations of working in vitro mean that care must be taken when extrapolating the results toward clinical application. Ultimately, clinical outcome studies are required to justify operative techniques.

CONCLUSION

In the setting of a biomechanical investigation in vitro of a grade III MCL injury that included lesions to the sMCL, dMCL, + POL reconstructions, a TS reconstruction with sMCL grafts restored native ER kinematics, while a DS reconstruction with sMCL and POL grafts did not. A TS reconstruction with the sMCL graft placed at the isometric point on the femoral medial epicondyle restored valgus rotations across the arc of knee flexion, whereas a DS reconstruction with a more posteriorly placed sMCL graft slackened with knee flexion.

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