Weave Technique for Reconstruction of Medial Collateral Ligament and Posterior Oblique Ligament: An Anatomic Approach Using Semitendinosus Tendon

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Abstract: Medial collateral ligament (MCL) is the most commonly injured ligament in knee. The majority of MCL tears can be managed conservatively, and reconstruction or augmentation is required in few selected cases. Anatomic MCL and posterior oblique ligament reconstruction have good functional outcome, but it requires 2 tunnels each in the tibia and femur, which may be a limitation in cases in which multiligament reconstruction is required. Several studies report the use of semitendinosus tendon with intact tibial attachment for MCL reconstruction. Since the attachment of semitendinosus is anterior to MCL footprint, it is non-anatomic and anisometric, which may lead to increased laxity of the reconstructed ligament in due course of time. To prevent the laxity in long term, the reconstruction has to be isometric and anatomic. We, hereby, are reporting our unique technique of MCL and posterior oblique ligament reconstruction using intact semitendinosus at tibial attachment and re-routing to the MCL which makes the reconstruction anatomic and isometric. A supplemental video demonstration of the technique is attached with this article.

The medial collateral ligament (MCL) is the most commonly injured ligament of the knee. The majority of MCL tears can be managed conservatively, and reconstruction may be indicated in valgoid knee, grade III injuries, and multiligament injuries.1 LaPrade and Wijdicks2 mention that the anatomic reconstruction results in better stability after the MCL reconstruction.2 However, the need of 2 tunnels each in tibia and femur has limited its use, especially in cases of multiple ligament reconstruction, and also the tibial fixation of the grafts remains a weak link. We, too, have experienced difficulty in fixing the graft on the tibial footprint of superficial MCL, as the bone in this area is very hard, and fixation with a soft interference screw has led to complications such as graft cut out and difficulty in insertion, since these screws are designed to be used in cancellous bone.

Among several techniques mentioned in literature, the use of semitendinosus tendon (SemiT) to reconstruct superficial medial collateral ligament (sMCL) and posterior oblique ligament (POL) is easy, as it does not require fixation in the tibia.3,4 However, anterior attachment of SemiT in relation to sMCL leads to non-anatomic and anisometric reconstruction, which has been reported to have poorer outcome.5 This led us to modify the technique described by Kim et al.3 by weaving the SemiT to tibial remnant of sMCL and reproducing anatomic MCL and POL reconstruction as mentioned by LaPrade and Wijdicks3 but with only 2 fixation screws in 2 tunnels. The aim of this paper is to sequentially explain our technique of anatomic sMCL and POL reconstruction using SemiT tendon with intact tibial attachment (Video 1).

Surgical Technique

The patient is placed in the supine position, and a tourniquet is applied to the upper thigh. General or regional anesthesia is administered based on preference of patient and anesthetist. The operative knee is...
painted and draped. Patient is positioned with hip and knee flexed to 90° and held with lateral side post and foot support.

**Diagnostic Arthroscopy**

A detailed diagnostic arthroscopy is performed with a 4-mm, 30° arthroscope through the anterolateral portal. Associated injuries are identified and adequately managed by making additional portals. The abnormal medial joint line opening is confirmed by applying valgus stress to the knee and drive-through sign. The joint opening is measured and confirmed on an image taken with image intensifier. The tip of the probe is used to estimate the preoperative joint opening through an anteromedial portal and applying the valgus stress.

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**Fig 1.** (A) A right knee is shown. The semitendinosus tendon is harvested using an open-ended tendon stripper, leaving the tibial attachment of tendon intact (arrow). (B) The harvested free end of the semitendinosus tendon is prepared and sutured using finger trap technique with ETHIBOND No. 2.
Steps

The MCL weave technique of MCL and POL reconstruction is performed in 4 definitive steps; SemiT harvest, graft weaving, fixation in femur, and POL reconstruction. The details of these steps are described to follow.

Step 1: SemiT Harvest and Preparation

The course of the hamstring tendon and medial femoral epicondyle are marked. An oblique incision centered over the hamstring tendons, slightly posterior to the midpoint between tibial tuberosity and posterior...
border of tibia, is given. The SemiT and gracilis tendon is identified by finger palpation once sartorial fascia is reached. A horizontal incision is given on sartorial fascia between these 2 tendons, and semitendinosus is isolated and freed from interconnection bands and vincula.

Once the SemiT is free (as judged by smooth tendon excursion), an open-ended stripper (Smith & Nephew, Andover, MA) is used to harvest it with intact tibial attachment (Fig 1A), and the muscles fibers attached to the free end are removed and cleaned. The graft end is sutured with finger trap technique using No. 5 ETHIBOND (Ethicon, Somerville, NJ) (Fig 1B).

Step 2: Graft Weaving

After clearing the footprint of SemiT, 2 vertical incisions are made about 8 to 10 mm apart and 1 to 1.5 cm long in the footprint of MCL, centering over the line drawn perpendicular to the posterior tibial line drawn from the center of semitendinosus footprint (Fig 2A). Subperiosteal elevation of the MCL insertion is performed with a curved mosquito forceps passed through anterior incision to posterior to create a soft-tissue tunnel, and a shuttle suture is held in loop with the tip of the mosquito forceps (Fig 2B). Then the shuttle suture is used to deliver the SemiT underneath the MCL insertion through the tunnel (Fig 2C) and weaved to it with 2-0 polyglactin suture (Fig 2D).

Step 3: Fixation in Femur

Following weaving, the incision of graft harvest is extended in a curvilinear fashion up to the medial epicondyle, and the epicondyle is exposed (Fig 3A). A point that is 3.2 mm proximal and 4.8 mm posterior to the medial epicondyle is marked. A Beath pin (Smith & Nephew) is passed proximally and anterolaterally from this point to exit from the anterolateral cortex (Fig 3B). The direction of Beath pin can be adjusted depending on the tunnels in the femur in case of multiligament reconstruction, to avoid tunnel convergence. Using a shuttle suture, the weaved SemiT is passed underneath the sartorial fascia, exiting near the Beath pin insertion site (Fig 3C). Then the SemiT graft is looped around the Beath pin, and marked at the loop. The isometry is confirmed by performing knee range of motion (ROM) and checking the displacement of the marked point (Fig 3D). If the mark remains unmoved during the ROM, the isometric point is confirmed for femoral tunnel placement. In case there is excessive movement of the mark is seen, the insertion of the Beath pin has to be changed since it is anisometric. At this point, help of image intensifier can be taken to locate the epicondyle and the isometric point.

Once the isometric point is confirmed, then the graft is looped around itself and whipstitched, for about 2.5 cm (Fig 3E) to tabularize it. The size of the tabularized graft is measured with an anterior cruciate ligament (ACL) sizer. A femoral tunnel is created over the Beath pin, based on the size of tabularized graft, by drilling up to 30 mm in femur. Then a suture is shuttled, and the thread in which the graft is looped, is pulled through the tunnel. The graft is fixed in the tunnel using a biodegradable screw (BIORCI; Smith & Nephew), which is one size bigger than the tunnel diameter at 30° of knee flexion and varus stress (Fig 3F).

Step 4: POL Reconstruction

After completing Step 3, the free end of the graft is reshuttled underneath the sartorial fascia towards the tibia (Fig 4A). The attachment site of POL was identified.
at the posteromedial tibia, which is just anterior to the
direct arm attachment of the semimembranosus
tendon. A Beath pin is inserted just anterior to the
direct fibers (from posterior to anterior) exiting near the
Gerdy tubercle (Fig 4B). A 6-mm cannulated reamer is
used to make a tunnel over the Beath pin. The length of
the tunnel is determined by the remaining length of the
SemiT graft. Graft fixation is done with a 7-mm
biodegradable screw (BIORCI, Smith & Nephew) in 30°
of knee flexion (Fig 4C). The aforementioned technique
has been depicted in schematic view (Fig 5; Step 1-4).

Postoperative Protocol and Rehabilitation
The wound is inspected on second, 4th, 9th and 14th
postoperative day. Sutures are removed on 14th post-
operative day. A hinged knee brace is used for 4 weeks
postsurgery. Isometric exercises of knee are started as
soon as pain is tolerable. Cryotherapy is provided with
ice packs for 3 weeks. Knee ROM is started immediately
based on pain tolerance. 90° of knee ROM is achieved
within 2 weeks and increased to 120° at 4 weeks. The
full range is achieved by 6 weeks postsurgery. Hinged
knee brace is applied during the knee ROM exercises.
Toe-touch walking with crutches is allowed for the first
4 weeks postsurgery and gradually progressed to ac-
ieve full weight-bearing walking without crutches next
2 weeks. Strengthening exercises are continued up to 6
months postsurgery. Sports-specific exercises are star-
ted at 6 months, and return to sports is allowed after 9
months of surgery. The aforementioned protocol is
modified and individualized based on other injured
associated structures in the knee.

Discussion
The indications of MCL reconstruction surgery are
expanding and evolving. In a study by Bollier and
Smith,6 it is mentioned that both MCL and ACL healing
is inappropriate if MCL is managed conservatively after
ACL reconstruction. They recommended simultaneous reconstruction of ACL and MCL in case of chronic injury to both the ligaments. Zhang et al. reported that the simultaneous ACL and MCL reconstruction had better outcomes, and they recommended simultaneous ACL and MCL reconstruction rather than the nonoperative management for MCL. In a systematic review of 10 studies with 275 knees, Varelas et al. mentioned that only 17% required isolated MCL reconstruction compared to 83% requiring combination of surgeries along with MCL reconstruction. Thus, an MCL tear has to be addressed in the treatment plan for multiligament injuries. Due to an increase in high-velocity injuries, the incidence of multiligament injury will increase in future. Similarly, increasing trend of MCL reconstruction even in grade II MCL injuries associated with ACL tears will increase the number of MCL reconstructions in future. We need a technique that is simple with fewer complications yet anatomical to provide adequate stability. Our technique meets the aforementioned requirements of posteromedial reconstruction surgeries.

In their research, Kim et al. mentioned good-to-excellent outcomes, with 92% of their patients having less than 3 mm of valgus opening at an average follow-up of 52 months. Although Lind et al. and Stannard et al. also reported good subjective outcomes with their similar techniques, only 50% of Lind’s, and 32% of Stannard’s patients had valgus opening less than 3 mm at an average follow up of 40 months. This may be attributed to the fact that the fixation of the graft anteriorly at the SemiT insertion was non-anatomic, anisometric, which led to significantly greater change in graft length and resulted in clinical laxity overtime, as mentioned by Feeley et al.

In contrast, LaPrade and Wijdicks performed anatomic reconstruction with 2 separate grafts for ACL and POL and found that 100% of their patient had less than 3 mm opening at an average follow-up of 18 months. However, the major drawback of anatomic reconstruction of the posteromedial corner, described by LaPrade, is that it requires 3 separate grafts and 2 tunnels each in femur and tibia, which may be a limitation in multiligament settings, as there is high chance of tunnel convergence. Apart from the aforementioned limitation, we have experienced a frequent graft amputation at tibial fixation site of sMCL even with a biodegradable screw, which one size smaller than the tibial tunnel diameter. Moreover, LaPrade’s technique requires 4 fixation implants (2 in femur and 2 in tibia), which may lead to more implant-related complications and increased overall cost of the surgery.

In our technique, we have tried to replicate tibial attachment anatomy by weaving the SemiT graft to the tibial remnant of MCL, and femoral anatomy by fixing

### Table 1. Pearls and Pitfalls of This Technique

| Pearls                                                                 | Pitfalls                                                                                                                  |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| Autologous SemiT graft is used, which avoids problems associated with allografts. | Minimum of 20 mm of SemiT length is required.                                                                         |
| Tibial attachment of SemiT is left intact and hence does not require fixation on tibial side. | In female patients, SemiT is very thin and may be considered weak to be used for reconstruction.                           |
| Tibial-side fixation with implants not needed for sMCL.               | Although sMCL is attached at anatomical location on both the tibia and femur, the POL at femur is not at precise anatomical location. |
| Weaving of SemiT through soft-tissue tunnel at sMCL footprint at tibia recreates native sMCL attachment. | Deep MCL is not reconstructed.                                                                                             |
| Graft is placed underneath the sartorial fascia.                     | Procedure cannot be performed in cases of MCL avulsion from its tibial attachment.                                       |
| POL is also reconstructed with same autograft at its anatomic insertion point at tibia. |                                                                                                                            |
| This technique can also be performed with separate mini-incisions at femur and tibia. |                                                                                                                            |

MCL, medial collateral ligament; POL, posterior oblique ligament; SemiT, semitendinosus tendon; sMCL, superficial medial collateral ligament.

### Table 2. Advantages and Disadvantages of the Weave Technique

| Advantages                                                                 | Disadvantages                                                                                                                  |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Only 1 tunnel in tibia and 1 in femur to reproduce both sMCL and POL.     | Size of the SemiT may be inadequate in some cases.                                                                            |
| Anatomic reconstruction of sMCL on both tibia and femur.                  | POL anatomy (on femoral side) is not reproduced.                                                                               |
| Less number of implants required and implant related complications.       |                                                                                                                             |
| Cost-effective.                                                           |                                                                                                                             |

POL, posterior oblique ligament; SemiT, semitendinosus tendon; sMCL, superficial medial collateral ligament.
the graft at anatomic location of sMCL attachment, as described by LaPrade and Wijdicks. We presume that the outcome should be comparable with the anatomic reconstruction mentioned by LaPrade Wijdicks. Early outcomes with our technique are encouraging, and we are conducting a prospective cohort study on this technique. A comparison between LaPrade’s, Kim’s, and our technique is diagrammatically represented in Figure 6.

Although our technique is simple and reproducible, it has some pitfalls and disadvantages. The advantages and disadvantages and pearls and pitfalls of this technique are summarized in Tables 1 and 2, respectively.

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