



AMERICAN ACADEMY OF
ORTHOPAEDIC SURGEONS

Management of Anterior Cruciate Ligament Injuries

Companion Consensus Statements

All statements in this document reflect the expert opinion of a multidisciplinary panel of experts. Companion consensus statements are created due to a lack of evidence on the topic under study. Prior to the creation of companion consensus statements, a systematic literature search is performed in an effort to find relevant literature. For evidence-based statements, please visit the Clinical Practice Guideline on Management of Anterior Cruciate Ligament Injuries.

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National Athletic Trainer's Association Companion Consensus Statements to the Management of Anterior Cruciate Ligament Injuries Clinical Practice Guideline

The following companion consensus statements were developed by panels nominated by the National Athletic Trainer's Association (NATA), the American Orthopaedic Society for Sports Medicine (AOSSM) and the American Physical Therapy Association (APTA) and each of the statements have been approved by their respective developing organization. All statements were endorsed by the American Academy of Orthopaedic Surgeons for publication on June 12, 2015. To view the preliminary recommendations that these companion consensus statements were based on, please refer to [Appendix I: Preliminary Recommendations](#).

Statement #1 (Developed by National Athletic Trainer's Association): In the absence of reliable evidence, NATA recommends that people who sustain an acute traumatic knee joint injury with symptoms (e.g., feel or hear a pop, experience a giving way episode, pain, swelling or difficulty weight bearing) receive a physical examination by a qualified health care professional that assesses the structural integrity of the knee joint capsule, ligaments and menisci, and includes a neurovascular exam as soon as possible following injury. Immediate treatment with ice, compression, elevation, immobilization, and crutches is also indicated and patients should be referred for further musculoskeletal evaluation, unless signs and symptoms indicate that an emergent condition is present (e.g. neurovascular, gross deformity, uncontrollable pain).

Statement #2 (Developed by National Athletic Trainer's Association): In the absence of reliable evidence, NATA recommends that following an acute traumatic knee joint injury, patients with an abnormal neurovascular finding on physical exam, gross deformity, or severe and uncontrollable pain should receive emergent care to include immobilization and ongoing serial assessments of neurovascular function during transport to an emergency medical facility.

Statement #3 (Developed by American Orthopaedic Society for Sports Medicine): In the absence of reliable evidence, AOSSM recommends that physicians consider aspirating painful, tense effusions after knee injury

Statement #4 (Developed by American Physical Therapy Association): In the absence of reliable evidence, it is the recommendation of APTA that a patient with an ACL tear who is not having ACL reconstruction undergo rehabilitation with goals of (1) full and pain free knee joint ROM is restored (equal to that of the contralateral limb), (2) thigh muscle strength and single hop test indexes are at least 90% (ratio of involved to uninvolved limb performance), and (3) self-reported knee function on reliable, valid, and responsive questionnaires is at least 90%.

Background

Per current AAOS methodology, preliminary clinical practice guideline (CPG) recommendations, or PICO questions, which return no evidence after the systematic literature review is conducted and do not meet AAOS criteria for forming a companion consensus statement (i.e. in instances where not making a recommendation would lead to loss of life or limb) are separated from the final guideline report and turned over to relevant specialty societies to form companion consensus statements. The clinical practice guideline workgroup suggests relevant specialty societies depending on the topic addressed by the PICO question and AAOS staff contacts the suggested specialty society requesting their assistance with nominating representatives to construct and vote on the most clinically applicable companion consensus statement, based on their experience and expertise (see Companion Consensus Statement Process for more details). If the suggested specialty society agrees to participate, AAOS staff provides the relevant materials to their nominated panel members, guides them through the process, and compiles the final companion consensus statement(s) for societal approval.

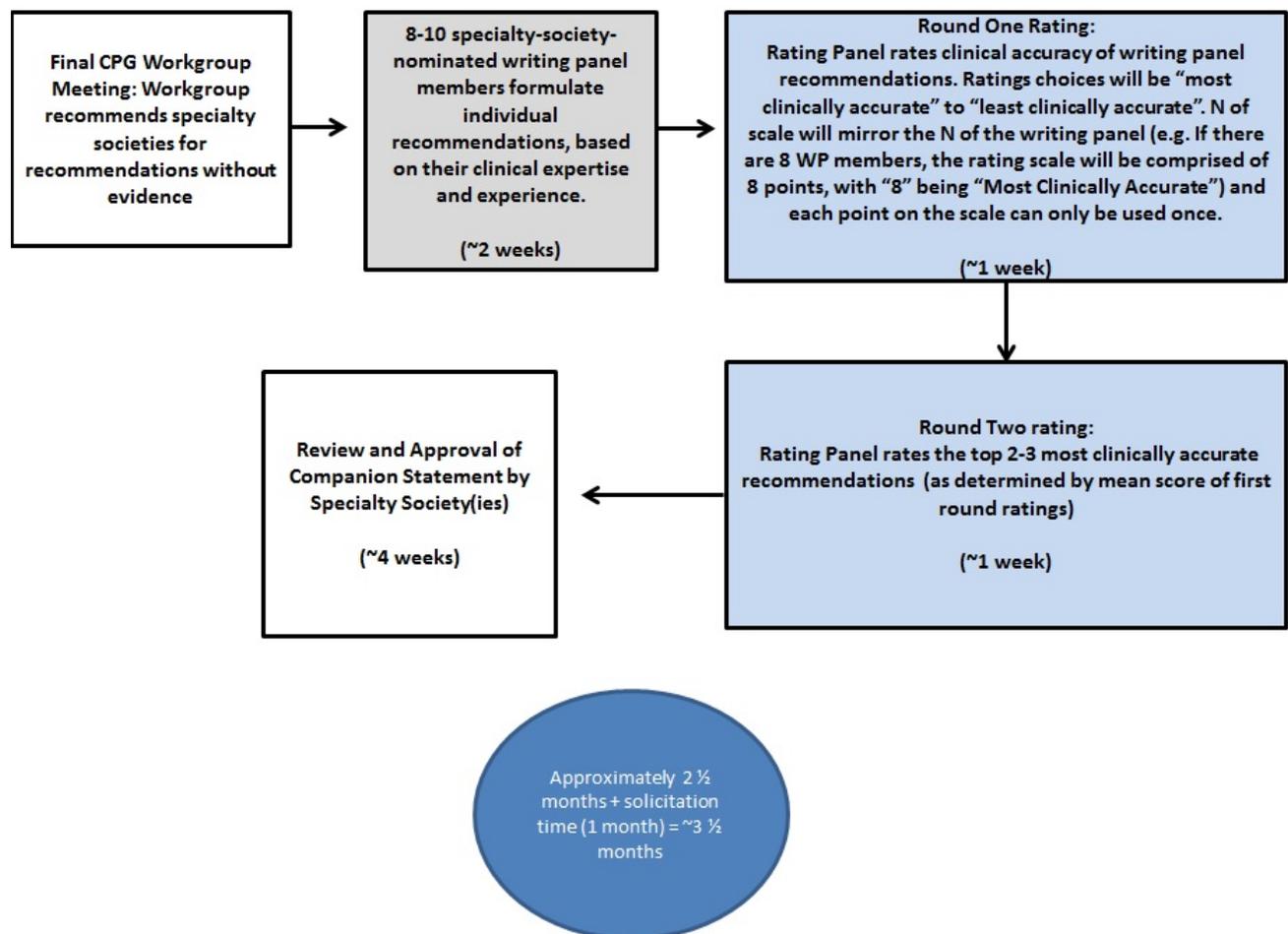
Companion Consensus Statement Process

1. At the final CPG meeting, the workgroup will review all topics for which there is no evidence to support a recommendation and will only develop consensus recommendations if failure to do so could have catastrophic consequences, for example, a threat to life or limb. The CPG workgroup will refer any remaining topics with no evidence to the appropriate specialty society(ies) best suited to address those specific recommendations.
2. Following the final guideline meeting (step 8 on [CPG Process Flowchart](#)), AAOS staff will construct the list of guideline recommendations that were referred to specialty societies by the guideline workgroup.
3. Relevant specialty societies are notified of their selection to produce a companion consensus statement, provided with the materials listed below, and given the option to accept or deny the offer to participate.
4. If participation is accepted, an informational packet will be sent to the relevant contacts from participating specialty societies, along with deadlines for assignment of specialty society members for writing panel (n=8 to 10) and rating panel members (n=8 to 10).
5. The CPG workgroup chairs will be available for discussion of each recommendation, specifically the intent of the PICO questions asked to ensure that the companion consensus process focuses on the correct issue.
6. After receiving writing panel and rating panel nominations, AAOS staff will follow up with each panel member and inform them of their charges (see [Figure 1](#)) and provide each of the panels with the relevant links to their electronic forms.
7. AAOS staff will send out relevant surveys/materials, timeline reminders, and status updates about the progress of the companion consensus statement process.

Materials that are provided to the Specialty Societies

1. List of their selected recommendations Bibliography of all excluded articles for each relevant recommendation
2. Format/language for forming a companion consensus statement (must be met to receive AAOS endorsement). That is, “In the absence of reliable evidence, it is the opinion of X that Y.”
3. Clear explanation of the target area of the target population that the guideline is addressing.

Figure 1. Flowchart for Companion Consensus Statements Construction Using Modified Delphi Method



All Delphi Panels should be constructed with appropriate levels of involvement of each specialty society suggested, unless that specialty society chooses not to be involved.

Appendices

Appendix I: Preliminary Recommendations

The following recommendations were constructed at the introductory meeting by the Clinical Practice Guideline on the Management of Hip Fractures in the Elderly volunteer clinician workgroup. No evidence was found for these preliminary recommendations, thus the workgroup suggested the Orthopaedic Trauma Association as the most relevant organization to construct companion consensus statements.

Draft Preliminary Recommendation 1

We recommend patients with an abnormal neurovascular finding or gross deformity receive emergent care and are no longer considered in this guideline.

Draft Preliminary Recommendation 2

We recommend that patients with a negative physical examination and negative plain films be evaluated for other causes of symptoms.

Draft Preliminary Recommendation 3

We recommend aspiration of symptomatic (painful, tense) effusions after knee injury.

Draft Preliminary Recommendation 4

We recommend in a patient with an ACL tear that is not having an ACL reconstruction, undergo rehabilitation until strength, range of motion, and function is restored.

Appendix II: Panel Members & AAOS Staff

National Athletic Trainer's Association

Writing Panel

Randal Cohen, ATC, DPT

Tamara Valovich McLeod, PhD, ATC, FNATA

Marc Norcross, PhD, ATC

Kenneth Cameron, PhD, MPH, ATC

Joe Hart, PhD, ATC

Mark Hoffman, PhD, ATC, FNATA

Voting Panel

Jenny Allen, PT, ATC

Lori Johannessen, ATC, LAT

David Bell, PhD, ATC

Chris Snoddy, ATC, LAT

Yohei Shimokochi, PhD, ATC

Grace Golden, PhD, ATC, CSCS

Rick Burkholder, MS, ATC

American Orthopaedic Society for Sports Medicine

Writing Panel

Robert Brophy, MD

Daniel Cooper, MD

Constance Chu, MD

Thomas DeBerardino, MD

Jason Drago, MD

Voting Panel

Mark Miller, MD

David Mcallister, MD

Scott Gillogly, MD

Richard Parker, MD

Chris Harner, MD

Sharon Hame, MD

American Physical Therapy Association

Writing Panel

Mark Paterno, PT, PhD, MBA, ATC, SCS

James Irrgang, PT, PhD, ATC, FAPTA

Stephanie Di Stasi, PT, PhD

Terry Grindstaff, PT, PhD, ATC, SCS

Laura Schmitt, PT, PhD

Airelle Giordano, PT, DPT, OCS, SCS

Voting Panel

David Logerstedt, PT, MPT, PhD, SCS

Trevor Lentz, PT, SCCS, SCS

Erin Hartigan, PT, OCS

Andrew Lynch, PT, PhD

Carol Courtney PT, PhD, ATC

AAOS Staff

William O. Shaffer, MD
Medical Director

Deborah S. Cummins, PhD
Director of Research and Scientific Affairs

Jayson N. Murray, MA
Manager, Evidence-Based Medicine Unit

Kaitlyn Sevarino
Evidence-Based Quality and Value Coordinator

Yasseline Martinez
Administrative Coordinator

Erica Linskey
Administrative Assistant

Appendix III: AAOS Endorsement Process

AAOS BODIES THAT APPROVED ENDORSEMENT OF THIS COMPANION CONSENSUS STATEMENT DOCUMENT

Committee on Evidence Based Quality and Value

The committee on Evidence Based Quality and Value (EBQV) consists of twenty AAOS members who implement evidence-based quality initiatives such as clinical practice guidelines (CPGs) and appropriate use criteria (AUCs). They also oversee the dissemination of related educational materials and promote the utilization of orthopaedic value products by the Academy's leadership and its members.

Council on Research and Quality

The Council on Research and Quality promotes ethically and scientifically sound clinical and translational research to sustain patient care in musculoskeletal disorders. The Council also serves as the primary resource for educating its members, the public, and public policy makers regarding evidenced-based medical practice, orthopaedic devices and biologics, regulatory pathways and standards development, patient safety, occupational health, technology assessment, and other related important errors. The Council is comprised of the chairs of the committees on Biological Implants, Biomedical Engineering, Performance Measures, Patient Safety, Research Development, and chair and Appropriate Use Criteria and Clinical Practice Guideline section leaders of the Committee on Evidence Based Quality and Value. Also on the Council are the second vice-president, two members at large, and representatives of the Diversity Advisory Board, Women's Health Issues Advisory Board, Board of Specialty Societies (BOS), Board of Councilors (BOC), Communications Cabinet, Healthcare Systems Committee, and Orthopedic Research and Education Foundation (OREF).

Board of Directors

The 17 member Board of Directors manage the affairs of the AAOS, set policy, and oversee the Strategic Plan.