Introduction
The American Academy of Orthopaedic Surgeons Evidence-Based Guideline on Management of Anterior Cruciate Ligament Injuries includes both diagnosis and treatment. This clinical practice guideline has been endorsed by the National Academy of Sports Medicine (NASM), the American Orthopaedic Society for Sports Medicine (AOSSM), the National Athletic Trainers’ Association (NATA), and the American Academy of Physical Medicine and Rehabilitation (AAPM&R). This brief summary of the AAOS Clinical Practice Guideline contains a list of the recommendations and the rating of strength based on the quality of the supporting evidence. Discussion of how each recommendation was developed and the complete evidence report are contained in the full guideline at www.aaos.org/guidelines.

Summary of Recommendations
ACL HISTORY AND PHYSICAL
Strong evidence supports that the practitioner should obtain a relevant history and perform a musculoskeletal exam of the lower extremities, because these are effective diagnostic tools for ACL injury.

Disclosure: The disclosure information for the Work Group members and the AAOS staff on this guideline are found in Appendix XI (page 516) of the guideline document at http://www.aaos.org/research/guidelines/ACLGuidelineFINAL.pdf.

Disclaimer: This Clinical Practice Guideline was developed by an AAOS multidisciplinary volunteer Work Group based on a systematic review of the current scientific and clinical information and accepted approaches to treatment and/or diagnosis. This Clinical Practice Guideline is not intended to be a fixed protocol, as some patients may require more or less treatment or different means of diagnosis. Clinical patients may not necessarily be the same as those found in a clinical trial. Patient care and treatment should always be based on a clinician’s independent medical judgment, given the individual patient’s clinical circumstances.

The complete AAOS guideline is available at http://www.aaos.org/research/guidelines/ACLGuidelineFINAL.pdf.
Strength of Recommendation: Strong ★★★★

ACL RADIOGRAPHS
In the absence of reliable evidence, it is the opinion of the work group that in the initial evaluation of a person with a knee injury and associated symptoms [giving way, pain, locking, catching] and signs [effusion, inability to bear weight, bone tenderness, loss of motion, and/or pathological laxity] that the practitioner obtain anteroposterior and lateral knee x-rays to identify fractures or dislocations requiring emergent care.

Strength of Recommendation: Consensus ★☆☆☆☆

ACL MAGNETIC RESONANCE IMAGING (MRI)
Strong evidence supports that the MRI can provide confirmation of ACL injury and assist in identifying concomitant knee pathology such as other ligament, meniscal, or articular cartilage injury.

Strength of Recommendation: Strong ★★★★

ACL PEDIATRIC
There is limited evidence in skeletally immature patients with torn ACLs, but it supports that the practitioner might perform surgical reconstruction because it reduces activity related disability and recurrent instability which may lead to additional injury.

Strength of Recommendation: Limited ★★☆☆☆

ACL YOUNG ACTIVE ADULT
Moderate evidence supports surgical reconstruction in active young adult (18-35) patients with an ACL tear.

Strength of Recommendation: Moderate ★★★☆

ACL MENISCAL REPAIR
There is limited evidence in patients with combined ACL tears and reparable meniscus tears, but it supports that the practitioner might repair these meniscus tears when combined with ACL reconstruction because it improves patient outcomes.

Strength of Recommendation: Limited ★★☆☆☆

ACL RECURRENT INSTABILITY
There is limited evidence comparing nonoperative treatment to ACL reconstruction in patients with recurrent instability, but it supports that the practitioner might perform ACL reconstruction because this procedure reduces pathologic laxity.

Strength of Recommendation: Limited ★★☆☆☆

ACL CONSERVATIVE TREATMENT
There is limited evidence to support non-surgical management for less active patients with less laxity.

Strength of Recommendation: Limited ★★☆☆☆

ACL SURGERY TIMING
When ACL reconstruction is indicated, moderate evidence supports reconstruction within five months of injury to protect the articular cartilage and menisci.

Strength of Recommendation: Moderate ★★★☆

ACL COMBINED MCL
There is limited evidence in patients with acute ACL tear and MCL tear to support that the practitioner might perform reconstruction of the ACL and nonoperative treatment of the MCL tear.

Strength of Recommendation: Limited ★★☆☆☆

ACL LOCKED KNEE
In the absence of reliable evidence, it is the opinion of the work group that patients with an ACL tear and a locked knee secondary to a displaced meniscal tear have prompt treatment to unlock the knee in order to avoid a fixed flexion contracture.
Strength of Recommendation: Consensus ★☆☆☆☆

ACL SINGLE OR DOUBLE BUNDLE RECONSTRUCTION
Strong evidence supports that in patients undergoing intra-articular ACL reconstruction the practitioner should use either single bundle or double bundle technique, because the measured outcomes are similar.

Strength of Recommendation: Strong ★★★★★

ACL AUTOGRAFT SOURCE
Strong evidence supports that in patients undergoing intra-articular ACL reconstruction using autograft tissue the practitioner should use bone-patellar tendon-bone or hamstring-tendon grafts, because the measured outcomes are similar.

Strength of Recommendation: Strong ★★★★★

ACL AUTOGRAFT VS ALLOGRAFT
Strong evidence supports that in patients undergoing ACL reconstructions, the practitioner should use either autograft or appropriately processed allograft tissue, because the measured outcomes are similar, although these results may not be generalizable to all allografts or all patients, such as young patients or highly active patients.

Strength of Recommendation: Strong ★★★★★

ACL FEMORAL TUNNEL TECHNIQUE
Moderate evidence supports that in patients undergoing intra-articular ACL reconstruction the practitioner could use either a tibial independent approach or transtibial approach for the femoral tunnel, because the measured outcomes are similar.

Strength of Recommendation: Moderate ★★★☆☆

ACL POST-OP FUNCTIONAL BRACING
Moderate evidence does not support the routine use of functional knee bracing after isolated ACL reconstruction, because there is no demonstrated efficacy.

Strength of Recommendation: Moderate ★★★☆☆

ACL PROPHYLACTIC BRACES
Limited evidence supports that the practitioner might not prescribe prophylactic knee braces to prevent ACL injury, because they do not reduce the risk for ACL injury.

Strength of Recommendation: Limited ★★☆☆★

ACL NEUROMUSCULAR TRAINING PROGRAMS
Moderate strength evidence from pooled analyses with a small effect size (Number Needed to Treat=109) supports that neuromuscular training programs could reduce ACL injuries.

Strength of Recommendation: Moderate ★★★☆☆

ACL POST-OP PHYSICAL THERAPY
For those undergoing postoperative rehabilitation after ACL reconstruction, moderate evidence supports early, accelerated, and non-accelerated protocols because they have similar outcomes.

Strength of Recommendation: Moderate ★★★☆☆

ACL RETURN TO SPORTS
Limited strength evidence does not support waiting a specific time from surgery/injury, or achieving a specific functional goal prior to return to sports participation after ACL injury or reconstruction.

Strength of Recommendation: Limited ★★☆☆★
Cruciate ligament injury - anterior; ACL tear; Knee injury - anterior cruciate ligament (ACL). Patient Instructions. ACL reconstruction - discharge. Images. Knee arthroscopy. ACL degrees. ACL injury. Brotzman SB. Anterior cruciate ligament injuries. In: Giangarra CE, Manske RC, eds. Clinical Orthopaedic Rehabilitation: A Team Approach. 4th ed. Philadelphia, PA: Elsevier; 2018:chap 47. Cheung EC, McAllister DR, Petrigliano FA. Anterior cruciate ligament injuries. In: Miller MD, Thompson SR, eds. DeLee, Drez, & Miller's Orthopaedic Sports Medicine. The anterior cruciate ligament (ACL) is probably the most commonly injured ligament of the knee. In most cases, the ligament is injured by people participating in athletic activity. As sports have become an increasingly important part of day-to-day life over the past few decades, the number of ACL injuries has steadily increased. This injury has received a great deal of attention from orthopedic surgeons over the past 15 years, and very successful operations to reconstruct the torn ACL have been invented. This guide will help you understand, where in the knee the ACL is located. The anterior cruciate ligament (ACL) is one of the ligaments inside your knee â€“ it joins your thigh bone (femur) to the front of your shin bone (tibia). An ACL injury is a partial or complete tear, a stretched ligament, or a detachment of the ligament from your bone. About anterior cruciate ligament (ACL) injury. The ACL passes in front of another ligament, the posterior cruciate ligament (PCL). The cruciate ligaments get their name from the fact they form a cross within the knee as they run in different directions from the thigh to the shin bone. Along with the other ligaments in your knee, your ACL keeps your knee stable and prevents your thigh and shin bones moving out of place. When your knee ligaments are stretched but not torn, theyâ€™re called a sprain.