The Real Truth About Returning to Jiu Jitsu After ACL Injury Transcript

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Podcast Introduction and Host Background

Do you train combat sports? Have you ever been injured? Dr. Megan Jimenez is an Army Orthopedic Sports Surgeon and Jiu Jitsu Brown Bell. This is Dr Jujitsu, your go-to podcast for combat sport, military performance, injury prevention and treatment.

New episodes drop the first Friday of each month. I'm Dr. Megan Jimenez. I am an orthopedic sports surgeon for the United States Army and Jiu-Jitsu athlete.

My goal with this podcast is to bring information from someone who wears two hats. As an Orthopedics surgeon who has also sustained many of these injuries, I think I can add some value to the community and hopefully help you along your injury path.

So today we're going to dive into ACL injuries. This is near and dear to my heart. ACL stands for anterior cruciate ligament and we are going talk about how they happen, when surgery is actually needed, recovery and what returning back to combat sports or any sport really looks like.

If you have a bum knee or you're go through an ACL injury, you've had an ACL injury or you're not sure what to do with your tear, I'm hoping that this episode can help you with you path and at least give you some good questions to ask your orthopedic surgeon when you meet them.

We're going to start with some anatomy which can be kind of tricky to talk about without a picture but the ACL or anterior cruciate ligament has two bundles.

One is in the front and one is more in back. And they have slightly different functions. But the ACL is the most important ligament of the knee. It's not the biggest.

That would be the PCL, which is just behind the ACL. The ACL, is most commonly talked about ligamen. You see professional athletes tearing ACLs all the time.

My goal is to tell you that it's is not a career ending injury, but it is something that does need to be addressed. So what does the ACL actually do? It keeps your shin bone or your tibia from going forward on your femur or thigh bone.

So the lower bone of the body from moving forward. But perhaps more importantly, it actually helps with rotation. And that's how a lot of ACL tears happen.

From excessive rotation with a planted foot. We're going to get into how these happen, but the anatomy itself kind of tells you how they happen. So why does the ACL matter to combat athletes?

Well, it's pretty important for stability of the knee. Not everybody requires their ACL, which is why when we tear it, we can consider not doing surgery.

ACL Anatomy and Why It Matters in Combat Sports

But for combat athlete, s we do a lot of rotation, especially kicking athletes, specially wrestlers, people who are pivoting, planting, shifting. There's a lots of stress that goes through the And the knee is the most commonly injured joint in combat sports.

There's a good paper from 2021 showing the epidemiology or how common these injuries are and occurring and the need was the common with meniscus tears being number one followed by ACL tears.

So that's why it's so important that we discuss these for combat athletes. In general, ACL tears occur from a non-contact injury. You might see football players, soccer players volleyball, basketball, all of these high-energy sports where people change direction or come to a sudden stop.

They pivot, they shift. We call them cutting sports. This is where ACL injuries happen. You might see somebody out in the middle of the field, they're not touched, there's no other players near them and they go to change direction and the collapse.

So this is how most ACL injuries occur. But in combat, athletes is a little bit different. A lot of times it does involve contact with a partner or with the competitor and we have things like take downs where the person defending a take down is at high risk.

There's also submissions such as heel hooks where we can have these injuries. So, combat sports is a little bit different. It can occur with another person.

And even in the pivoting sports, it can occurs with contact, but that's not the most common. I do think that with combat athletes, small kind of micro tearing of the ACL may occur.

over someone's career, over time, and then eventually somebody may come in with a pop or sudden instability, but not much swelling, not many other symptoms, that may have just been their ACL completing the tear.

That's a theory that I have, especially with kicking, very high energy, Muay Thai kicks, the planted leg and the kicking leg both take on a lot of rotational force.

So I do think this mechanism is a little bit different from the regular athletic population or the more traditional sports. We talk about the common injuries, the sudden change in direction, which can occur in wrestling and standing up.

But a lots of jujitsu athletes have more of a game that involves sitting down or we call it pulling guard, so sitting to your butt. This might have a lower risk of ACL tears off the bat because we do know that takedowns carry a high risk.

Particularly, there are takedowns called the Scissor Takedown and Tanya Toshi, which both create a stress, if this was my knee here, on the outside of the knee, and then it causes it to collapse in.

And that puts a lot of stress on ACL, so imagine somebody's entire body weight coming down on outside someone's knee. These two take downs do result in that valgus stress.

If you see somebody with bow legs, that can kind of show you what valgus looks like. And that inward collapse of the knee creates a lot of stress on the multiple ligaments, but many times the most catastrophic injury can be the ACL tear.

Competitions where leg locks are legal, such as the heel hook, do show that or do have a higher propensity for injury to the need and ankle. but particularly the ACL.

And these have to be approached with caution. So I sustained an ACL tear with a heel hook, not tapping in time and not realizing how much danger I was in.

It's really changed the way that I teach people to approach leg locks and just knowing that you're in a bad situation is very important because you really don't feel the ACL tear when it occurs in these positions or not typically.

And so by the time that you realize it's often too late. Another position that's important is the lockdown position. It's kind of tough to describe. So I would, if you don't really know too much about jiu-jitsu, you can kind Google lockdown jui- jitsu and the bottom person is holding the top athlete with their leg in a very tight position applying rotational force, which is kind of the common denominator of ACL tears, is going to be that rotational forced to create the tear.

How ACL Tears Happen in Combat Athletes

And the person on top is often resisting it. So sometimes we probably need to just give in to that sweep and free our knee so that we're not at such risk.

Moving on to diagnosis and symptoms. We kind of talked about that classic mechanism. So oftentimes physicians and orthopedic surgeons, we can tell that somebody's had an ACL tear just based on their story.

The typical patient comes in and says, okay, I was running this way and I went to just change a sudden direction. or stop suddenly and pivot. And then I felt a big pop.

You know, sometimes people in the stands can hear them. My coach heard a pop, everyone in field stopped, and I collapsed. Lots of swelling. Sometimes there you need help getting carted off the field or kind of walking off.

But I noticed that that doesn't happen as much in jiu-jitsu. I've seen people tear ACLs. After I tore it, I didn't really realize I had, And I was ready for another round.

if there was one available. Everybody's story is gonna be a little bit different, but most of the time, as Orthopedic Surgeons Week, we know that classic story.

Now, those people that present with a not-so-classic story, that's where it becomes a bit more challenging. So, for example, my story… it was a heel hook, but there wasn't a lot of control around the knee.

It was purely rotational, which I think created a little bit less energy. If there was more control on the need when it occurred, I would have had a much greater injury or I'd have tapped a bit sooner feeling some of it.

But with pure rotation, that kind of leads to that partial or high grade ACL tear where you don't have as much swelling and some fibers are intact. So some of these stories are super important, especially with combat athletes who don't present immediately.

So let's talk about some other common injury patterns for jiu-jitsu in particular. We talked about takedowns, we talked Taniyotoshi, the scissor takedaun or the Ikanibasami being very dangerous, creating that inward pressure on the knee and these are actually banned in some schools.

I spoke with Paige Yvette over at Legion and she said that there's several takedowns that are banned at the school because there is such a high chance of injury.

And 37% of ACL tears do occur from takedsown. Typically the person that's defending the takedawn is the one that gets injured. Okay we talk about submissions, we talked about positions.

Remember submissions are leg locks. Positions can be the lockdown but they can also be things like 50-50 if someone is trying to barrel through. This actually happened to my other knee so I had an ACL sprain on the other side because I was in a 50 50 position on bottom.

Clock was running out. I got a little bit lazy too with my foot on my partner's hip and then they tried to kind of knee cut through a fifty-fifty and Didn't really work, but I did feel the stress on my knee.

Thankfully nothing too crazy from that But you know, they still take time to recover. So delahiva, reverse delhiva anything where your foot is Kind of free in space or your leg is free and space and your food is hooked around your partner's leg Definitely poses a risk, especially if your partners being a little bit more erratic or trying to pass very quickly I find that sometimes in the reverse, delohiva or position, people tried to knee cut and blast through that reverse delahiva, which I don't love because it puts the bottom person really at risk.

So being aware of that as both the top and bottom player I think could help reduce some injuries. When I play bottom delohiva or reverse and I see the person trying to cut, knee-cut quickly, aggressively, I will bail and just

move to the next thing because its not worth your knee getting injured.

The next thing we move to after we've heard the story of our athletes as we go to our physical exam and there's three main findings that will tell you that or clue you in that there might be an ACL tear.

the first one is a lockman exam we bend the knee to about 30 degrees I would hold the femur and the tibia, remember the thigh bone and shin bone and I would pull anterior or forward on the shin bone and feel how much translation there is.

I feel like I've done this test more on Jiu-Jitsu mats sometimes than in my clinic because I have a lot of people that come up to me. They're like, oh, I'm unstable.

Can you just feel my knee? And I am often diagnosing an ACL tear right there on mats that somebody may have had for a long time. But the Lachman is the best exam.

It's the most accurate. and it's one that all orthopedic surgeons do. There's also the anterior drawer test, which is when we bend the knee to 90 degrees.

I often sit on the foot and then I use both hands to pull the tibia or pull a shin bone forward and I kind of see what that feels like. It really is a feel thing and when I try to teach residents about it, it is challenging.

So I'm pulling forward on tibi or on shinbone and trying to see if there's a good end point. If there is nice rock solid firm end-point that the ACL is doing what it needs to be doing.

otherwise it kind of feels a little bit more mushy and that's where you get your positive test. A pivot shift is there a third test that doctors will use to diagnose you and it has it pretty much recreates the injury a bit and then we're using rotation to get this test a Little harder to do because you need a relaxed person and and the knee will often kind Of pop when you Get the positive tests so a, little tougher to, do all right moving on to the next topic do All ACLs need surgery No, all ACL tears do not need surgery.

This is a big myth. I have a lot of athletes, a lots of soldiers that come into my office and they're like, I've got an ACL tear, and I need surgeries.

And that's not necessarily true. Although many times we do go to surgery, especially in younger patients who are more active and who're feeling a sense of instability, this is not true and we can treat patients conservatively and many jujitsu and combat athletes are missing ACLs in my opinion.

This hasn't really been shown in literature, but you don't need an ACL to do jujitsu, especially if you sit to your butt more and if your more active from the bottom.

You would probably realize it more if were wrestling, if we're cutting side to side. I do have a story of a friend who didn't know they tore their ACL.

I came to the gym, examined it, said, look, I think you tore your ACL.

Diagnosing an ACL Tear on Exam

And it had already been several months. They were like, no, it was a heel hook. It just felt like a sprain. Then they carried on, carried. About a year or two later, complaining of more instability, and then all of a sudden the knee was locked.

And the big risk of no surgery is you can have further damage to the knee, to cartilage, the meniscus. So now they were dealing with a menuscus that had locked their knee plus an ACL tear.

Menuscous and ACL and then moved on to surgery. And this was a more chronic picture. This was over a couple

of years. I think a lot of athletes do go through this.

you're not unstable, you have an ACL tear, but you don't have any sense of instability. This is a big, this is good positive note, You might be a coper.

And copers, there's a whole classification of people that can cope without an ACL. So I often use this classification scheme to see if we can avoid surgery in some patients.

You have to be able to single leg hop. There's some surveys and questionnaires that you can fill out. history of instability is probably the most important for me when I'm looking at people who could be copers.

If they're constantly giving out, giving, out giving-out they may not succeed with a non-operative treatment with just physical therapy. But also if they haven't gone to physical therapist yet and say somebody stuck them in a brace which is not typically what we do for ACL tears when you get them acutely we want to be moving, strengthening, and getting going.

But if patients come to my office after six weeks with a brace on and they're unstable, we may be able to try a course of physical therapy to see if we can strengthen the legs and keep them out of surgery.

So it's definitely a possibility, especially if you fit into this COPR classification. Another newer thing with non-operative management is something called cross-bracing, where the knee is bent to 90 degrees and in a and I believe that's about four weeks or so, and then you slowly come out of the brace over three months.

It's got pretty decent compelling literature to support it. They do use MRI at three-months in their paper to see if there's any healing in the MRI, but I will tell you that MRI Healing isn't the most accurate thing.

We can have MRI, what looks like healing of the ACL on MRI without surgery, but this is just scar tissue and a lot of times it's not functional. I've had this before where we've repeated MRIs after a patient went through a season because they had to play to get into college for basketball.

we get the new MRI and to our surprise, it looks healed. But then you feel the knee and it is not the more stable. They're still having instability events.

You go into surgery and its really just wispy scar tissues that the MRI picked up. maybe a little more anecdotal but there is also literature to show that healing on MRI does not necessarily correlate to how the patient's feeling and how they're going to be able to return to sport.

So to me also the cross bracing doesn't seem super reasonable because then we can also get stiffness and we also can get some weakness in the legs potentially.

But I'm definitely interested, I am always open to see what could come from this and if we could treat more patients conservatively that would be awesome too because ACL surgery is pretty big.

So if you don't get surgery on your ACL that doesn't mean you go running back to sport because you have a chance of your knee giving way and those instability events.

You still have to go to physical therapy. And it still can take up to that 9 to 12 months. The Delaware Oslo ACL cohort is a group in Delaware that has some pretty good papers on non-operative treatment of ACLs.

And they have a great protocol that you can look at if you're considering doing a nonoperate treatment for your ACL. But my biggest recommendation would be to stay off the mats, stay away from your sport while you are recovering and getting your knees strong.

And that group does report that it can take, again, up to nine to 12 months. But everybody's different with conservative care. The goal is to get the legs strong and we're not really looking for anything to heal, per se.

So when should you consider surgery? If you're kind of in that non-operative game where you are trying to do non operative care, if you have a lot of instability and you aren't really progressing with rehab, you concerned that your knee isn't stable.

Non-Operative Treatment and When Surgery Is Needed

those are really the big reasons to go on and consider surgery. Okay, let's go onto the next topic, which is ACL surgery, when is a good time to get surgery?

I always tell my patients that we need to give you strong, full range of motion, you should almost feel like you don't need the surgery at the time of surgery and some people don' t, we've already talked about non-operative care, but really, the goal with this is to have that leg super strong before surgery and not rush into it.

Rushing into surgery when your knee is still swollen, upset and angry is not a good idea. You're just causing a second trauma to the joint while you go into the surgery, and then you're leading yourself up for failure after the surgery because you haven't fully rehabbed before.

So I tell people, typically, it's about four to six weeks, but it could be longer. It just depends on how your strengthening goes and how much rehabilitation you're doing before the surgery.

So graft options is a big topic. Um, It's always coming back because we really do have a lot of grafts options. We can take an autographed or an allograft.

An autograph comes from your own body. And alligraft comes a cadaver or somebody who's done their body to science. Now, autograft, we have many options.

There's BTB, which is your patella tendon, and then we take a little piece of bone from your kneecap, then bone for your shinbone. That's one graft. Another graft is a quadriceps tendon which we just above the knee cap.

Sometimes people take that with a piece a bone. Hamstring is pretty classic one and still the most common graft in the world. Most common doesn't mean it's the best graft, it just the common one done.

And then we have our allograft, which is our cadaver tissues, and those can be a variety of different tissues from different areas of the body, but we kind of categorize them all into just a donor tissue, so not coming from the patient.

BTB is the most tried and true. I do believe it is a very strong graft, this is what most football players get. It's strong, there's bone that can heal into bone.

Quadriceps is typically all tendon. It does tend to be a little bit of a quicker surgery, probably because of the ease of harvesting that quadriceps graft over the BTB.

Biggest thing with quadriceps graft is a lot of physical therapists have told me that right after surgery there is some quad weakness that's pretty hard to get back.

But the literature does show that both BTD and quad, because you're taking from that extensor mechanism from the front of leg that helps your knee extend, does result in decreased strength for both of those grafts.

With the BTB, sometimes you can get knee pain, so front of the knee where you take that little piece of bone, which is sometimes why BTD is avoided in combat athletes or wrestlers, but I would say that this is a very low percentage and people still do very well.

So BT and quadriceps are the two graphs that I typically use in my practice and the ones that i recommend and I often let patients choose between those two.

Hamstring graft, again one of Hamstrings do have a little bit of a higher failure rate, especially in young people, unless other procedures are added to them, which we won't go into today, but hamstring I typically avoid in the active population, and especially younger females.

Allograft, same thing. This is typically my graft for older patients, but even then, if I have 35, 40-year-old patient, very active, no arthritis, tears their ACL, feels unstable, we're probably still going to consider taking from your tissue.

But this is a conversation that you have with your surgeon. Should we use my own tissue or an allog raft? The cool things about the algorithm are you don't have to take tissue from your own body.

So sometimes that area where you took the tissue is more painful than where had the actual surgery. And so these are things to kind of weigh with your doc and see.

But if I were getting an ACL reconstruction where I needed a new tissue, I would probably go with my own. and either go BTB or even probably quadriceps because I'm around that 35 to 40 age, which is where I typically recommend quadriceps.

One thing I wanted to say about allograft tissue is it is a big no-no in my practice for young athletes, Which is pretty much what I treat because i treat active-duty soldiers and young dependents playing sports.

So allographs coming from another tissue I do not recommend in younger patients and in the athletic population. So the last thing I wanted to talk about was ACL repair.

So those were all reconstructions where we take a graph from somewhere else and make your new ACL. Repair is actually what I had and it's pretty controversial, which is why it is kind of interesting that I have that procedure done.

And if you still have good ACL fibers and you are reasonably acute within a couple of months of the injury, This is a possibility. I still had good fibers and we were able to stitch through my ACL tissue and bring it back to the bone and a little bit of a more extensive recovery early on, but you can return back support earlier with this repair.

It's about five to six months versus nine to 12 months with the reconstruction. So something to always consider asking. But most ACLs are not amenable to this because they usually have more of an explosion rather than a tear.

I do think that combat athletes and jujitsu athletes have more of that avulsion injury or the pulling off of the bone rather than the full explosion in the middle of ACL.

I think there's a higher chance of combat athlete having this because of rotational force rather then the big pivot plant. kind of like blow up of the knee.

So that's a theory that I have. And if you're a combat athlete, definitely a reasonable question to ask. I had a patient ask me recently, hey, am I a candidate for repair?

But they were out about two years from the injury and the MRI didn't show any ACL tissue there. It had kind degenerated and it was pretty much just gone at that point.

Not a great candidate and we moved to reconstruction. So let's talk about the rehab portion and the return to combat sports.

ACL Surgery Options and Graft Choices

Now this isn't my forte. I'm an orthopedic surgeon so I work on indicating people. So I did use some help from my buddy Matt Piekarski. He is an awesome physical therapist and jujitsu black belt.

And so he's got some pretty cool courses on returning athletes to Combat Sports in particular. and I utilize a lot of

his course to help me with this section.

With the rehab, I also went through rehab for my ACL and so that's why it is a little bit more helpful because I can tell you more about my experience as well.

There are a lot of phases to ACL reconstruction therapy. I tell my patients, if you get your ACL reconstructed, The actual therapy is much more challenging than the surgery or anything else and really it's more of a mental battle because it is going to take some time and you are going start feeling good around that 3 to 6 mark.

You are gonna start feel like you can go do things but you cant because that graft has not healed in yet. And some literature shows the graft doesn't even heal for about 2 to 3 years.

But we can't really keep athletes out of sport for that long. That's pretty crazy. And keeping athletes even for a year is a long time, in my opinion.

Really the mental game is is big portion of it. If you can afford a sports psychologist, I recommend it because they can help you with those mental barriers of not being part of your team, of being able to show up at the gym all the time to train.

You can still go to the gym, you can participate in some things depending on where you are in the recovery phase, but you cannot go full send. So it is a pretty challenging mind game.

Early on you had your ACL surgery, now we're going to rehab. Different surgeons get patients in at different times. I'm more in camp where I get patient in right away.

You had the ACL Surgery, I often operate on Tuesdays. I'm usually saying by Friday, go in. And our physical therapists take down all your dressings, everything that's covering your knee, and we start mostly just with swelling and making sure you get full extension of the knee.

That's really the early, early stuff in my book. So full-extension of a knee is one of most important things, I think, for those first couple weeks until you see me again.

My first post-op visit with my patients is about two weeks after surgery. We're making sure you have good extension and that your quadriceps are starting to activate.

Now quadiceps activation is going to be super important for after ACL surgery or after any knee surgery really. So knees have about five to 10 degrees of hyperextension, right?

So when you think of a leg being straight, we often say, okay, We want zero degrees. But really the knee hyper extends just a touch. and that really allows for us to heel strike.

So when we're walking, it allows us put the heel on the ground and start to walk. And that is what our hyperextension is needed for. Now, some patients have a ton of hyporextention and hyperlaxity and oftentimes I see that in my young females and they tore their ACL, likely because, well, because of the trauma, but they might have had an increased risk because their hyperlaxity.

So I tell them, you know, if your other side has 10 to 15 degrees of hyperextension after this surgery, we don't need 10-15, right? That 5-10 is great, and this is also partially part of reason that you tore it.

Those are very different circumstances, one to consider. So getting that hyperextension, getting our quadriceps moving, and getting your swelling down are the keys to the first six weeks.

Quadricep activation is gonna be a key the whole time. Swelling is going to be the key to whole the time because sometimes we tend to do too much and our knee will talk to us.

And if we start having increased swelling, we're probably doing too much. And combat athletes are known to do too and not particularly listen to where we should be.

So use your knee swelling and how much pain you're having as your feedback. Icing, I know it's controversial. Some people say don't ice. But I do believe in icing and there is some literature to support icing before you do your physical therapy and before your workouts.

to help with quadriceps strengthening. Also, it can increase testosterone. So if you're looking at that, ice is a great method. But that's a whole other topic that we can discuss about when to ice, how to do it safely.

Another thing I'm a big fan of is compression sleeves. I actually did a post on Instagram with some compression slaves and other things that I really like in the rehab process.

The longer the compression sleeve, the better. If it goes from your hip to your toes, great. I do prefer one that goes from kind of hip or groin area, mid thigh down to the ankle.

But realize that if you are having a lot of swelling and you put that on, the swelling may go down your foot. So it just kind depends on how much swelling you have.

I love compression sleeves that are gonna help with swelling pretty much throughout the whole recovery process. Another big topic is open chain exercises.

Things like quadriceps, leg extensions. These used to be taboo. They used be shunned, but that is kind old school teaching. Now there is good support and good evidence for using open chain pretty quickly after surgery.

If you're a little bit more conservative, that four to six week mark might be the time to start. And in all honesty, you are probably not going to feel like doing those exercises until four or six weeks because of all your swelling, because all the acute stuff after the surgery Doing those open chain exercises is safe.

Repair vs Reconstruction and Return-to-Sport Rehab

It used to be the rule that we only do closed chain because we were afraid of the graft kind of tearing or that graft is fresh and injuring it, but that is not the case and that's been proven with a couple of studies here more recently.

So open chain, totally safe. Go by your orthopedic surgeon's recommendations though on when to start it and everybody's a little bit different. There was a study that showed increased strength in both the quadriceps and hamstrings at three and six months after ACL surgery if open-chain exercises are utilized.

An important thing to note is All ACL surgeries aren't the same. You can have an isolated ACL tear, but many times people have a ACL injury with a meniscus tear.

If your menuscus is fixed, I'm gonna do a whole episode on menascus because this is a, a hole other beast, But your first six weeks are gonna look a little bit different than maybe your friend who had just ACL surgery.

Those first six weeks are going to be more limited depending on how you tore your meniscus, how bad it was. Sometimes we have to make you non-weight-bearing for six-weeks.

Other times you can weight-bear in full extension, which is typically the case, but some of those more fragile tears can require non weight bearing. In a brace for 6 weeks, then we come out of the brace.

So you have make sure that you're aware of what procedures were done. Make your physical therapist aware what procedure was done so that the therapy can be tailored to your surgery.

So the next point, bracing after ACL surgery. This is also a little bit controversial among orthopedic surgeons, so I would tell you to listen to your surgeon for what their post-operative protocol is because it's clearly worked for them.

Now personally, I do not like to brace my ACLs after surgery, you might have a brace for a couple of days while you're just kind of getting the bambi legs under you and using crutches, but after a As long as you had an ACL reconstruction, isolated, and I say it's okay, then totally fine with you just getting after it.

You know, start getting to the gym. More so for mental health and lifting. As far as the legs go for lifting, though, you listen to your physical therapist.

Ask them what you can and can't do at the at each stage. But yes, the literature does not support bracing after ACL surgery. Some patients also ask for a return to sport brace, which is kind of a, it's a little bit of bulky brace.

I don't offer it. I don't love using the brace because the goal of your return to sport is that you've done everything appropriately, your legs are strong, and you don' t need the braces.

So again, literature does not support it with isolated ACLs, even with ACL and meniscus for return sport. Now, when can you get back to sport? This is very strict.

This 9 to 12 months. I know you might say, okay, I had a friend who went back at 5 to 6 months, 3 months even. this is dangerous. The ACL, this new tissue, is trying to heal and become your tissue.

And this does not happen overnight. It takes at least 9 months There are several studies that show the retail rate to be extremely high if you back before the 9 month mark after surgery.

This is three to seven times increased risk. One study even showed one in four athletes retore that graft if they got back before nine months. The risk goes down significantly after nine month, so typically tell patients who are not getting back.

Before that, you're going to feel great. It's going be very difficult. but you can keep strengthening and there's still things to do, you're just not going to be going into competition ideally.

For rolling, again I took a lot of this from Mike Piekarski, a physical therapist who treats a LOT of combat athletes. He usually tells people around five to six months, it's okay to start getting back to technique.

Drilling with trusted partners, I would say. Don't go with the new white belt, you go trusted with partners. I hope even smaller than you would be ideal, your same size or smaller.

And then rolling about that nine to 12 month mark because we all know how combat athletes are. You can go and do technical sparring or just do chokes.

Let's not use our legs, let's just work on our choking mechanics, and then all of a sudden they're full sending in a six minute round to the death. So I am very cautious, especially with my combat athletes, in telling them what they can and can't do.

And then it also just depends on if I trust that they will do too much, we hold back. But if patients just want to, or athletes just wanna get back in there and start doing little things, then we can keep them at just those little thing and keep their graph safe, that's okay too.

but nine to 12 months for rolling, and then competition, regardless of sport, I usually say is about a year. So that pretty much sums up kind of the overview of whole spectrum of ACL tears from what an ACL is, what the symptoms are and how we diagnose it as orthopedic surgeons, and then even moving along to treatment options, conservative versus operative management.

Just some final thoughts, just tearing your ACL does increase your risk for arthritis, whether you get surgery or not. It is that incident, that event, we're not too sure, although there's some pretty good data that's coming out about what happens in the knee, what environment looks like that might predispose to earlier arthritis down the road.

That is regardless of what you get done. Now if you're having continued instability events and trying conservative care, this can also increase your risk for cartilage wear and arthritis.

So ACLs are so important in our knees and Whether you get surgery or not, seeing a doctor is important. Doing the appropriate physical therapy and returning the right way is crucial for regardless of what treatment option is chosen.

The biggest advice I can give with ACL surgery is working on mental health and staying active in your community. So if you have your ACL tear and you're starting your recovery process, Don't just keep yourself out of the gym.

Still go. If you teach, you can still teach. I started teaching again about four weeks after my ACL. Um, I was in a brace and that's, that could even be a whole other topic because it was a repair instead of a reconstruction.

And so I teaching at four-weeks in brace. There's a lot of stuff I could not do. So I would articulate that, say it with my words, but just being there, just be in the presence, even going to class and sitting there with your leg elevated in ice, watching the class, i do recommend that for the mental health.

It is a very long recovery. Patience is key and sticking the course and not coming off of it. You know, you will come off the of course. Of course, You will.

Come off off. The course a bit just because setbacks can happen. Sometimes you'll feel a little bit better and then try to do something and you get set back a couple of weeks.

That's okay. The big thing is not to go and do some thing too aggressive where you put your graft at risk if you are having surgery or having an instability event if your not doing surgery.

So just follow your physical therapist guidelines and I hope that this helped with a lot of questions that you guys might have had on ACL tears. Feel free to follow me on LinkedIn, on Instagram, Facebook.

Send me a message. I have started a newsletter as well. You can email me back if you want to hear any topics. Happy to discuss them or if have any ways to help make my episodes better.

What worked for you, what didn't work for, I am all ears and I'm happy to try and have guests you might want see on the podcast.