ANDREW L. MERRITT, MD
ORTHOPEDIC SURGERY | SPORTS MEDICINE

Proliance Orthopedic Associates
Renton | Covington | Maple Valley | Lakeland Hills
Ph: 425.656.5060 Fax: 425.656.5047

MY CHILD TORE THEIR ACL — WHAT NOW?

A Parent's Guide to Understanding ACL Injuries in Young Athletes

Andrew L. Merritt, MD
Orthopedic Surgery · Sports Medicine & Joint Replacement

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Your kid just got hurt on the field. Someone said it might be their ACL. Maybe the ER confirmed it, or maybe you're still waiting on an MRI. Either way, you're probably feeling a mix of worry, confusion, and a hundred questions running through your head.

Take a breath. This is a serious injury, but it's also one of the most well-understood and successfully treated injuries in sports medicine. I've done over 100 ACL surgeries a year for my entire career, and I can tell you: with the right care and the right team, the overwhelming majority of young athletes get back to the sports they love.

This guide is designed to walk you through everything you need to know — from the moment of injury all the way through return to sport. My goal is to make sure that by the time you sit down with your surgeon, you're not overwhelmed. You're informed, you're asking good questions, and you're ready to be a great teammate in your child's recovery.

~200,000 ACL tears per year in the U.S.	**80%** chance of ACL tear if swelling follows a pivot injury
9–12 mo typical return-to-sport timeline	**15–23%** re-tear risk in athletes under 25

What Actually Happened to the Knee?

The ACL — anterior cruciate ligament — is a ligament that runs through the center of the knee, connecting the thigh bone (femur) to the shin bone (tibia). Its main job is to prevent the knee from rotating and to keep the shin bone from sliding forward. In sports, it's one of the most important stabilizers of the knee during cutting, pivoting, and change-of-direction movements.

ACL tears almost always happen the same way: a non-contact pivoting or shifting moment — a bad landing from a jump, a sudden change of direction, a plant-and-pivot in soccer or basketball. The foot is

planted, the body turns, and the force exceeds what the ligament can handle. Parents often describe watching their child's knee "buckle" inward, sometimes with an audible pop.

The classic signs right after an ACL tear:

- A pop or buckling sensation in the knee
- Rapid, significant swelling (within hours)
- Feeling like the knee is "giving way" or unstable

Key number:
If a young athlete has a pivoting injury followed by swelling, there's an **80% chance it's an ACL tear.** That swelling is the knee's way of telling you something significant happened. Don't wait on this one.

Why Are Young Female Athletes at Higher Risk?

If you're the parent of a female athlete, you've probably heard that girls tear ACLs at much higher rates than boys. This is true, and it's not just bad luck — there are real anatomical and biomechanical reasons for it.

Female athletes tend to have:

- A smaller ACL with less tissue to handle the same forces
- A narrower groove in the femur where the ACL sits — which can act like a "guillotine" during a sudden shift
- Wider hips, which changes the angle of force on the knee during landing
- Hormonal influences that may make ligaments slightly more lax
- A tendency toward "quad-dominant" movement patterns — the quads do more of the work while the hamstrings (critical ACL protectors) are underused

The good news is that most of these factors can be addressed with proper training. ACL prevention programs focused on landing mechanics, hip and hamstring strength, and core stability genuinely work.

Step 1: Get Evaluated Quickly

If you suspect an ACL injury, get your child seen by an orthopedic surgeon or orthopedic urgent care as soon as possible. This is not a "wait and see" situation. Here's why speed matters:

- **You need an MRI.** An MRI is essential to fully understand the injury. It will also show whether there are other injured structures — meniscus, cartilage, other ligaments — that change the treatment plan and recovery timeline.
- **Early diagnosis starts early rehab.** Physical therapy should start right away. Getting a jump on pre-surgical rehab leads to significantly better outcomes after surgery.
- **Instability causes more damage.** Every time that knee buckles without a stable ACL, there's a chance of additional damage to the meniscus and cartilage.

If you're in the greater Seattle area, you can be seen promptly at:

Proliance Bone & Joint Urgent Care
150 Andover Park W., Tukwila, WA 98188
Phone: 425-979-2663
Hours: Tue–Fri 12:00pm–7:00pm | Sat–Mon 10:00am–7:00pm

What the MRI Will Show

The MRI is the gold standard for diagnosing an ACL tear. Here's what I look for:

- **The ACL itself —** whether it's completely torn, partially torn, or stretched. A completely torn ACL in a young athlete looks like a frayed, disorganized mess where a clean, taut band of tissue should be.
- **The bone bruise —** one of the most telling signs. When the knee shifts during an ACL tear, the outer femur and tibia crash into each other, leaving a characteristic bruise. In severe cases this can be an actual small fracture ("dent") in the bone.
- **The meniscus —** the two C-shaped cushions inside the knee. These are injured in a significant percentage of ACL tears and can change both the complexity of surgery and the recovery timeline.
- **Other ligaments —** particularly the MCL (inner side of the knee), which can be stretched or torn at the same time. Most MCL injuries in this setting heal on their own without surgery.

The MRI is your roadmap. It tells us exactly what we're dealing with and helps us plan the right surgical approach.

Does My Child Need Surgery?

For young, active athletes who want to return to cutting and pivoting sports: **yes, almost universally.**

The ACL does not reliably heal on its own. In young athletes, the tear is typically complete, and the tissue often gets reabsorbed by the body over time, leaving nothing to repair. Without a stable ACL, the knee will continue to feel loose and give way during rotational activities.

Every instability episode puts stress on the meniscus and shear forces on the cartilage. Studies have consistently shown that an unstable knee leads to much higher rates of meniscus tears and cartilage damage over time — and those problems are far more difficult to treat than the original ACL tear. Reconstructing (or repairing) the ACL is protective in the long run.

Non-surgical treatment may be considered in older, lower-demand patients who are not planning to return to pivoting sports. But for a teenage soccer player, basketball player, or skier? Surgery is the answer.

What Surgery Involves

There are two surgical options for ACL injuries: reconstruction and repair. Most people have only heard of reconstruction, but repair is a real option in the right situation — and it's something we evaluate for every patient.

ACL Reconstruction

Reconstruction is the most common approach. Because the torn ACL typically can't be stitched back together, we remove the damaged tissue and replace it with a new piece of tissue called a graft — essentially building a new ligament from scratch. The surgery involves drilling precise tunnels in the femur and tibia, pulling the graft through, and securing it with specialized fixation hardware. Performed arthroscopically through small incisions, it takes approximately 45–60 minutes.

Graft choice is one of the most important decisions in the whole process. The right choice depends on your child's age, sport, activity level, anatomy, and the nature of the tear:

- **Bone-Patellar Tendon-Bone (BTB):** Often called the "gold standard" for competitive athletes — bone-to-bone healing is fast and reliable. Some harvest-site discomfort, particularly with kneeling. Not used in kids who are still growing.
- **Hamstring Tendon:** Smaller incision, less initial pain. Generally not recommended for athletes with hypermobility or knock-knee alignment due to slightly higher failure rates.
- **Quadriceps Tendon:** Newer but increasingly popular. Thick, strong graft with minimal harvest site pain. A great option especially in growing athletes.
- **Allograft (cadaver tissue):** No donor site, fastest surgery, but higher failure rate in young high-demand athletes. Generally reserved for patients over 40 or complex multi-ligament reconstructions.

I perform all of these and tailor the recommendation to each patient individually.

ACL Repair — When We Can Save Your Own Ligament

In select cases, instead of replacing the ACL entirely, we can repair it — keeping your child's own ligament in place and stitching the torn portion back to where it originally attached. Not every ACL tear qualifies. The key requirements are the quality of the remaining tissue and the location of the tear.

When repair is an option, we often use the BEAR Implant — a biologic scaffold made of bovine collagen that is placed at the repair site and soaked in the patient's own blood. It acts as a protective bridge, giving the torn ACL tissue something to heal against during the early healing phase.

Why consider repair over reconstruction?

- It's your child's own tissue — not a graft harvested from elsewhere
- Generally less painful than reconstruction
- Emerging data suggests repair may carry a lower long-term arthritis risk compared to reconstruction
- Some studies have shown retear rates as low as 5% for ACL repairs with the BEAR implant, compared to ~15% for reconstruction in high-demand young athletes

Timing note:

If repair is being considered, surgery needs to happen **within approximately 50 days of the injury.** The native ACL tissue degrades over time, and once it's gone, repair is no longer possible. This is another reason why prompt evaluation matters — not just to protect the knee, but to keep your options open.

Both reconstruction and repair take approximately one hour. The right choice for your child is a conversation we'll have in clinic after reviewing the MRI and understanding your athlete's specific situation.

Before Surgery: Prehab

One of the most important things parents don't always realize: **surgery should not happen immediately after the injury** — at least for most reconstructions.

For ACL reconstruction, we typically wait 4–8 weeks before operating. During an acute injury, the knee is swollen, stiff, and the quad muscles are in shock. Operating in that environment leads to worse outcomes — specifically, a much higher risk of post-operative stiffness and poor quad function.

For ACL repair, the timeline is tighter — surgery needs to happen within approximately 50 days of the injury. Even so, we still use the time before surgery productively.

Regardless of which approach is planned, the pre-surgical period is used for prehab:

- Reduce swelling and inflammation
- Restore full range of motion
- "Wake up" the quad muscles and restore basic strength
- Optimize nutrition — adequate protein and collagen supplementation can meaningfully support recovery

Patients who go into surgery with good range of motion and quad control recover dramatically faster and more completely than those who rush in. Think of prehab as an investment that pays off on the back end.

The Recovery Timeline: What to Expect

ACL recovery is a 9 to 12 month process for return to cutting and pivoting sports. That's the reality. It's long, and it tests everyone's patience. But the reason for the timeline isn't arbitrary — it's biology.

After surgery, the graft goes through a process called ligamentization. Here's the counterintuitive part: the graft actually gets weaker before it gets stronger. For the first three months, the body uses the graft as a scaffold — breaking it down and rebuilding it with new collagen and blood supply. The graft is at its weakest around 3–6 months after surgery, which is exactly when many athletes start to feel great and want to push too hard. This is the danger zone.

Timeline	What's Happening
Injury to Surgery (4–8 weeks)	Prehab with physical therapy. Reduce swelling, restore motion, build quad strength.
Surgery to 6 Weeks	Weight-bearing with crutches and brace. PT starts within the first week. Focus on swelling, range of motion, and quad activation. Most kids return to school within 1–2 weeks.
6 Weeks to 3 Months	Gradually increasing strengthening and range of motion. Daily activities become more normal.

3 to 6 Months	Running typically starts around 3 months (if no meniscus repair). No twisting or cutting yet — strictly straight-line activities. The graft is still vulnerable.
6 to 9 Months	Controlled pivoting and sport-specific drills under PT supervision. Neuromuscular training on both legs is critical here.
9 to 12 Months	Return to cutting and pivoting sports, provided strength testing confirms the athlete is ready. This isn't just a calendar milestone — the athlete has to earn it.
12 Months to 2 Years	The graft continues to mature and strengthen for up to two full years. Most re-tears happen in this window — continued good mechanics and prevention training matter.

The Return to Sport Question

Every parent wants to know the same thing: when can my child play again?

> The minimum is 9 months. Returning before that significantly increases the risk of re-tearing the graft — studies show a **seven-fold higher reinjury rate** when athletes return at 6 months compared to 9 months. The graft may feel strong enough to play at 6 months, but without full vascularization and maturation, it's far more fragile than it seems.

For many families, there's no compelling reason to rush to the 9-month mark. If your child is a sophomore in high school and their season ends before 9 months anyway, it may make more sense to aim for 12 months and significantly lower the re-tear risk. I discuss this with every family individually.

The long-term outcomes of ACL surgery in young athletes are generally excellent. The goal — and the realistic outcome when everything is done right — is a full return to sports at the same level as before the injury.

What About Re-Injury Risk?

Athletes under 25 who return to cutting sports after ACL reconstruction have approximately a **15–23% chance of tearing their ACL again** — either the reconstructed knee or the other one. In fact, in many studies, the non-injured knee is actually more likely to be torn, because the same anatomical risk factors and movement patterns that caused the first tear are present in both legs.

This is exactly why ACL prevention training — focused on landing mechanics, hamstring and hip strength, and core stability — is so important not just for the recovering athlete, but for their teammates. We can't eliminate re-tear risk, but we can reduce it significantly.

Continued physical therapy, proper warm-up routines, and prevention programs after return to sport are not optional extras. They're part of the long game.

Long-Term Considerations

An ACL injury leaves a mark, and parents deserve to know this going in. Even with a successful reconstruction, there is an increased lifelong risk of developing arthritis in the injured knee. This is

largely related to the initial trauma of the injury itself — the bone bruising and any cartilage damage that occurred at the moment of the tear.

The good news: a stable, well-treated knee is far better protected long-term than an unstable one. Newer data also suggests that ACL repair may carry a lower arthritis risk than reconstruction — preserving your own native tissue appears to be kinder to the joint over time.

Staying at a healthy weight, keeping the leg muscles strong, and avoiding sustained high-impact running as a primary fitness activity later in life are all things that can help minimize arthritis risk down the road.

What I Tell Every Family

ACL injuries are scary because they happen fast and the recovery is long. But I want you to know this: I've walked hundreds of families through exactly what you're going through right now, and the path forward is clear. You don't have to figure this out alone.

The best outcomes come from three things: **a motivated patient, precise surgical technique, and a patient, well-executed rehab program.** Your job as a parent is to support the motivation and the patience. My job is to handle the surgery. Physical therapy does the rest.

I do about 100 ACL surgeries a year. I trained at the Hospital for Special Surgery in New York — the #1 ranked orthopedic hospital in the country — and served as an assistant team physician for the New York Giants. I've treated athletes from youth sports all the way to the professional level. This is what I do.

If your child has been diagnosed with an ACL tear, or if you suspect one, please get evaluated promptly. My offices are in Renton, Covington, and Maple Valley, and same-day or next-day evaluation is often available through Proliance Bone & Joint Urgent Care.

Key Takeaways

- If your child has swelling after a pivoting injury, get an MRI — there's an 80% chance it's an ACL tear.
- Reconstruction and repair are both options; early evaluation keeps both on the table (repair must happen within ~50 days).
- Prehab before surgery matters — better range of motion and quad strength going in means faster recovery coming out.
- Return to cutting sports takes 9–12 months minimum. The graft is weakest at 3–6 months when athletes feel best.
- Prevention training after return to sport reduces re-tear risk — for your athlete and for their teammates.

Watch my full ACL video series on YouTube — anatomy, surgery, recovery, and return to sport:

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