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ORIGINAL ARTICLE

Result of Anterior Cruciate Ligament Reconstruction by the Peroneus Longus Tendon

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ABSTRACT

Background: *ACL injuries are common in young active individuals and often impair knee stability and sports performance. While hamstring and patellar tendon autografts are widely used, the peroneus longus tendon (PLT) has gained attention as a suitable alternative due to its adequate graft properties and low donor-site morbidity.* ***Aim of the study:*** *To evaluate functional outcomes, knee stability, donor-site morbidity, and return-to-sports rates after ACL reconstruction using PLT autograft.* ***Methods:*** *A prospective observational study was conducted at Satkhira Medical College from January 2023 to December 2024. Thirty-two patients (18–45 years) with isolated ACL tears underwent reconstruction using the ipsilateral PLT. Functional outcomes (IKDC, Lysholm, Tegner, VAS) and AOFAS scores were recorded preoperatively and at final follow-up. Knee stability was assessed using Lachman, pivot shift, and KT-1000 tests. Donor-site morbidity, complications, and return-to-sports status were also documented. Data were analyzed with paired t-tests and chi-square tests ($p<0.05$).* ***Results:*** *The mean age was 28.5 years; 71.9% were male. Significant postoperative improvements were observed in IKDC, Lysholm, Tegner, and VAS scores (all $p<0.001$). KT-1000 difference improved from 6.1 mm to 1.7 mm, and normal Lachman and pivot shift tests were restored in 78.1% and 87.5% of patients, respectively. Donor-site morbidity was minimal, with only 6.3% showing mild eversion weakness. Overall, 75% returned to pre-injury sports within 9–12 months.* ***Conclusion:*** *PLT autograft provides strong functional improvement, reliable knee stability, minimal morbidity, and a high return-to-sports rate. It represents a safe, effective alternative graft option for primary ACL reconstruction.*

Keywords: *ACL, Peroneus longus tendon, Knee stability, Autograft, Sports return*

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INTRODUCTION

Anterior cruciate ligament (ACL) is a thick, fibrous ligament located inside the knee joint that connects the femur to the tibia [1]. Worldwide, ACL injuries are among the most common knee-ligament injuries; ACL tears account for roughly 50 % of all knee ligament injuries [2]. In Bangladesh, about 38% of knee injuries were found to involve ACL damage [3]. Anterior cruciate ligament (ACL) reconstruction using the peroneus longus tendon (PLT) autograft is increasingly recognized as a promising alternative to traditional grafts like hamstring or patellar tendons. Studies show that PLT grafts provide comparable functional outcomes, including improvements in IKDC, Lysholm, and Tegner scores, with minimal donor-site morbidity and complications such as infection or stiffness being rare [4]. The PLT graft typically has a larger diameter (around 8-9 mm) than hamstring tendon grafts, which may contribute to its strength and durability, and biomechanical testing indicates its tensile strength is similar or superior to hamstring grafts [5]. Harvesting the PLT is relatively straightforward, involves a small incision, and results in less thigh muscle atrophy and donor-site morbidity compared to hamstring grafts, with ankle function generally preserved postoperatively [6]. Long-term follow-ups up to 2 years demonstrate sustained knee stability and function with PLT grafts, and no significant differences in graft failure rates compared to hamstring grafts have been reported [7]. Risk factors for anterior cruciate ligament reconstruction (ACLR) failure or complications include both patient-specific and surgical factors. Younger age, especially under 21 years, is strongly associated with higher revision rates, with males and those with lower body mass index (BMI) also at increased risk [8]. Anatomical factors such as increased posterior tibial slope (PTS) significantly raise the risk of both initial ACL injury and graft failure after reconstruction [9]. Delayed surgery beyond 12 weeks post-injury and concomitant injuries, particularly grade 2 medial collateral ligament (MCL) injury, increase postoperative knee instability and risk of failure [10]. Other risk factors for poor outcomes or complications include high activity levels post-surgery, preoperative knee laxity, concomitant meniscal or cartilage injuries, and comorbidities such as diabetes or cerebrovascular disease, which also increase readmission risk [11]. Anterior cruciate ligament reconstruction (ACLR) treatments primarily involve surgical reconstruction using autografts such as patellar tendon, hamstring tendon, or, less commonly, quadriceps tendon and allografts, with the choice influenced by anatomical,

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biomechanical, and clinical considerations [12]. The all-inside ACLR technique, which uses a minimally invasive approach with quadrupled semitendinosus grafts and suspension fixation, aims to reduce surgical trauma and speed recovery while maintaining good clinical outcomes [13]. Rehabilitation is a critical component of treatment success, with evidence supporting early weight-bearing, supervised exercise programs, and the early introduction of open kinetic chain exercises to improve function and reduce pain, while postoperative bracing and high-intensity plyometric exercises show limited benefit [14]. Biological augmentation methods, including platelet-rich plasma and stem cells, have been explored to enhance graft healing, but current clinical evidence remains limited and inconclusive [15]. The study aimed to assess knee function, graft performance, and donor-site outcomes following ACL reconstruction using the peroneus longus tendon patients.

METHODS & MATERIALS

This prospective observational study was conducted at the Department of Orthopaedics, Satkhira Medical College, Satkhira, Bangladesh between January 2023 and December 2024. The study was approved by the Institutional Ethics Committee, and informed consent was obtained from all participants prior to enrollment. The study adhered to the principles of the Declaration of Helsinki. A total of 32 patients fulfilling the inclusion criteria were enrolled consecutively.

Inclusion Criteria

- Age 18–45 years.
- Isolated ACL tear confirmed clinically and by MRI.
- Primary ACL reconstruction planned using peroneus longus tendon.
- Able to follow rehabilitation and provide consent.

Exclusion Criteria

- Multi-ligament injuries or fractures.
- Previous knee surgery.
- Osteoarthritis, inflammatory or neuromuscular disorders.
- Significant systemic illness affecting healing.
- Unable to follow postoperative protocol.

Data Collection

Data were collected prospectively from all eligible patients enrolled in the study. A standardized data collection form was used to ensure uniform documentation of demographic characteristics, mechanism of injury, side of involvement, and time from injury to surgery. Clinical evaluation findings, including Lachman test, pivot shift test, and KT-1000 measurements, were recorded preoperatively by experienced orthopedic surgeons. Intraoperative details such as graft diameter, graft length, tunnel measurements, operative time, and associated meniscal or chondral injuries were documented immediately after surgery. Functional outcome data, including IKDC, Lysholm, Tegner activity scale, VAS pain score, and AOFAS foot and ankle score, were collected both preoperatively and during the final follow-up visit. Postoperative complications, donor-site morbidity, and ankle eversion strength were assessed at routine follow-up intervals. Return-to-sports status was evaluated at 9–12 months postoperatively based on patient-reported activity level and clinical clearance. All data were verified by independent reviewers for accuracy before being entered into the study database.

Surgical Technique

All procedures were performed under spinal or general anesthesia with a tourniquet applied. The peroneus longus tendon was harvested from the ipsilateral leg through a standard lateral approach. Graft length and diameter were measured, and femoral and tibial tunnels were created arthroscopically following anatomical ACL reconstruction principles. Meniscal and chondral lesions were managed concurrently as indicated. The graft was fixed using interference screws on both femoral and tibial sides. Operative time was recorded for all cases.

Statistical Analysis

Data were analyzed using SPSS version 26 (IBM Corp., Armonk, NY, USA). Continuous variables were expressed as mean ± standard deviation (SD), and categorical variables as frequencies and percentages. Paired t-tests were used to compare preoperative and postoperative continuous outcomes, while categorical outcomes were analyzed using the chi-square or Fisher's exact test, as appropriate. A p-value <0.05 was considered statistically significant.

RESULT

The mean age of the participants was 28.5±5.8 years, with half of the patients aged 25–34 years, and equal smaller proportions 25% each, younger than 25 years and 35 years or older. The male-to-female distribution was 71.88% males and 28.13% females. The right knee was affected in 59.38%, and the left knee in 40.63%. The primary mechanism of injury was sports trauma, 56.25%, followed by road traffic accidents, 25.00% and falls, 18.75%. The mean duration from injury to surgery was 5.2±2.5 months (Table 1). The mean graft diameter was 8.0±0.5 mm, and the mean graft length was 24.2±1.8 cm. Femoral and tibial tunnel diameters were 8.2±0.4 mm and 8.3±0.5 mm, respectively. Meniscal injuries were present in 40.63%, with 21.88% medial, 12.50% lateral, and 6.25% involving both menisci. Chondral lesions were recorded in 15.63%. The mean operative time was 77.4±11.6 minutes (Table 2). The International Knee Documentation Committee (IKDC) score improved from 47.5±7.2 preoperatively to 84.2±6.0 at final follow-up ($p<0.001$). The Lysholm score increased from 51.9±8.4 to 88.7±5.5 ($p<0.001$), and the Tegner activity score improved from 2.0±0.8 to 5.2±1.1 ($p<0.001$). The visual analog scale (VAS) for pain decreased from 6.0±1.3 to 1.3±0.6 ($p<0.001$). The American Orthopedic Foot and Ankle Society (AOFAS) score remained relatively unchanged, from 97±3 preoperatively to 98±2 postoperatively ($p=0.12$) (Table 3). Superficial infection occurred in 3.13%, and a cyclops lesion was observed in 3.13%. Kneeling pain at the donor site was reported in 6.25%, while donor-site weakness in the peroneus longus area occurred in 3.13%. Ankle eversion strength was normal in 93.75%, with mild weakness in 6.25% and no cases of moderate or severe weakness (Table 4). According to Table 5, the Lachman test showed moderate to severe laxity (Grade 2–3) in 87.50%, while postoperatively, 78.13% had normal knee stability (Grade 0) and 21.88% had slight laxity (Grade 1) ($p<0.001$). Similarly, the pivot shift test was grade II–III (clunk/severe) 81.26% before surgery, while 87.50% tested negative, and 12.50% had Grade I (glide) postoperatively ($p<0.001$). KT-1000 side-to-side difference improved from a mean of 6.1±1.4 mm preoperatively to 1.7±0.6 mm postoperatively ($p<0.001$). Return to pre-injury level of sports at 9–12 months was achieved in 75.00%, whereas no patients had returned to pre-injury levels before surgery ($p<0.001$).

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Table – I: Baseline characteristics of the study population (*n* = 32)

Variable	Frequency (n)	Percentage (%)
Age (years)		
<25	8	25.00
25–34	16	50.00
≥35	8	25.00
Mean ± SD	28.5 ± 5.8	
Gender		
Male	23	71.88
Female	9	28.13
Side of Injury		
Right	19	59.38
Left	13	40.63
Mechanism of Injury		
Sports trauma	18	56.25
Road traffic accident (RTA)	8	25.00
Fall	6	18.75
Time from Injury to Surgery (months)		
Mean ± SD	5.2 ± 2.5	

Table – II: Intraoperative findings and graft characteristics of the study population

Variable	Frequency (n)	Percentage (%)
Graft Diameter (mm)		
Mean ± SD	8.0 ± 0.5	
Graft Length (cm)		
Mean ± SD	24.2 ± 1.8	
Femoral Tunnel Diameter (mm)		
Mean ± SD	8.2 ± 0.4	
Tibial Tunnel Diameter (mm)		
Mean ± SD	8.3 ± 0.5	
Meniscal Injury		
Medial	7	21.88
Lateral	4	12.50
Both	2	6.25
None	19	59.38
Chondral Lesions	5	15.63
Mean Operative Time (min)		
Mean ± SD	77.4 ± 11.6	

Table – III: Functional outcomes before and after ACL reconstruction among the study population

Outcome Measure	Preoperative Mean ± SD	Final Follow-up Mean ± SD	p-value
IKDC Score	47.5 ± 7.2	84.2 ± 6.0	<0.001
Lysholm Score	51.9 ± 8.4	88.7 ± 5.5	<0.001
Tegner Activity Score	2.0 ± 0.8	5.2 ± 1.1	<0.001
VAS Pain Score	6.0 ± 1.3	1.3 ± 0.6	<0.001
AOFAS Score (Foot/Ankle)	97 ± 3	98 ± 2	0.12

Table – IV: Postoperative morbidity and donor-site assessment following surgery

Variable	Frequency (n)	Percentage (%)
Superficial Infection	1	3.13
Deep Infection	0	0.00
Cyclops Lesion	1	3.13
Kneeling Pain	2	6.25
Donor-Site Weakness (Peroneus Longus Area)	1	3.13
Ankle Eversion Strength		
Normal	30	93.75
Mild weakness	2	6.25
Moderate/Severe	0	0.00

Table – V: Objective knee stability and return to sports after ACL reconstruction using peroneus longus tendon

Parameter	Preoperative Result (n, %)	Postoperative Result (n, %)	p-value
Lachman Test			
Grade 0 (Normal)	0(0.00)	25(78.13)	<0.001
Grade 1 (Slight Laxity)	4(12.50)	7(21.88)	
Grade 2–3 (Moderate–Severe Laxity)	28(87.50)	0(0.00)	
Pivot Shift Test			
Negative	0(0.00)	28(87.50)	<0.001
Grade I (Glide)	6(18.75)	4(12.50)	
Grade II–III (Clunk/Severe)	26(81.26)	0(0.00)	
KT-1000 Side-to-Side Difference (mm)			
Mean ± SD	6.1 ± 1.4	1.7 ± 0.6	<0.001
Return to Pre-injury Level of Sports (9–12 months)	0(0.00)	24 (75.00)	<0.001

DISCUSSION

Anterior cruciate ligament (ACL) injury is one of the most common knee injuries leading to instability and functional limitation, especially among young and active individuals. Surgical reconstruction is often required to restore knee stability and allow return to daily and sports activities. Various graft options have been used for ACL reconstruction, including hamstring, patellar tendon, and quadriceps tendon. Recently, the peroneus longus tendon has emerged as an alternative graft with promising strength, minimal donor-site morbidity, and satisfactory functional outcomes. Our study population was young with mean age of 28.5±5.8 years. Our study is consistent with Ertilav et al. who reported mean age of 29.2±7.7 years [16]. Most of the participants in the study were male (71.88%). Study similarly shows higher male representation, which likely reflects exposure and participation patterns in contact and pivoting sports [17]. Sports-related trauma was the most frequent mechanism (56.25%) in this study. Other similar study reported even higher proportion of sports-related injuries [4]. These differences typically reflect local activity patterns: centers that serve large athletic populations often show higher sports proportions, whereas trauma centers may see more RTAs. Laterality in our sample favored the right knee (59.38%). The mean time from injury to surgery in our series was 5.2±2.5 months. Our time interval is comparable to other study in which surgeries were performed after an initial conservative period or when logistical factors delayed definitive reconstruction [18]. The mean graft diameter in this study (8.0 ± 0.5 mm) lies well within the range commonly reported for PLT autografts. Using a quadrupled-strand hamstring autograft with a diameter of ≥8 mm for ACL reconstruction significantly lowers failure rates and has a protective effect, especially in patients younger than 27 years [19]. Reported PLT graft lengths vary by harvesting technique but commonly exceed 24 cm, which allows for double- or triple-bundle preparation or adequate tunnel fixation. Our mean graft length was 24.2 cm. Hossain et al. reported a mean peroneus longus graft diameter of 8.15 mm with an average length of 28.17 cm [20]. Our recorded femoral and tibial tunnel diameters was 8.2 mm and 8.3 mm respectively. The near 1:1 correspondence between graft and tunnel diameters is expected when surgeons aim for snug fit and appropriate interference fixation; it also underlines that, in practice, PLT dimensions translate directly into standard tunnel sizing without needing routine augmentation. Meniscal injury was present in most patients (13/32) with medial tears most common (21.88%). This result indicates our sample is typical of real-world ACLR populations where concomitant intraarticular pathology is common [21]. In this study, the mean operative time was 77.4±11.6 min. We observed large and statistically significant improvements across knee-specific functional measures: IKDC increased from 47.5±7.2 to 84.2±6.0, Lysholm from 51.9±8.4 to 88.7±5.5, Tegner activity score from 2.0 ± 0.8 to 5.2±1.1, and VAS pain decreased from 6.0±1.3 to 1.3±0.6 (all p<0.001). Ankle/donor-site function measured by AOFAS was high pre- and postoperatively (from 97 to 98) and did not change significantly (p=0.12). Overall these results indicate marked clinical improvement in knee function and pain with negligible clinically meaningful donor-site morbidity. Both Rhatomy et al. and Hossain et al. reported significant improvements in functional outcomes following ACL reconstruction, as measured by the Modified Cincinnati, IKDC, and Tegner-Lysholm scores after 24 months of follow-up [20,22]. Angthong et al. previously observed potential donor-site morbidity associated with using the peroneus longus tendon, including reduced peak eversion and inversion torque, compromised ankle function, and concerns regarding ankle stability [23]. However, in our study, the donor ankle exhibited excellent functional performance based on FADI and AOFAS assessments. This favorable outcome may be attributed to the preserved peroneus brevis tendon, which acts as an efficient primary evertor of the ankle [24]. We observed one superficial infection (3.13%), no deep infections, one cyclops lesion (3.13%), kneeling pain in two patients (6.25%), donor-site weakness in one patient (3.13%). Our single superficial infection is therefore within expected ranges [25]. We found preserved ankle-eversion strength in the large majority (93.75%) with only mild weakness in 2 patients (6.25%). This supports the use of PLT as an alternative autograft when avoiding hamstring or patellar donor morbidity is desirable [26]. These findings indicate a favorable safety profile for PLT harvest with minimal clinically meaningful ankle morbidity. Objective knee stability outcomes in the present study were highly satisfactory. Postoperatively, 78% of patients demonstrated a normal Lachman test, and 87.5% had a negative pivot-shift test, indicating excellent anterior–posterior stability. Khajotia et al. similarly reported 72% normal Lachman and 60% negative pivot-shift findings at six months, along with favorable IKDC and Lysholm scores [27]. The mean KT-1000 side-to-side difference improved from 6.1 mm preoperatively to 1.7 mm postoperatively, reflecting substantial restoration of ligamentous stability. These results align with prior studies using peroneus longus tendon autografts, including an all-inside AH PLT series reporting a reduction from 7.0 mm to 1.1 mm [28]. Notably, 75% of patients returned to pre-injury sports within 9–12 months, underscoring PLT's functional efficacy as an ACL graft.

Limitations of the study: This study was limited by its single-center design, which may affect the generalizability of findings across diverse populations and surgical settings. Follow-up duration, although sufficient to assess early functional outcomes, may not capture long-term graft durability, late-onset complications, or degenerative changes. Additionally, patient-reported outcomes and return-to-sport assessments were subject to individual reporting bias, and variations in rehabilitation adherence could have influenced functional recovery.

CONCLUSION

Anterior cruciate ligament reconstruction using the peroneus longus tendon demonstrated excellent functional recovery, significant improvement in knee stability, and a high rate of return to pre-injury sports within 9–12 months. Donor-site morbidity was minimal, with preserved ankle eversion strength in the majority of patients. Based on these findings, the peroneus longus tendon represents a safe, reliable, and effective autograft option for primary ACL reconstruction. It is recommended as a viable alternative, particularly in patients where hamstring or patellar tendon grafts are unsuitable.

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