

association between MVPA and KOOS sport and recreation ($\beta = 0.72$, 95% CI 0.2, 1.3) that was not modified by injury history.

Conclusions: Youth and young adults spend 13 minutes less daily time in MVPA, 3–15 years after sustaining a traumatic knee injury compared to matched-controls. This may be partly explained by a perceived reduction in knee function related to sport and recreational activities (e.g. running/jumping). Reduced knee function in the years following sport injury may be the reason why youth and young adults are engaging in less strenuous PA than their non-injured counterparts. This lends evidence to providing rehabilitation programs that address these concerns, by encouraging the continuation or modification of activities that will allow previously injured individuals to return to activities that are appropriate to their needs. Early PA intervention may be key to preventing the onset or development of post-traumatic osteoarthritis in this at-risk group.

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LIMITING THE RISK OF OSTEOARTHRITIS AFTER ANTERIOR CRUCIATE LIGAMENT INJURY: ARE WE MISSING THE OPPORTUNITY TO INTERVENE?

A. Davis[†], R. Wong[†], K. Steinhart[†], J. Astephen Wilson[†], L. Cruz[§], D. Cudmore[‡], T. Dwyer^{||}, L. Li[¶], P. MacDonald[#], P. Marks^{††}, L. Nimmon[‡], D. Ogilvie-Harris[†], N. Urquart[‡], J. Chahal^{‡‡}. [†]Krembil Res. Inst. Univ. Hlth. Network, Toronto, ON, Canada; [‡]Dalhousie Univ., Halifax, NS, Canada; [§]Univ. of Toronto, Toronto, ON, Canada; ^{||}Women's Coll. Hosp., Toronto, ON, Canada; [¶]Arthritis Res. Ctr. of Canada, Vancouver, BC, Canada; [#]Pan Am Sports Clinic and Univ. of Manitoba, Winnipeg, MB, Canada; ^{††}Sunnybrook Hlth. Sci. Ctr., Toronto, ON, Canada; ^{‡‡}Univ. Hlth. Network, Toronto, ON, Canada

Table 1

HCP discussion of OA risk with ACL patients

	CASEM (n = 129) % (95% CI)	PT (n = 275) % (95% CI)	Orthopedic Surgeon (n = 72) % (95% CI)
Discuss OA risk factors			
Never	0.8 (0.1, 4.3)	9.1 (6.2, 13.1)	1.4 (0.2, 7.5)
Sometimes	29.5 (22.3, 37.8)	56.6 (50.8, 62.4)	19.4 (12.0, 30.0)
Always	69.8 (61.4, 77.4)	34.3 (28.9, 40.2)	79.2 (68.4, 86.9)
Factors influencing OA risk discussion (yes)			
Age	41.1 (32.8, 49.9)	49.0 (42.9, 55.1)	50.0 (38.7, 61.2)
Sex	6.5 (3.3, 12.8)	7.6 (4.9, 11.6)	17.1 (10.1, 27.6)
Body weight	45.6 (39.4, 56.3)	53.0 (46.8, 59.2)	56.3 (44.8, 67.3)
Activity level	52.0 (43.3, 60.7)	64.4 (58.2, 70.2)	54.3 (42.7, 65.4)
Type of acute management	36.7 (28.6, 45.8)	35.5 (29.6, 41.8)	50.0 (38.7, 61.2)
Concurrent joint injury	73.8 (65.3, 80.8)	82.8 (75.5, 87.0)	93.1 (84.8, 97.0)
Revision ACL reconstruction	62.9 (53.9, 71.2)	69.7 (6.5, 75.3)	82.6 (72.0, 90.0)
Timing of OA risk discussion (yes)			
Initial ACL management	80.6 (72.8, 86.6)	59.9 (53.6, 65.9)	91.3 (82.0, 95.9)
3–6 months post-injury	35.5 (27.6, 44.2)	46.1 (40.2, 52.8)	17.4 (10.2, 28.0)
>6–12 months post-injury	21.7 (15.4, 29.8)	27.8 (22.5, 33.9)	17.4 (10.2, 28.0)
>12 months post-injury	18.5 (12.7, 26.3)	18.1 (13.7, 23.5)	10.1 (0.5, 19.5)

Purpose: Fifty percent of people with anterior cruciate (ACL) injury develop knee osteoarthritis (OA) within 6–10 years, even with ligament reconstruction. Despite evidence that targeted exercise, appropriate physical activity and weight management effectively limit symptomatic knee OA, only 27% (62/233) of Australians and Americans with ACL reconstruction 1–5 years previously, remembered discussing OA risk with any health care professional (HCP) and only 25 of these people were able to recall strategies for managing risk. In order to develop an intervention that limits development and progression of knee OA, the first step is to understand what HCPs (surgeons, primary care physicians (PCPs) and physiotherapists (PTs)) managing people with ACL injury do or do not tell their patients about their OA risk. The objective of this study was to determine: 1) if OA risk factor information is provided to non-elite athletes with ACL injury; 2) what factors influence discussion of OA risk; and, 3) when in the course of care OA risk is discussed.

Methods: We surveyed practicing sports surgeons, PCPs and PTs who provide care to non-elite athletes with acute ACL injury. Retired HCPs or those no longer practicing in Canada were excluded. The electronic survey was distributed through an e-blast and newsletter link to the Canadian Academy of Sport and Exercise Medicine (CASEM) (largely PCPs) and the Sports and Orthopedic Divisions of the Canadian Physiotherapy Association members. Orthopedic surgeons were contacted via phone and or email and completed the survey via fax, mail or online. The survey included four sections: practitioner demographics; frequency and specific factors discussed; when post-injury risk factors are discussed; and, recommendations for how and with whom risk factors and their management should be discussed. Descriptive statistics with 95% confidence intervals (CI) were calculated for all data.

Results: There were 129 CASEM, 275 PTs and 72 orthopedic surgeon respondents. All Canadian provinces and 2 of 3 territories were represented. 53, 35 and 90 percent of CASEM, PT and surgeon respondents were male. 70% or more had greater than 5 years' experience treating people with ACL injury. Table 1 shows that while more than 2/3s of CASEM and orthopedic surgeons always discuss OA risk, only 1/3 of PTs do. All groups reported that patient sex and type of acute management were least likely to influence the decision to discuss OA risk. A high proportion of providers discussed OA risk as part of initial management with many fewer respondents reporting such discussions 6 months after injury. Despite a lower proportion of PTs reporting always discussing OA risk, 80, 99 and 84% of CASEM, PT and surgeons indicated that PTs were best suited to provide OA risk information.

Conclusions: These results suggest that there is a communication gap as HCPs, particularly PTs, who routinely manage people with ACL injury do not consistently discuss OA risk post injury. Additionally, any discussions occur only early post injury when the focus is likely on ACL recovery such that there is a lack of emphasis on managing OA risk at final follow-up, when it's likely most important. Educational strategies are needed to develop care pathways inclusive of support for OA risk management post ACL injury.

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GAIT MECHANICS AND TIBIOFEMORAL LOADING IN MEN OF THE ACL-SPORTS RANDOMIZED CONTROL TRIAL

J.J. Capin, A. Khandha, R. Zarzycki, A.J. Arundale, M.L. Ziegler, K. Manal, T.S. Buchanan, L. Snyder-Mackler. Univ. of Delaware, Newark, DE, USA