Anterior cruciate ligament (ACL) injuries most commonly occur during sports that involve sudden stops and changes in direction, such as basketball, soccer, tennis, and volleyball. Depending on the severity of the ACL injury, treatment may include surgery to replace the torn ligament followed by rehabilitation exercises to help the patient regain strength and stability. However, controversy exists as to the efficacy of postoperative bracing after ACL reconstruction.

Because most studies designed to prove the efficacy of knee bracing after ACL reconstruction have been equivocal, Decoster et al. questioned orthopedic sports medicine physicians about their brace prescription practices via a mailed survey. Most physicians used functional braces for patients undergoing ACL reconstruction, preferred custom braces, and braced patients for 9 months after reconstruction. Thirty-six percent reported having recently made changes in their brace prescription practices, including using bracing less often.

In 1998, Muellner et al. evaluated the effects of bandaging after reconstructive surgery of the ACL. The study demonstrated that withholding the use of a brace had no adverse effect on early outcomes with respect to stability and function. On the contrary, bracing seemed to not be mandatory after ACL reconstruction when the central third of the patellar tendon was used.

However, after 1998, bracing after ACL reconstruction has become a common practice. Some clinicians believe that bracing improves the outcome of ACL reconstruction. Although some articles in the literature are in favor of the use of a postoperative brace after anterior cruciate ligament (ACL) reconstruction, this review found that several systematic reviews and other reports on the topic do not support the use of a postoperative brace after ACL reconstruction. There is no scientific evidence so far to support the routine use of a functional knee brace following a successful ACL reconstruction in the postoperative course. Most authors believe that bracing is not necessary. There is insufficient evidence to inform current practice. Good-quality randomized trials are required to remedy this situation. Future studies should better define the role of a brace following ACL surgery. A search of MEDLINE for articles published between January 1, 1995, and September 30, 2013, was performed. Key search terms used were ACL reconstruction and knee brace. Ninety-one articles were found, but only 28 focused on the subject of bracing after ACL reconstruction and were selected for this review. Several systematic reviews and randomized, controlled trials on the topic do not recommend the use of postoperative brace after ACL reconstruction. Postoperative bracing after ACL reconstruction does not seem to help with pain, function, rehabilitation, and stability. The literature does not support the use of a postoperative brace following ACL reconstruction. [Orthopedics. 2016; 39(4):e602-e609.]
tion by improving extension, decreasing pain and graft strain, and providing protection from excessive force. However, over the past few years, there has been controversy about the role of postoperative bracing following ACL reconstruction. Despite changes in rehabilitation protocols, extension deficit remains an important potential cause of significant morbidity following ACL reconstruction. Bracing after ACL reconstruction for rehabilitation and functional return to activities has been common practice.

The purpose of this review was to define whether postoperative bracing after ACL reconstruction is necessary and to provide insight into the role of braces after ACL reconstruction with regard to pain, function, rehabilitation, and stability. This study is necessary because the data reported so far in the literature are inconclusive regarding the need for knee bracing after ACL reconstruction.

Materials and Methods

A search of MEDLINE for articles published between January 1, 1995, and September 30, 2013, was performed. Key search terms used were ACL reconstruction and knee brace. Ninety-one articles were found, but only 28 focused on the subject of bracing after ACL reconstruction and were selected for this review. The Figure shows a flow chart of the author's search strategy.

Results

Some articles were in favor of the use of a postoperative brace after ACL reconstruction, and others were opposed.

Studies in Favor of Bracing After ACL Reconstruction

Kuster et al showed that a compression sleeve improves the total integration of the balance control system and muscle coordination after ACL reconstruction.

Melegati et al analyzed the effects of a rehabilitation brace locked in extension for the first week of recovery of full extension after ACL reconstruction by means of bone–patellar tendon–bone reconstruction. They compared 2 groups of patients who underwent ACL reconstruction. The brace was unlocked twice per day for physiotherapy. In group A, patients wore a postoperative brace with range of motion (ROM) between 0° and 90°. In group B, patients wore the same postoperative brace locked in full extension for the first week. In both groups, the brace was unlocked (0°-120°) at the beginning of the second postoperative week and then removed at the beginning of the third week. All patients followed the same rigorous, accelerated rehabilitation protocol. Each patient was evaluated pre- and postoperatively (at weeks 2, 4, and 8) with bubble-level heel-height difference (HHD) measurements and KT1000 (MEDmetric Corp, San Diego, California) arthrometric assessment at postoperative month 4. At 4- and 8-week follow-up, bubble-level HHD measurements showed that the extension of the operated knees in group B was significantly greater than that in group A. However, KT1000 arthrometric scores showed no difference between the 2 groups.

Two tests were performed by Rebel and Paessler after ACL reconstruction to determine the effect of a knee brace on coordination (test 1) and electromyographic muscle activity in drop-jumps (test 2). Test 1 studied 25 patients with ACL reconstruction under 3 test conditions (1-legged static, 2-legged static, and 2-legged dynamic) compared with a control (n=30). The results showed highly significant improvements in all braced conditions. In test 2, 10 patients undergoing ACL reconstruction and 10 healthy individuals performed a 2-legged drop-jump; this was performed 15 times and then repeated 15 times with a knee brace worn on the reconstructed limb. Changes in electromyographically determined muscle activity (vastus medialis, vastus lateralis, biceps femoris, gastrocnemius) were observed, but they were significant in only a few cases because of high variability. Drop-jumps with a knee brace improved jumping height, increased the maximum knee angle in the ground contact phase, and reduced the maximum knee angle in the landing phase. Patients thus developed an increased confidence in the stability of their knees. Rebel and
Paessler⁶ concluded that the benefits of the knee brace were due to the mechanical action, an enhanced coordination, and a psychological effect.

According to Beynnon et al.,³ application of a functional brace or neoprene sleeve to the ACL-deficient limb does not improve the threshold to detection of passive knee motion. However, application of an elastic bandage to a knee with an ACL tear improves joint position sense. Reconstruction of a torn ACL is associated with a deficit in the threshold to detection of passive knee motion, and, during the first year of healing, the use of a neoprene sleeve provides improvement. Two years after ACL reconstruction, there was no deficit in the threshold to detection of passive knee motion, and the use of a brace had no effect on this outcome.

Mikkelsen et al.¹⁰ investigated whether postoperative ACL braces together with postoperative bandages allow the knee to reach full extension. In 10 uninjured knees with known hyperextension, the knees were bandaged in the same way as after an ACL reconstruction. The knees were then studied radiologically in a Hyper brace (Albrect GmbH, Stephanskirchen, Germany) set at 0°, -5°, and -10° of knee extension. Not a single knee was found to be straight in the brace set at 0°. At -5°, most of the knees were straight or in slight hyperextension. It took -10° to get all knees straight or in hyperextension. In this prospective, randomized study, 44 patients who underwent an arthroscopic ACL reconstruction with a bone–patellar tendon–bone graft were randomized to use either a brace set at -5° or a straight brace (0°) for at least the first 3 postoperative weeks. Preoperatively and 3 months postoperatively, ROM was determined using a goniometer with long arms, and sagittal knee laxity was measured with a KT2000 (MEDmetric Corp) arthrometer at manual max. Pre- and postoperative pain was evaluated with the visual analog scale (VAS). The same examiner (blindfolded to what type of brace was used) performed all the measurements. At 3 months, 2 of 22 patients with the brace set at -5° and 12 of 22 patients with the straight brace had a loss of full extension of 2° or more. No significant differences were found between the groups in terms of knee flexion, sagittal knee laxity, or postoperative pain. Although extension deficit after ACL reconstruction can be prevented in other ways, a Hypex brace set at -5° seems to be an easy way of ensuring full knee extension.

Stanley et al.⁹ determined the effects of a knee extension constraint brace on knee flexion angle, peak posterior ground reaction force, and movement speed in functional activities in patients after ACL reconstruction. Six male and 6 female patients who were 3.5 to 6.5 months post-ACL reconstruction participated in the study. Three-dimensional videographic and force plate data were collected while patients performed level walking, jogging, and stair descent wearing a knee extension constraint brace, a nonconstraint brace, or no brace. Knee flexion angle at initial foot contact with the ground, peak posterior ground reaction force, and movement speed were compared across brace conditions and between sexes. Wearing the knee extension constraint brace increased the knee flexion angle at initial foot contact for each activity when compared with the other 2 brace conditions. Wearing the knee extension constraint brace also decreased peak posterior ground reaction force during walking, but not during jogging and stair descent. Although the knee extension constraint brace did not consistently reduce the peak posterior ground reaction force in all functional activities, it consistently increased knee flexion angle and should reduce ACL loading. These results suggest that the knee extension constraint brace has potential as a rehabilitation tool to alter lower extremity movement patterns of patients after ACL reconstruction to address high reinjury rates.

Giotis et al.¹⁰ tested whether knee bracing restores normal rotational knee kinematics in ACL-reconstructed knees during high-demand athletic activities in a Level II prospective, comparative study. Twenty male patients who had undergone unilateral ACL reconstruction with a bone–patellar tendon–bone autograft were assessed in vivo. Mean time from surgery to data collection was 26 months. An 8-camera optoelectronic system was used to collect kinematic data while each patient performed 2 demanding tasks: immediate pivoting after descending from a stair and immediate pivoting after landing from a platform. Each task was performed under 3 conditions for the reconstructed knee: wearing a prophylactic brace (braced condition), wearing a patellofemoral brace (sleeved condition), and without a brace (non-braced condition). As a control group, patients with intact ACLs were tested without bracing. For both tasks, the ROM of tibial rotation was significantly lower in the intact knee compared with all 3 conditions of the ACL-reconstructed knee. Placing a brace or a sleeve on the ACL-reconstructed knee resulted in lower rotation than the non-braced knee, whereas no significant differences were found between the sleeved and braced conditions. Bracing limited the excessive tibial rotation in ACL-reconstructed knees during pivoting that occurs under high-demand activities. However, full restoration to normative values was not achieved. Therefore, braces have the potential to decrease rotational knee instability that remains after ACL reconstruction.

In a prospective study, Pförninger and Kremer¹¹ analyzed 2 different postoperative treatments on patients with acute and isolated disruption of the ACL who were treated with reconstruction using the semitendinosus tendon. The patients were randomized and divided into 2 groups: those using a postoperative brace set at full extension (group A) or those using the same brace set at a flexion of 20° (group B) on the first 3 days postoperatively. All patients undertook a standard accelerated rehabilitation protocol and were assessed
after 3, 6, and 12 months postoperatively. The patients in group A reached full extension faster than those in group B, with no loss of knee stability. Postoperative extension led to an earlier return to work and sport activities. The muscle strength side-to-side difference measurement was lower in group A. The severity and intensity of postoperative pain, swelling, and giving way was reduced in group A, as was the risk of arthrofibrosis. Therefore, immediate postoperative extension, compared with the postoperative flexion of 20°, optimized the operative results after ACL reconstruction

Mayr et al\(^2\) compared the clinical outcomes of rehabilitation after ACL reconstruction using a water-filled soft brace with those using a hard brace. In a prospective, randomized clinical trial, they showed that patients treated with a soft brace had significantly higher International Knee Documentation Committee (IKDC) subjective ratings at 6 weeks to 12 months postoperatively and rated significantly higher in Tegner activity scores and Lysholm knee scores at 6 and 12 months postoperatively. The water-filled soft brace was better regarding effusion, swelling, extension deficit, and patient-measured mid-term outcome. The soft brace is a safe, easy-to-use, and effective alternative to the hard brace.

According to Palm et al,\(^3\) ACL elastic knee braces increase postural stability by approximately 22% in patients with ACL rupture. However, they reported no difference in postural stability between uninjured and injured legs in the braced condition.

Strutzenberger et al\(^4\) compared the effect of 2 different functional brace designs (shell and sleeve brace) on functional achievements in ACL-deficient patients. Results showed a significant decrease in knee joint laxity for sleeve and rigid shell bracing. The sleeve brace revealed a significant increase in dynamic balance after perturbation and a significant increase in dynamic lower limb peak rate of force development compared with the non-braced condition. Braces might not be needed in simple daily life tasks but could provide beneficial support in more dynamic settings when patients return to sporting activities after an ACL injury.

**Studies Opposed to Bracing After ACL Reconstruction**

Forty patients were prospectively investigated by Muellner et al\(^5\) to evaluate the effects of bandaging after ACL reconstructive surgery. For the 6-week postoperative course, the operated knee was bandaged in 20 patients (group A) and braced in another 20 (group B). The isokinetic torque for extension and flexion and ROM were investigated at 6, 12, 24, and 52 weeks postoperatively. At 24 weeks and 1 year postoperatively, stability of the knee joint (KT1000) and clinical outcome (Orthopädische Arbeitsgemeinschaft Knie) were evaluated. No statistically significant differences between the 2 groups were found for extension and flexion strength. Free ROM was achieved significantly earlier in group A than in group B. No statistically significant differences regarding the stability of the operated knee joint or the early outcome were found between the 2 groups. This study demonstrated that not using a knee brace had no adverse effect on the early outcome with respect to stability and function. On the contrary, bracing seemed to not be mandatory after ACL reconstruction when the central third of the patellar tendon was used.

A systematic review of Level 1 evidence (12 randomized, controlled trials [RCTs]) reported by Wright and Fetzer\(^6\) found no evidence that pain, ROM, graft stability, or protection from subsequent injury were affected by brace use. Kartus et al\(^7\) evaluated the effect of a standard postoperative rehabilitation knee brace on function, stability, and postoperative complications at 2-year follow-up after ACL reconstruction. Seventy-eight consecutive patients with a unilateral chronic ACL rupture reconstructed by the same surgeon using the endoscopic all-inside technique, patellar tendon autograft, and interference screw fixation were included in the study. The rehabilitation followed a standard protocol. Group A included 39 patients who were supplied postoperatively with a knee brace for a median of 4 weeks (range, 3-6 weeks). Group B included 39 patients for whom a brace was not used. Median age was 27 years in group A and 26 years in group B. All 78 patients were reexamined by 2 independent observers after a median follow-up period of 25 months in group A and 24 months in group B. There were no differences in the parameters studied (median KT1000 total side-to-side difference between reconstructed and uninjured knees at 89 N, median Lysholm score, median Tegner activity level, median IKDC score, and median sick leave taken). This study indicated that the use of a postoperative rehabilitation brace after an arthroscopic ACL reconstruction does not appear to influence either objective stability or subjective function by 2-year follow-up.

In a meta-analysis of the knee-brace literature, Martinek and Friederich\(^8\) analyzed the results from clinical and experimental studies. No published clinical data showed that braces have any effect on postoperative outcome after ACL reconstruction. Also, no evidence of a significant bracing effect could be demonstrated in experimental in vivo or in vitro studies, except a limited stabilizing function for lower shear stress below the physiological loads. Consequently, the systematic use of braces in rehabilitation after ACL reconstruction cannot be recommended.

Risberg et al\(^9\) evaluated the effect of ACL reconstruction and functional knee bracing on knee proprioception. Twenty patients who experienced acute ACL disruption and underwent reconstruction with a bone–patellar tendon–bone graft participated in a controlled rehabilitation program and were studied at a mean follow-up of 2 years. A control group of 10 healthy individuals was also studied. In both groups, proprioception was evaluated.
by measuring the threshold to detection of passive motion (TDPM) with the knee at 15° of flexion with and without a functional knee brace applied. The Knee Osteoarthritis Outcome Score (KOOS), Cincinnati knee score, and 2 functional knee tests were also used as outcome measurements. Anteroposterior displacement of the tibia relative to the femur was evaluated with the KT1000 arthrometer. There were no significant differences in TDPM between the ACL-reconstructed and contralateral knees or between the ACL-reconstructed group and the healthy control group. Bracing did not produce a significant change in the TDPM for the ACL-reconstructed group or for the control group. There were low to moderate correlations between TDPM and the other outcome measurements. This study indicated no significant difference in proprioception between the ACL-reconstructed knee and the contralateral uninvolved knee 1 year or more postoperatively. Functional knee bracing did not seem to improve proprioception in patients who have undergone ACL reconstruction and had been followed for an average of 2 years postoperatively.

In a cross-sectional comparative clinical trial, Wu et al19 studied 31 patients who had undergone unilateral ACL reconstruction for more than 5 months. Patients were tested under all 3 bracing conditions: (1) DonJoy Brace (DJO LLC, Vista, California), (2) mechanical placebo brace, or (3) no brace. They were tested running and turning 10 times on a 22-meter figure-8 runway and running and jumping (and landing) on a semicircular path. Three parameters were measured: speed of running and turning, speed of running and jumping, and accuracy of landing after the jump. Patients performed similarly in conditions 1 and 2 in all the tests, but the speeds of running and turning were significantly slower in conditions 1 and 2 than condition 3. Results of the run and jump tests were not different among all conditions. Knee bracing may not improve functional performance of patients 5 months after ACL reconstruction. The use of such a brace could actually slow down running and turning, irrespective of the mechanical constraints of the brace. These functional outcomes need to be noted when such a brace is used in this group of patients.

Members of the American Orthopaedic Society for Sports Medicine (AOSSM) were surveyed by Delay et al20 to determine their current ACL reconstruction technique and opinions regarding pre- and postoperative management. Both the experience of the surgeon and their annual number of ACL reconstructions performed were recorded. Most responding surgeons routinely perform ACL reconstructions 3 to 6 weeks following an acute ACL injury using an endoscopic technique. Bone–patellar tendon–bone with interference screw fixation was the technique of choice for most respondents, with the majority performed on an outpatient basis. Rehabilitation protocols showed more variation regarding postoperative weight bearing, immobilization and bracing, length of physical therapy, and return to sport. Most surgeons prefer early postoperative full weight bearing with an average of 3.8 weeks of postoperative bracing. Physical therapy typically ranged from 1 to 4 months, with return to sport at 6 to 7 months, generally with a functional brace.

Birmingham et al21 evaluated the effects that an ACL brace has on various measures of knee proprioception and postural control. Thirty patients (mean age, 27 years) who had undergone unilateral ACL reconstruction were tested with and without their own custom-fit brace on their involved limb. Proprioception was assessed using joint-angle replication tests completed on an isokinetic dynamometer. Postural control was assessed using a series of single-limb standing balance tests completed on a force platform. The balance tests included standing on the stable platform with eyes open, standing on a foam mat placed over the platform with eyes open, standing on the platform with eyes closed, and standing on the platform after landing from a maximal single-limb forward hop. In general, bracing appeared to improve performance during tasks characterized by relatively limited somatosensory input but not during tasks characterized by increased somatosensory input. The small magnitude of the improvements, coupled with their apparent lack of carryover to more difficult and functionally relevant tasks, called into question the clinical benefit of the effects of bracing.

Birmingham et al22 investigated the effect of a knee brace on knee flexion and extension muscular strength of patients after ACL reconstruction to evaluate whether the effect of the brace depends on patient symptoms and muscular strength. Twenty-seven patients (14 women and 13 men; mean age, 28 years) underwent arthroscopically assisted ACL reconstruction using a semitendinosus and gracilis autograft. A custom-fit ACL functional knee brace was used. The brace effect was calculated as the change in peak torque observed with the brace, expressed as a percentage of peak torque observed without the brace, during isokinetic concentric knee flexion and extension movements performed at 90°. Patient symptoms were quantified using a disease-specific health-related quality of life questionnaire. Knee flexion strength decreased significantly with the brace. The brace effect during knee flexion varied considerably and was significantly related to peak torque observed without the brace. All other comparisons and correlations were not significant. These findings suggest that brace effects depend on patient strength. A brace may inhibit knee flexion strength in stronger patients, yet result in no change or even improvements in strength in weaker patients. Future research is required to further elucidate which patients may derive the most benefit or detriment from bracing.

Harilainen and Sandelin23 prospectively randomized 60 patients to brace and no-brace groups after bone–patellar tendon–bone ACL reconstruction. The brace group wore a rehabilitation knee brace
for 12 weeks postoperatively, whereas the no-brace group was mobilized immediately, and crutches were discarded 2 weeks postoperatively. The groups were comparable with respect to age, sex, time from injury to surgery, and concomitant injuries. There were no differences either preoperatively or 5 years postoperatively (80% of patients reviewed) between the groups in terms of Lysholm knee score, Tegner activity score, degree of laxity, or isokinetic peak muscle torque. Thus it appears that knee braces are not needed in postoperative rehabilitation after ACL reconstruction with patellar tendon graft.

Andersson et al24 assessed the current evidence in RCTs on ACL injuries. The use of a postoperative knee brace did not affect the clinical outcome after ACL reconstruction.

A systematic review reported by Lobb et al25 showed strong evidence (consistent evidence from multiple high-quality RCTs) of no added benefit of bracing (0-6 weeks postoperatively) compared with standard treatment in the short term.

Kruse et al26 identified 29 Level I or II studies published between 2006 and 2010 that met their inclusion criteria and were evaluated with use of the CONSORT (Consolidated Standards of Reporting Trials) criteria. Topics included in this review were postoperative bracing, accelerated strengthening, home-based rehabilitation, proprioception and neuromuscular training, and 6 miscellaneous topics investigated in single trials. Bracing following ACL reconstruction was neither necessary nor beneficial and added to the cost of the procedure.

Dubljanin-Raspopovic et al27 reported that there is no scientific evidence so far to support the routine use of a knee brace following ACL reconstruction in the controlled rehabilitative postoperative course.

Rougier et al28 assessed the postural strategies developed over the first 2 months postoperatively by ACL patients during rehabilitation and highlighted sensorimotor impairment recovery. They found that wearing a knee brace incurred no particular changes in postural control behaviors.

The Table summarizes the main demographic data and levels of evidence of the included studies.

**Table**

Demographic Data and Levels of Evidence of the Included Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>No. of Patients</th>
<th>Mean Age, y</th>
<th>Follow-up, mo</th>
<th>Level of Evidence a</th>
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Abbreviation: NA, not available.

aAccording to the Journal of Bone and Joint Surgery.

**DISCUSSION**

The most important factors in ACL reconstruction are the surgical technique, the surgeon’s experience, and the post-operative rehabilitation program. Pro-
 proprioception, ROM, and strength might be improved by the appropriate rehabilitation program, and a possible negative effect can occur if we consider that a patient without a knee brace can repeat some exercises in a free program, whereas a patient with a brace loses this potential benefit. However, the provided primary stability of the graft/technique is not always optimal, and additional protection should be taken into account; furthermore, we should consider that many patients do whatever they want without a strict rehabilitation program or safe supervision, as many professional athletes do.

In a systematic review of the Level I evidence (12 RCTs), Wright and Fetzer\textsuperscript{15} hypothesized that the use of braces could not be rationalized by evidence of improved outcome, including measurements of pain, ROM, graft stability, or protection from injury. They found no evidence that these outcomes were affected by brace use.

According to Dubljanin-Raspopovic et al.,\textsuperscript{22} functional braces increase knee stability under low clinical loads. However, their biomechanical investigation showed that functional knee braces do not restore normal knee stability under high forces related to certain activities. Furthermore, functional braces do not significantly influence proprioceptive abilities or functional performance but have a negative effect on thigh atrophy and inhibit joint muscle stabilizing activity.

Older surgical techniques used in the past to treat injuries of the ACL led to the development of a large number of functional braces. Today, with advances in surgical techniques and more aggressive rehabilitation treatment in the postoperative course, the use of functional braces after ACL reconstruction is a controversial issue.

Physicians were surveyed by Decoster et al.\textsuperscript{19} about their brace prescription practices via mail. Most physicians used functional braces for ACL patients, preferred custom braces, and braced patients for 9 months after ACL reconstruction. Thirty-six percent reported having recently made changes in their brace prescription practices, including using bracing less often.

Some authors are in favor of the use a brace after ACL reconstruction, and others are opposed to it. Most studies reported that knee braces are not needed in postoperative rehabilitation after ACL reconstruction, although some authors are still using some kind of brace.

A systematic review of Level I evidence on the use of postoperative bracing after ACL reconstruction by Wright and Fetzer\textsuperscript{15} found no evidence that pain, ROM, graft stability, or protection from subsequent injury were affected by brace use. In another systematic review of Level I or II studies, Kruse et al.\textsuperscript{25} demonstrated that bracing following ACL reconstruction remains neither necessary nor beneficial and adds to the cost of the procedure.

Literature with a lower grade of evidence is controversial and does not clarify whether a postoperative brace is necessary after ACL reconstruction. However, most authors believe that bracing is not necessary. Future studies should better define the role of bracing after ACL surgery.

Given the generally high surgical success rates, there has been no scientific evidence so far to support the routine use of a functional knee brace following a successful ACL reconstruction in the controlled rehabilitative postoperative course.\textsuperscript{27}

**CONCLUSION**

Although some studies in the literature are in favor of the use of a postoperative brace after ACL reconstruction, the current review found that several systematic reviews and other reports on the topic do not support the use of a postoperative brace after ACL reconstruction. Postoperative bracing after ACL reconstruction does not seem to help pain, function, rehabilitation, and stability. There is insufficient evidence to inform current practice. Good-quality randomized trials on the subject are warranted.

**REFERENCES**


