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From Ankle to Knee: Donor-Site Morbidity after Peroneus Longus Tendon Graft for ACL Reconstruction Assessed by the Kitaoka Ankle-Hindfoot Score – A Prospective Cohort Study

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Learning Point of the Article:

Peroneus longus tendon autograft for ACL reconstruction produces negligible, reversible donor ankle morbidity with near-complete recovery of function by 6 months.

Abstract

Introduction: Peroneus longus tendon (PLT) autograft is increasingly used for anterior cruciate ligament (ACL) reconstruction, but concerns persist regarding donor ankle morbidity and potential compromise of lateral ankle stability. This study prospectively evaluated donor-site morbidity after PLT harvest using the Kitaoka Ankle-Hindfoot Scale over a 6-month follow-up period.

Materials and Methods: This prospective observational cohort study included 45 patients with isolated ACL tears who underwent arthroscopic single bundle ACL reconstruction using autologous full thickness PLT grafts. All patients were operated at a single tertiary-care center. The Kitaoka Ankle-Hindfoot Scale was recorded preoperatively and postoperatively at 14 days, 4 weeks, 12 weeks, and 6 months. Only patients without pre existing ankle or foot pathology were included. Donor ankle pain, function, alignment, and total scores were analyzed using paired t-tests and repeated--measures analysis of variance.

Results: The cohort had a mean age of 29.95 years, and the mean interval between injury and surgery was 4.4 months. All patients had normal pre-operative donor ankle function with a mean Kitaoka score of 100. At 14 days, the mean score decreased to 71.42 ± 6.92, indicating transient functional impairment. Scores improved to 92.95 ± 5.19 at 30 days, 97.86 ± 4.63 at 90 days, and 99.11 ± 3.81 at 180 days. The change in total score between pre-operative and 6-month follow-up (100.0 ± 0.0 vs. 99.11 ± 3.81) was not statistically significant ($P = 0.064$). Component analysis showed no significant deterioration in pain (40 vs. 38.88 ± 3.17; $P = 0.160$), function (50 vs. 49.74 ± 0.63; $P = 0.065$), or alignment (10 vs. 10; no change). Between 14 days/30 days and 6 months, the increase in total scores was highly significant ($P < 0.0001$). At final follow-up, 42 patients (93.3%) had excellent and 3 (6.7%) had good donor ankle function. No cases of ankle instability, gait abnormality, or major functional compromise were observed.

Conclusion: Harvesting the PLT for ACL reconstruction results in minimal and reversible donor-site morbidity, with donor ankle function returning to near normal levels by 6 months. PLT autograft is a safe and mechanically reliable graft choice with preservation of ankle biomechanics as reflected by sustained Kitaoka Ankle-Hindfoot scores.

Keywords: Peroneus longus tendon, anterior cruciate ligament reconstruction, donor-site morbidity, Kitaoka ankle-hindfoot score, ankle function.

Introduction

Anterior cruciate ligament (ACL) tears are among the most common ligamentous injuries in active individuals and frequently necessitate surgical reconstruction to restore knee

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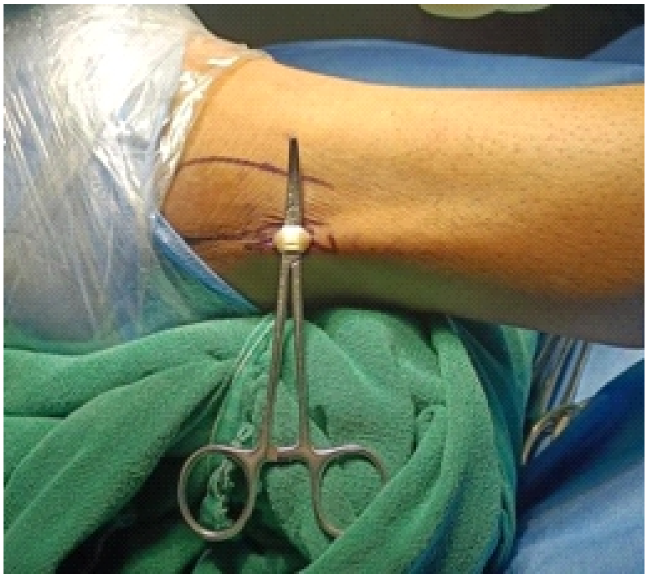


Figure 1: 1.5 cm longitudinal incision.

stability and function. Traditional autograft options such as bone-patellar tendon-bone (BPTB) and hamstring tendons have well-documented advantages, but each is associated with specific donor-site complications including anterior knee pain, patellar fractures, and hamstring weakness or sensory disturbances [1].

Peroneus longus tendon (PLT) autograft has emerged as a promising alternative due to its adequate length, favorable graft diameter, and high tensile strength, and is increasingly utilized not only in ACL reconstruction but also in procedures such as medial patellofemoral ligament reconstruction and deltoid ligament repair. Despite encouraging biomechanical and clinical data, the potential for donor ankle morbidity – particularly altered eversion strength or lateral ankle instability – remains a major barrier to its widespread acceptance [2].

Because the peroneus longus and peroneus brevis tendons act synergistically, it has been proposed that peroneus brevis can compensate for the harvested PLT, thereby preserving ankle function [3]. Several clinical series have reported minimal or no donor-site morbidity after PLT harvest, whereas a few have raised concerns about transient strength deficits or mild instability [4,5]. This study aims to prospectively quantify donor-site ankle morbidity following PLT harvest for ACL reconstruction using the Kitaoka Ankle-Hindfoot Scale, a validated, joint-specific functional score.

Materials and Methods

Study design and setting

This was a prospective observational cohort study conducted in the department of orthopedics at a tertiary care teaching hospital. Forty-five consecutive patients undergoing arthroscopic single-bundle ACL reconstruction with autologous PLT graft were enrolled.

Inclusion criteria included patients with age between 18 and 45 years, isolated ACL tear diagnosed clinically and confirmed radiologically, no pre-existing ankle or foot pathology or deformity on the donor side and patients' willingness and ability to comply with the scheduled follow-up visits for at least 6 months. Exclusion criteria include any existing ankle or foot pathology or deformity on the side of graft harvest, professional athletes or elite sportspersons, multi-ligamentous knee injuries, and associated fractures around the knee or ankle.

Pre-operative assessment

All patients underwent detailed clinical and radiological evaluation of the knee to confirm isolated ACL insufficiency and of the donor ankle to document baseline status. Pre-operative Kitaoka Ankle-Hindfoot Scores were recorded for the donor ankle in all patients.

Surgical technique

All patients fulfilled the inclusion criteria before surgery. A full-thickness PLT autograft was harvested from the ipsilateral limb. A longitudinal skin incision of approximately 1.5–2 cm was made 2–3 cm proximal and 1 cm posterior to the posterior prominence of the lateral malleolus to optimize exposure while minimizing soft-tissue trauma and risk to neurovascular structures (Fig. 1).

The sural nerve was carefully identified and protected throughout the dissection. The PLT was isolated, sharply

Figure 2: Harvesting of the graft.

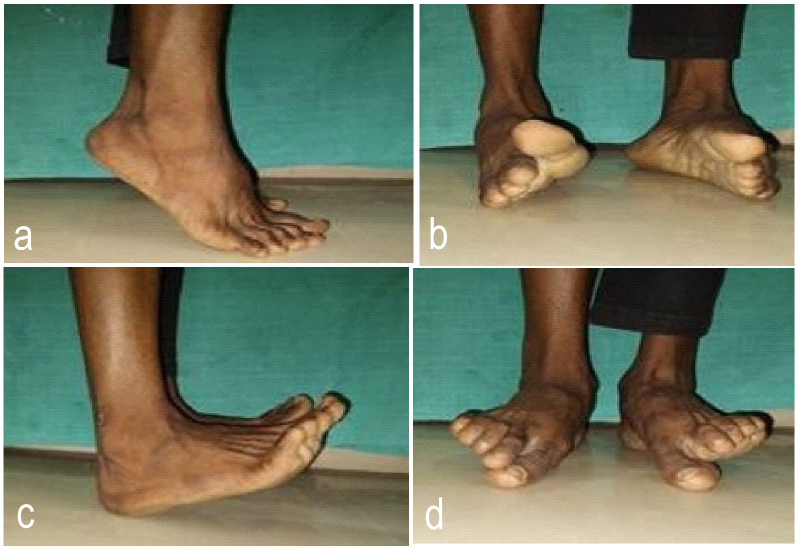


Figure 3: Movements at 6 months follow-up. (a) Plantarflexion, (b) inversion, (c) dorsiflexion, and (d) eversion.

transected distally, and harvested proximally using a closed tendon stripper (Fig. 2). The graft was then prepared on the back table and pre-tensioned. Depending on the native tendon diameter, it was folded into a triple-strand configuration, aiming for a final composite graft diameter of at least 8 mm. Graft dimensions were checked to ensure compatibility with the planned femoral and tibial tunnels.

Standard arthroscopic single-bundle ACL reconstruction was performed using established tunnel placement and fixation techniques. Graft fixation was achieved with appropriate devices according to surgeon preference; intra-articular tension and range of motion were verified at the end of the procedure.

Post-operative protocol and rehabilitation

A standardized post-operative protocol was followed for all patients. Immediate post-operative care included limb elevation, cryotherapy, and analgesia as needed. Early quadriceps activation and knee range-of-motion exercises were initiated as per standard ACL rehabilitation protocols, with protected weight-bearing using crutches initially and progression to full weight-bearing based on pain tolerance and knee stability.

Specific ankle rehabilitation included active and passive range-of-motion exercises for plantarflexion, dorsiflexion, inversion, and eversion as pain allowed. Strengthening exercises for ankle evertors and inverters were gradually introduced. Final ankle movements and strength were evaluated at follow-up visits, with representative movements at 6 months, as shown in Fig. 3.

Outcome measures

Donor-site morbidity was assessed using the Kitaoka Ankle-Hindfoot Scale, which allocates up to 40 points for pain, 50 for function, and 10 for alignment, for a total score of 100. Scores were categorized as: Excellent: ≥90, Good: 75–89, Fair: 60–74, and Poor: <60.

The scale was administered preoperatively and at 14 days, 4 weeks (30 days), 12 weeks (90 days), and 6 months (180 days) postoperatively for the donor ankle.

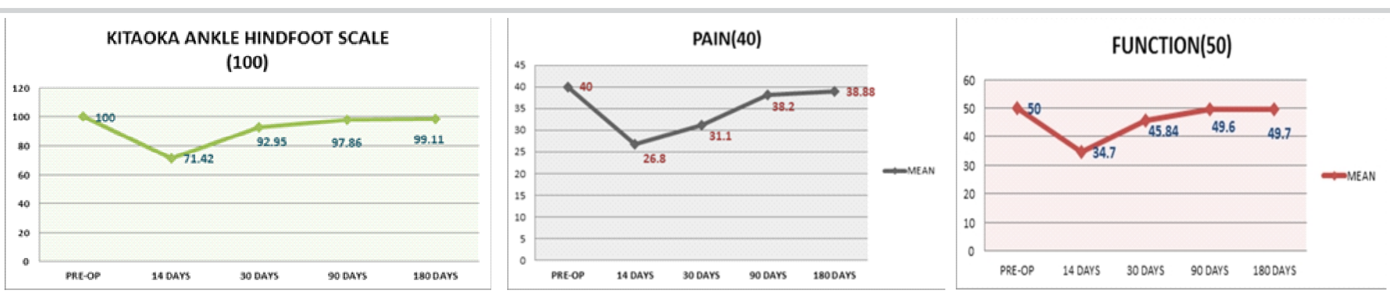
Statistical analysis

Data were analyzed using the Statistical Package for the Social Sciences version 22.0. Continuous variables were expressed as mean ± standard deviation. Paired t-tests were used to compare pre-operative and post-operative Kitaoka scores for pain, function, alignment, and total score at final follow-up. Repeated-measures analysis and paired comparisons were performed between early post-operative time points (14 days, 30 days, and 90 days) and 180 days. $P < 0.05$ was considered statistically significant.

Results

Demographic profile

The mean age of the study population was 29.95 years. The mean interval between injury and surgical intervention was 4.4 months. Males constituted approximately 75.6% of the cohort.



Graph 1: (a) Variation in kitaoka ankle hindfoot scale. (b) Variation in kitaoka scale – pain component. (c) Variation in kitaoka scale – function component.

Table 1: Variation in Kitaoka ankle hindfoot scale

Total	Max	Min	Mean	Standard deviation
Pre-operative	100	100	100	0
14 Days	78	61	71.42	6.92
30 Days	97	85	92.95	5.19
90 Days	100	88	97.86	4.63
180 Days	100	88	99.11	3.81

All patients had normal donor ankle function preoperatively, with a mean Kitaoka Ankle-Hindfoot Score of 100.

Temporal variation in total Kitaoka score

There was a transient decline in donor ankle function in the early post-operative period, followed by progressive improvement (Table 1). The mean total Kitaoka score decreased from 100 preoperatively to 71.42 ± 6.92 at 14 days, indicating early post-operative morbidity.

Subsequently, scores improved steadily to 92.95 ± 5.19 at 30 days and 97.86 ± 4.63 at 90 days, reaching 99.11 ± 3.81 at 180 days (Graph 1). The differences in total scores between 14 days and 180 days, and between 30 days and 180 days, were highly significant ($P < 0.0001$ for both comparisons), confirming substantial recovery of donor ankle function over time (Table 3).

Pain, function, and alignment components

Component-wise analysis of the Kitaoka scale is summarized in Table 2.

Pain: The mean pain score decreased marginally from 40 preoperatively to 38.88 ± 3.17 at 180 days ($P = 0.160$), a difference that was not statistically significant. Function: The mean function score changed from 50 preoperatively to 49.74 ± 0.63 at 180 days ($P = 0.065$), again without statistical significance. Alignment: Alignment remained unchanged at 10 preoperatively and at 6 months for all patients.

The overall mean total score decreased slightly from 100 to 99.11 ± 3.81 at 180 days ($P = 0.064$), indicating that donor ankle function was effectively preserved without clinically meaningful long-term compromise.

Paired comparisons over time

Paired analysis of total Kitaoka scores revealed: Pre-operative versus 180 days: 100 versus 99.11 ± 3.81 ($P = 0.064$; not significant), 14 days versus 180 days: 71.42 ± 6.92 versus 99.11 ± 3.81 ($P < 0.0001$; significant), 30 days versus 180 days: 92.95 ± 5.19 versus 99.11 ± 3.81 ($P < 0.0001$; significant), and 90 days versus 180 days: 97.86 ± 4.63 versus 99.11 ± 3.81 ($P = 0.15$; not significant).

Categorical outcomes

Kitaoka outcome categories at each follow-up are presented in Table 4. At 14 days, 57.8% of patients had good scores and 42.2% had fair scores, reflecting early morbidity but no poor outcomes. 30 days, 71.1% had excellent and 28.9% good outcomes. At 90 days, 82.2% of patients achieved excellent scores and 17.8% remained good. At the final 6-month follow-up, 42 patients (93.3%) had excellent and 3 (6.7%) had good donor ankle function, with no fair or poor results.

Clinical examination and complications

On clinical examination at final follow-up, patients demonstrated excellent ankle range of motion and strength in plantarflexion, dorsiflexion, inversion, and eversion (Fig. 3). No patient developed ankle instability, significant gait abnormality, or functional limitation affecting daily activities or return to work. There were no neurovascular complications related to graft harvest.

One superficial wound infection (approximately 2% of cases) at the harvest site was noted, which responded to local care and antibiotics without residual sequelae.

Discussion

Graft selection in ACL reconstruction remains an area of active debate, with several autograft and allograft options available. Commonly utilized grafts include BPTB, hamstring tendon,

Table 2: Comparison of ankle hindfoot scale during follow-up

Scale	Follow-up period	Mean	Standard deviation	*t*-test	*P*-value
Pain	Pre-operative	40	0	1.131	0.16
	180 Days	38.88	3.17		
Function	Pre-operative	50	0	1.89	0.065
	180 Days	49.7	0.63		
Alignment	Pre-operative	10	0	--	--
	180 Days	10	0		
Total	Pre-operative	100	0	1.902	0.064
	180 Days	99.11	3.81		

Table 3: Variation in total ankle hindfoot scale during follow-up

Follow-up period	Mean ankle hindfoot score	Standard deviation	Paired *t*-test	*P*-value
Pre-operative	100	0	1.902	0.064
180 Days	99.11	3.81		
14 Days	71.42	6.92	29.933	0.0001
180 Days	99.11	3.81		
30 Days	92.95	5.19	9.035	0.0001
180 Days	99.11	3.81		
90 Days	97.86	4.63	2.527	0.15
180 Days	99.11	3.81		

quadriceps tendon, PLT, synthetic grafts, and allografts. Each graft option offers distinct biomechanical properties and donor-site profiles that influence surgical choice and post-operative outcomes.

Historically, the BPTB graft has been regarded as the gold standard due to its excellent biomechanical strength and bone-to-bone healing characteristics. However, its use is frequently associated with donor-site morbidity, including anterior knee pain, kneeling discomfort, patellar tendon shortening, patellar fracture, chondromalacia patellae, patellar tendon rupture, and persistent quadriceps weakness. These complications may significantly affect patient satisfaction and functional recovery. Hamstring tendon grafts, another widely used option, are generally associated with lower rates of anterior knee pain; however, they are not without drawbacks. Harvest of the semitendinosus and gracilis tendons may result in medial thigh muscle atrophy, hamstring weakness, and sensory disturbances due to injury to the infrapatellar branch of the saphenous nerve. Such complications may manifest as long-term hypoesthesia or paresthesia and may negatively influence patient-reported outcomes.

In response to these limitations, the PLT has emerged as a promising alternative autograft for ACL reconstruction. The PLT provides adequate graft diameter and tensile strength while potentially minimizing donor-site morbidity around the knee. In the present study, the PLT was selected as the graft of choice in an effort to avoid the complications associated with more traditional graft sources while maintaining favorable functional outcomes.

Donor-site functional assessment in our cohort was performed using the Kitaoka Ankle–Hindfoot Score, a validated scoring system that evaluates pain, functional activity, and alignment of the ankle joint. At 6 months postoperatively, the changes observed in pain (from 40 ± 0.0 to 38.88 ± 3.17), function (from 50 ± 0.0 to 49.74 ± 0.63), and alignment (no change) were minimal and statistically insignificant. The overall mean score decreased slightly from 100.0 ± 0.0 to 99.11 ± 3.81 (P = 0.064), indicating that donor ankle function remained largely preserved following PLT harvest.

These findings are consistent with previously published literature demonstrating minimal functional compromise of the donor ankle after PLT harvesting. Hackla et al. reported a small, statistically insignificant reduction in American Orthopedic Foot and Ankle Society (AOFAS) scores from 100.0 to 96.0 at 6 months postoperatively (P = 0.06) [6]. Similarly, Sharma et al. observed a mean post-operative AOFAS score of 94.5 ± 1.5, while Cao et al. reported a mean score of 96.3 (range 84–100) with no significant difference compared with the contralateral ankle (P > 0.05) [7,8]. Kumar et al., in a study involving 100 patients, reported a mean score of 97.87 ± 3.21, further supporting the functional safety of PLT autograft harvesting [9].

Additional studies have corroborated these favorable outcomes. Rhatomy et al. reported a high mean AOFAS score of 97.3 ± 4.2 following PLT graft harvest [10]. Angthong et al., in a biomechanical and clinical evaluation, observed no statistically significant difference between pre-operative (97.7 ± 1.1) and post-operative scores (95.4 ± 12) at a mean follow-up of 13 months (P = 0.09) [5].

Longitudinal studies have also demonstrated sustained preservation of ankle function. Sahu et al. reported progressive improvement in AOFAS scores between 6 weeks, 3 months, and 6 months postoperatively (P = 0.001) [11]. Bi et al. demonstrated durable ankle function over a 3-year follow-up period, with mean AOFAS scores of 98.4 preoperatively, 91.6 at 1 year, 96.2 at 2 years, and 96.8 at 3 years [12]. Similarly, Kerimoglu et al. noted only minor complaints in 2 of 29 patients following PLT harvest, without any long-term functional deficits[13]. Khajotia et al. further confirmed preservation of ankle function in nearly all cases, supported by objective testing of foot evertor strength[14].

Other studies have reported comparable results. Duan En Trang et al. documented no significant donor-site complaints or neurological deficits following PLT harvest [15]. In a

Table 4: Kitaoka ankle hindfoot score outcome on follow-up

Outcome (100)	14 Days	30 Days	90 Days	180 Days
Excellent (90–100)	0	32	37	42
Good (75–89)	26	13	8	3
Fair (60–74)	19	0	0	0
Poor (<60)	0	0	0	0

comparative analysis of 130 patients, Keyhani et al. found no significant differences in ankle function between patients undergoing PLT harvest and those with anatomically intact ankles [16].

Gok et al., in a comparative evaluation, reported slightly lower AOFAS scores in the donor ankle (93.46 ± 3.8) compared with the contralateral ankle (97 ± 1.8) [17]. Similarly, the mean foot and ankle disability index (FADI) score at the donor site was 93.48 ± 4.6 compared with 98.19 ± 2.1 on the unaffected side. Although these differences were statistically significant, they did not translate into clinically meaningful impairment. Importantly, no donor-site pain, ankle weakness, neurological deficits, or limitations in return to sporting activity were observed.

Comparative graft studies further support the safety of PLT harvest. Saeed et al. reported a higher incidence of donor-site morbidity in patients undergoing hamstring tendon harvest compared with those in whom the PLT was used [18]. Agarwal et al. similarly demonstrated no significant differences in post-operative ankle function scores between the two cohorts [19]. In one of the largest reported series involving 439 patients, Hossain et al. documented excellent post-operative ankle function with mean AOFAS and FADI scores of 97.63 ± 3.20 and 98.46 ± 2.31, respectively, indicating minimal functional compromise following PLT harvest [20].

In our cohort, no patients demonstrated poor functional outcomes at the donor ankle. At 2 weeks postoperatively, 57.8% of patients had good function while 42.2% had fair outcomes. By 1 month, 71.1% achieved excellent scores. This proportion increased to 82.2% at 3 months and further improved to 93.3% by 6 months, with the remaining patients maintaining good functional status. These progressive improvements suggest that any early post-operative functional limitations are transient and resolve with rehabilitation.

Collectively, the findings from the present study and previously published literature support the use of the PLT as a reliable autograft option for ACL reconstruction. Donor-site morbidity appears minimal, and ankle function remains well preserved over time. Biomechanically, the preserved function may be explained by compensatory activity of the peroneus brevis muscle and the intrinsic adaptability of ankle biomechanics following tendon harvest. Consequently, PLT autograft represents a viable and safe alternative graft choice in ACL reconstruction, particularly in patients where avoidance of knee donor-site morbidity is desirable.

Conclusion

Harvesting the PLT for ACL reconstruction results in minimal and reversible donor-site morbidity, with donor ankle function returning to near normal levels by 6 months. PLT autograft is a safe and mechanically reliable graft choice with preservation of ankle biomechanics as reflected by sustained Kitaoka Ankle-Hindfoot scores.

Clinical Message

Surgeons can confidently consider the PLT as an ACL graft source, as donor ankle morbidity is transient, clinically insignificant, and largely resolved within 6 months, with preservation of ankle stability and function.

Declaration of patient consent: The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given the consent for his/ her images and other clinical information to be reported in the journal. The patient understands that his/ her names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Conflict of interest: Nil **Source of support:** None

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