# MCL RECONSTRUCTION

## A Hockey-Specific Return to Ice and Contact Progression

Evidence-Based Rehabilitation Timeline (Weeks 0-28+)

**Prepared for clinical use**

This document is intended for physicians, physical therapists, athletic trainers, strength and conditioning coaches, performance staff, hockey athletes, parents, coaches, and rehabilitation professionals involved in return-to-hockey decision-making following medial collateral ligament reconstruction.

**Important note**

Every MCL reconstruction is unique. This accelerated timeline is intended for an uncomplicated, isolated MCL reconstruction in a hockey athlete with excellent clinical response. The target is to build toward game participation around 24-28+ weeks when all criteria are met. Slow the plan for POL reconstruction, ACL/PCL/PLC involvement, meniscal repair, cartilage procedure, revision surgery, persistent effusion, extension loss, medial pain, or surgeon-specific restrictions. Progression should be based on graft stability, knee response, strength, skating tolerance, workload response, psychological readiness, and medical team recommendations, not time alone.

# 1. Clinical Purpose and Guiding Decision Rule

Six months is a target - not a promise

Clinical purpose. Provide a structured, hockey-specific rehabilitation framework after MCL reconstruction, progressing from early protection through motion, strength restoration, valgus-control development, return to skating, team practice, contact preparation, and game participation near the 6-month mark when criteria are met.

Primary decision rule. Progress the athlete when the knee is quiet, medial-sided stability is appropriate, strength and movement quality have earned the next dose, and skating/workload response supports advancement. This version compresses the return-to-play runway toward 24-28+ weeks for isolated reconstructions, but time-based milestones remain reference points, not clearance criteria.

# 2. What the Research Tells Us

MCL evidence adapted to hockey demands

No seminal hockey-specific MCL reconstruction rehabilitation protocol exists. Current clinical decision-making should combine modern multiligament reconstruction frameworks, recent MCL reconstruction outcome literature, contact-sport data, and the only published criterion-based on-ice hockey progression.

| Key Finding | Clinical Meaning | Implication for Hockey Rehabilitation |
|---|---|---|
| MCL reconstruction has favorable outcomes | Mowers et al. reported improved IKDC, Lysholm, and Tegner scores after repair and reconstruction, with reconstruction showing lower reported stiffness/failure ranges than repair. | Expect good function when stability and ROM are protected, but monitor stiffness and medial-sided symptoms closely. |
| Multiligament protocols use phases | Nielsen/LaPrade describe recovery, transition, rebuild, and restore phases with team-based, criterion-driven progression. | Build a staged plan: motion and protection first, then strength, impact, skating, chaos, contact, and games by 24-28+ weeks if criteria remain clean. |
| Hockey valgus demand is unique | On-ice side-cutting creates a different hip/knee strategy than off-ice cutting and may load the medial knee differently. | Prepare adductors, hip abductors, trunk, deceleration, edges, crossovers, and lateral skating before high-speed team work. |
| On-ice progression must be earned | Capin et al. provide a four-phase on-ice framework that can be adapted from ACL reconstruction to MCL reconstruction. | Separate easy skating from full hockey readiness, and layer speed, edges, reaction, fatigue, contact, and boards progressively. |

# 3. Quick Reference Timeline

Progression is criteria-based

| Phase | Time | Primary Focus | Hockey Exposure | Primary Advancement Theme |
|---|---|---|---|---|
| 1 | 0-6 wks | Protection, ROM, quad activation | No skating | Protect medial reconstruction |
| 2 | 7-16 wks | Gait, full ROM, strength base | Off-ice stick skills only | Capacity before impact |
| 3 | 12-18 wks | Running, plyometrics, adductor/hip strength | No ice until criteria met | Valgus-control foundation |
| 4A | 16-20 wks | Early on-ice skating | Open ice, controlled edges | First skate earned |
| 4B | 20-24 wks | Speed, transitions, noncontact drills | Team skill/no contact | Repeatable hockey movement |
| 4C | 22-26 wks | Reactive skating and contact prep | Limited contact to full practice | Chaos and board readiness |
| 4D | 24-28+ wks | Return to competition | Games after criteria | 6-month game target |

# 4. Detailed Phase-by-Phase Clinical Guideline

Medial stability before hockey chaos

## PHASE 1 | WEEKS 0-6 | RECOVERY, PROTECTION, MOTION, AND QUAD ACTIVATION

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|---|---|
| **Clinical Intent** | • Protect the reconstructed MCL and any concomitant procedures, begin controlled knee motion, control effusion, restore full extension, and preserve quadriceps activation. |
| **ROM / Weight Bearing** | • Knee motion often begins POD 1 when cleared by the surgeon<br>• Common early ROM arc: 0-90 degrees, progressing toward 0-115 degrees by phase end<br>• Weight bearing and brace use per surgeon; multiligament reconstructions commonly remain NWB for 6 weeks |
| **Strength / Activation** | • NMES and quadriceps setting immediately as appropriate<br>• Straight leg raise when no lag<br>• Hip/core isometrics and safe proximal strengthening<br>• Submaximal adductor squeezes only when cleared and non-painful |
| **Hockey Preparation** | • Team meetings and video review allowed<br>• Upper-body and trunk training as tolerated<br>• No skating, running, jumping, slide board, or fall-risk activity |
| **Clinical Monitoring** | • Effusion, extension, quad lag, medial pain, incisions, gait, brace fit, and any valgus stress symptoms |
| **Avoid / Defer**<br>**• Valgus stress or lateral cutting**<br>**• Early skating or slide board**<br>**• Open-chain valgus-loaded positions**<br>**• Forcing flexion through medial pain**<br>**• Progressing despite effusion or extension loss** | Criteria to Progress<br>• Pain controlled at rest and with exercise<br>• Full extension or symmetrical extension restored<br>• Flexion progressing toward surgeon target<br>• Effusion <=1+ and non-reactive<br>• Quad activation adequate with no SLR lag |

## PHASE 2 | WEEKS 7-12 | TRANSITION, GAIT NORMALIZATION, AND STRENGTH BASE

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|---|---|
| **Clinical Intent** | • Transition from protection into progressive loading, normalize gait, restore full ROM, build quadriceps/hamstring/hip capacity, and establish frontal-plane control without stressing the graft. |
| **ROM / Gait** | • Full symmetrical ROM by the end of the phase when appropriate<br>• Normalize gait as weight bearing advances<br>• Continue swelling and extension monitoring after each loading increase |
| **Strength Benchmarks** | • Target quadriceps LSI >=70% in early transition<br>• Target quadriceps LSI >=80% before running and impact introduction<br>• Hamstring, calf, hip abductor, and hip adductor strength progression |
| **Exercise Progression** | • Bike, pool, and low-impact conditioning<br>• Bilateral squats to split squats<br>• Step-ups in multiple directions<br>• Deadlift/sumo deadlift patterns<br>• Copenhagen level 1 to short-lever as tolerated |
| **Hockey Preparation** | • Off-ice stickhandling while stationary<br>• No skating until off-ice impact, strength, valgus control, and medical clearance criteria are met |
| **Avoid / Defer**<br>**• Running before quad and gait criteria**<br>**• Crossover/cutting or slide board before valgus control**<br>**• Deep loaded knee flexion if medial pain or swelling occurs**<br>**• Contact drills or unpredictable perturbations** | Criteria to Progress<br>• Full or near-full ROM<br>• Normalized gait without reactive swelling<br>• Quad LSI trending >=70-80%<br>• No increased medial gapping on clinical exam<br>• Single-leg squat/step-down controlled without valgus collapse |

### Transition checkpoint

Do not confuse walking normally with hockey readiness. MCL reconstruction athletes need confirmed medial stability, a quiet knee, quadriceps capacity, hip/adductor strength, and controlled frontal-plane mechanics before impact and skating are layered in.

## PHASE 3 | WEEKS 12-18 | REBUILD AND OFF-ICE SPORT-SPECIFIC PREPARATION

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| **Clinical Intent** | • Bridge general rehabilitation to hockey-specific demands by adding running, plyometrics, deceleration, change of direction, and progressive adductor/hip strengthening while preparing for a first-skate window around weeks 16-20. |
| **Entry Benchmarks** | • Quadriceps and hamstring strength LSI approximately >=80-85%, with higher thresholds preferred before first skate<br>• Hop and functional testing initiated and trending >=85% LSI when appropriate<br>• No effusion after impact preparation<br>• Valgus stability confirmed clinically and/or radiographically when indicated |
| **Off-Ice Progression** | • Return to running when criteria are met<br>• Low-intensity plyometrics and landing re-education<br>• Lateral shuffles, carioca, T-drill, and pro-agility progression<br>• Deceleration and cutting before reactive cutting |
| **Adductor / Hip Focus** | • Copenhagen short-lever progressing toward long-lever<br>• Lateral slide board introduction only after strength and swelling criteria<br>• Single-leg deadlift, step-up, split squat, lateral lunge<br>• Hip strength profiling at hockey-specific angles when available |
| **Hockey Preparation** | • Stickhandling, shooting mechanics, and conditioning can continue off ice<br>• No team practice or contact; first skate requires separate clearance criteria and a quiet 24-hour response |
| **Avoid / Defer**<br>**• Slide board as conditioning too early**<br>**• Reactive cutting before planned COD is clean**<br>**• High-volume adductor loading with medial knee pain**<br>**• Skating before impact and valgus-control criteria are met** | Criteria to Progress<br>• No pain or effusion after impact drills<br>• Quadriceps/hamstring/adductor capacity progressing<br>• Landing and deceleration mechanics controlled<br>• Running and agility tolerated<br>• Medical team agrees on first-skate readiness |

## 5. First-Skate Gate

Earn the first skate

| Domain | Minimum Before First Skate |
|---|---|
| Knee response | No reactive effusion, no extension loss, no medial pain increase after off-ice loading. |
| Strength | Quad/hamstring LSI about >=80-85%; hip adductor and abductor strength appropriate for level; no medial pain with lateral drills. |
| Movement | Controlled single-leg squat, landing, deceleration, and planned COD without dynamic valgus. |
| Medical | Surgeon/rehab clearance; valgus stability acceptable on exam and stress imaging when used. |

## PHASE 4A | WEEKS 16-20 | EARLY ON-ICE PHASE

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| **Clinical Intent** | • Reintroduce skating as a controlled exposure, not a conditioning test. The first skate should confirm that the knee tolerates glide, push-off, edge loading, and low-speed crossovers. |
| **Entry Criteria** | • First-skate gate met<br>• Pain-free running/agility progression<br>• No effusion or extension loss<br>• Strength and movement quality adequate for controlled edge work |
| **On-Ice Progression** | • Easy laps and forward straight-line skating<br>• Backward skating<br>• Controlled stopping and wide turns<br>• Basic crossovers at comfortable speed<br>• Short sessions, usually 20-30 minutes initially |
| **Off-Ice Complement** | • Progressive resistance training<br>• Adductor/abductor maintenance<br>• Single-leg stability<br>• Low-to-moderate plyometrics and bike/elliptical conditioning |
| **Dose Rule** | • Add one variable at a time: duration, intensity, edge complexity, puck skill, or fatigue. Do not increase all in the same week. |
| **Avoid / Defer**<br>**• Crowded ice or uncontrolled drills**<br>**• High-speed tight turns or reactive cutting**<br>**• Slide board plus skating volume spike**<br>**• Contact, puck battles, or board pressure** | Criteria to Progress<br>• No pain, swelling, or extension loss during or after skating<br>• Skating mechanics symmetric at low speed<br>• Comfortable crossovers tolerated<br>• Knee returns to baseline next day |

## PHASE 4B | WEEKS 20-24 | INTERMEDIATE ON-ICE PHASE

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| **Clinical Intent** | • Progress speed, power skating, planned direction changes, puck skills, and noncontact team patterns while protecting the knee from large workload spikes as the athlete approaches the 6-month window. |
| **On-Ice Progression** | • Power skating drills<br>• Planned turns, stops, and starts<br>• Acceleration/deceleration<br>• Backward-to-forward transitions<br>• Puck handling, passing, and controlled shooting |
| **Team Integration** | • Individual ice before team ice<br>• Predictable routes before reactive routes<br>• Noncontact team drills before small-area pressure<br>• Replace some individual work as team exposure increases |
| **Avoid / Defer**<br>**• Reactive battle drills**<br>**• Full practice without restrictions**<br>**• Live contact or board battles**<br>**• Fatigue-driven loss of alignment** | Criteria to Progress<br>• Intermediate drills tolerated across multiple sessions<br>• No effusion response<br>• Movement quality repeatable under moderate fatigue<br>• Strength/function trending toward >=90% |

## PHASE 4C | WEEKS 22-26 | LATE ON-ICE PHASE AND CONTACT PREPARATION

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| **Clinical Intent** | • Prepare the athlete for unanticipated direction changes, anaerobic repeatability, opponent pressure, board play, and limited-to-full contact practice exposure before game clearance. |
| **Entry Criteria** | • Quad and hamstring strength >=90% or clearly approaching 90% with excellent absolute capacity<br>• Hop/functional testing >=90% or clearly approaching 90% with excellent movement quality<br>• No pain or effusion with intermediate skating<br>• Medial stability confirmed; stress radiography when indicated |
| **Late On-Ice Work** | • Interval sprints and repeat shift simulation<br>• Unanticipated direction changes<br>• Tighter turns and reactive edge work<br>• Puck handling under time and space pressure |
| **Contact Progression** | • Angling without collision<br>• Controlled board approach and puck retrieval<br>• Stick pressure and puck protection<br>• Limited battle drills progressing to full practice |
| **Avoid / Defer**<br>**• Games before full-contact practice tolerance**<br>**• High-volume contact while fatigued**<br>**• Uncontrolled open-ice hits**<br>**• Ignoring medial knee soreness, swelling, or extension loss** | Criteria to Progress<br>• Full practice progression tolerated<br>• No effusion or instability symptoms<br>• Athlete confident with boards/contact<br>• Testing battery completed before unrestricted contact |

## PHASE 4D | WEEKS 24-28+ | RETURN TO COMPETITION

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|---|---|
| **Clinical Intent** | • Return to games near the 6-month mark only when medial stability, objective testing, skating exposure, contact tolerance, and psychological readiness support unrestricted hockey participation. |
| **Final Clearance** | • Quad and hamstring strength LSI >=90%, often 95%+ for elite/high-risk athletes<br>• Hop/function tests >=90%<br>• >2 dynamic functional tests passed<br>• No pain, effusion, or extension loss<br>• Psychological readiness acceptable<br>• Target 24-28+ weeks for isolated reconstruction when all criteria are met; use 8-9+ months for multiligament, repair, cartilage/meniscus, revision, or reactive knees |
| **Return to Games** | • Multiple full-contact practices tolerated<br>• Use modified minutes, role restrictions, or reduced back-to-back exposure initially<br>• Avoid back-to-back games immediately after clearance when possible<br>• Continue strength, adductor, and workload monitoring in-season |
| **Avoid / Defer**<br>**• Clearing because skating looks good**<br>**• Back-to-back games immediately after initial clearance**<br>**• Returning before full-practice tolerance**<br>**• Stopping strength/adductor work once games resume** | Criteria to Progress<br>• Medical clearance complete<br>• Testing battery passed<br>• Full-contact practice tolerated<br>• Shared decision-making completed |

# 6. Criteria-Based Return-to-Hockey Testing Battery

Objective data plus repeated tolerance

Criteria-based testing should occur before unrestricted full contact clearance, especially when targeting game participation around 24-28 weeks. The goal is convergence across medial stability, clinical exam, strength, function, movement quality, psychological readiness, workload response, and hockey-specific exposure.

| Domain | Recommended Criteria Before Full Contact |
|---|---|
| Clinical exam | Pain-free functional ROM; full extension maintained; no giving-way episodes; effusion remains baseline after hard sessions; valgus stress exam stable. |
| Medial stability | No increased medial gapping clinically; stress radiography used when indicated to confirm side-to-side stability before contact. |
| Strength | Quadriceps and hamstring strength >=90% LSI; consider 95%+ or EPIC/preinjury estimates for elite athletes or bilateral deconditioning concerns. |
| Hip/adductor profile | Adductor and abductor strength appropriate for role; consider ADD:ABD ratio >=0.80 and angle-specific testing at 0, 25, and 50 degrees when available. |
| Functional testing | >2 dynamic tests: single hop, triple hop, crossover hop, timed hop, vertical/horizontal power, deceleration, COD, and fatigue testing as appropriate. |
| Movement quality | No dynamic valgus collapse, trunk/pelvis loss, stiff landing, asymmetrical braking, or reconstructed-side avoidance in planned and reactive tasks. |
| Skating quality | Equal push-off, controlled edges, stops, crossovers, transitions, and reactive skating without guarding or next-day swelling. |
| Contact exposure | Angling, board approach, puck protection, stick pressure, controlled battles, and full-contact practice completed before games. |
| Psychological readiness | Athlete reports confidence with reconstructed-side loading, medial knee stress, crossovers, board contact, and game workload. Consider ACL-RSI or team-specific scales. |

### Pass/fail principle

A single failed domain should delay unrestricted competition. The athlete can often continue skating, strength training, skill work, and controlled practice while the limiting domain is targeted. Do not reduce return to hockey to one hop test, one strength number, or one date.

# 7. Off-Ice Strength and Conditioning Priorities

Prepare the athlete for edge and valgus demands

Hockey skating requires strong medial knee control, hip adductor capacity, trunk control, and the ability to repeatedly decelerate and redirect in valgus-loaded positions. Off-ice work should prepare the athlete for those demands before the ice adds speed and chaos.

| Exercise / Category | Primary Clinical Value | Phase to Introduce | Progression Note |
|---|---|---|---|
| Quad + NMES | Combat inhibition and restore knee control | Recovery | Start POD 1 when cleared; build toward >=60% LSI by phase end. |
| Submax adductor squeeze | Early medial-chain activation | Recovery | Pain-free, low effort; avoid medial knee irritation. |
| Step-up / split squat | Quad, hip, adductor magnus, frontal-plane control | Transition | Progress height, load, and directions. |
| Deadlift / sumo deadlift | Posterior chain plus deep adductor contribution | Transition | Excellent bridge from strength to skating power. |
| Copenhagen short to long lever | High adductor demand and groin resilience | Transition/Rebuild | Build slowly; long lever later and only when tolerated. |
| Lateral slide board | Skating-specific lateral push-off and adductor endurance | Rebuild | Start technical, not conditioning; progress speed later. |
| Landing/deceleration | Reduce dynamic valgus and braking asymmetry | Rebuild | Double-leg to single-leg; planned before reactive. |
| Reactive agility | Prepare for unanticipated hockey decisions | Restore | Use visual/auditory cues after strength and landing criteria. |

## 8. Hockey-Specific Exposure Ladder

Skating readiness is not hockey readiness

| Level | Exposure | Advance When |
|---|---|---|
| 1 | Off-ice strength, landing, deceleration, adductor work, and stick skills | Quiet knee, stable exam, full extension, and good single-leg control. |
| 2 | Easy skating and controlled puck touches | No symptoms during or the day after skating. |
| 3 | Controlled edges, stops, turns, and comfortable-speed crossovers | Movement is smooth and not protective; no next-day swelling. |
| 4 | Speed changes, transitions, passing, shooting, and noncontact skill drills | Planned speed and skill demands can be repeated. |
| 5 | Noncontact practice and small-area movement | Repeatability across multiple practices without swelling or confidence drop. |
| 6 | Controlled opponent pressure, puck protection, and board approach | Confidence with reconstructed-side loading near boards. |
| 7 | Limited contact and full-practice progression | No effusion, instability symptoms, avoidance, or protective behavior. |
| 8 | Competition | Testing passed, medical clearance complete, full-contact practice tolerated, 24-hour knee response clean. |

## 9. Hockey-Specific Clinical Pearls

Practical rules for return to hockey

1. Skating is not playing hockey. Easy open ice does not prove readiness for contact, boards, reaction, fatigue, or collision.
2. The MCL gets stressed by edges and valgus load. Build adductor, abductor, trunk, deceleration, and crossover capacity before high-speed team drills.
3. Replace, do not just add. As team exposure increases, reduce some individual skating or conditioning to avoid workload spikes.
4. Watch the next day. Swelling, stiffness, medial soreness, or extension loss after skating means the dose was too high.
5. Six months is a target, not a promise. The accelerated track is appropriate only when the reconstruction is isolated, the knee stays quiet, stability is confirmed, and objective testing supports the decision.

# 10. Key References

Evidence base


| # | Reference |
|---|---|
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### Use note

This guideline is intended to support clinical reasoning, not replace surgical precautions or individualized medical decision-making. Modify progression for repair instead of reconstruction, POL reconstruction, ACL/PCL/PLC involvement, meniscus repair, cartilage procedure, revision surgery, persistent effusion, extension loss, medial pain, or surgeon-specific restrictions. Return to ice is earned. A 6-month game target is possible for the right isolated reconstruction, but full hockey is still built through criteria, not assumed by the calendar.