

clinical outcome and to further reduce the significant number of ACLR failures.<sup>4</sup>

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### Author's Reply

We would like to acknowledge the important contribution from Sorel and colleagues on this topic and thank them for their interest in our review. As discussed by Sorel et al., the correlation among graft size, graft tension, and patient outcomes has yet to be established in the literature. Indeed, the effect of either graft size or graft tension has received little attention. Our review focused specifically on graft tension and highlighted the lack consensus regarding optimal tension. The little work that has examined the effect of graft size on patient outcomes has conflicting results.

For example, Mariscalco et al.<sup>1</sup> reported that a reduction in graft cross-sectional area resulted in a poorer outcome on the Knee Injury and Osteoarthritis Outcome Score, whereas Kamien et al.<sup>2</sup> reported that graft size did not affect outcomes based on the Tegner score and failure rate after ACLR. However, neither of these studies discussed tension, much like the studies on tensioning fail to discuss graft size.

On the basis of a theoretical model as proposed by Sorel et al., we agree that graft size and tension are likely to be correlated. On the basis of the currently available clinical evidence, it is reasonable to conclude that 78.5 to 90 N may result in less side to side difference in anterior stability. It is vital, however, that further research is conducted in this field to elucidate the relation between graft size and tension and how this affects outcomes after ACLR. We believe our review has taken the first step to establish an argument for optimal tension, although further work on how this tension is achieved and the relation to graft size is required.

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