Tibial tuberosity conformation as a risk factor for cranial cruciate ligament rupture in the dog

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**Summary**

The influence of the tibial tuberosity conformation on cranial cruciate ligament (CrCl) rupture was evaluated and the size of the tibial tuberosity of healthy dogs (group H) was compared with dogs with CrCl rupture (group R) and dogs treated by tibial tuberosity advancement (TTA) (group T). The medio-lateral radiographs of 219 stifle joints were evaluated. Relative tibial tuberosity width (rTTW), proximal tibial tuberosity angle (PTTA), tibial plateau angle (TPA), tibial width (TW) and tibial plateau length (TPL) were measured on each radiograph. Body weight (BW) was measured and relative body weight (rBW) was calculated. The data from group H was compared with that of group R and group T. Group H had significantly larger rTTW, lower BW, lower rBW and smaller PTTA than group R. A comparison of groups H and T showed that dogs from group H were significantly younger, had a lower BW, a lower rBW, a greater PTTA and a smaller rTTW. In each of the comparisons, the TPA and the TW/TPL were not significantly different. The conformation of the canine tibial tuberosity has a significant influence on CrCl rupture. We hypothesized that the smaller the tibial tuberosity width, the larger the cranial tibial thrust, which results in more rapid CrCl degeneration, thus leading to rupture in a younger population of dogs. The rTTW could be a helpful measurement for breeding selection. Only dogs with a rTTW of more than 0.90 should be used for breeding.

**Keywords**

Tibial tuberosity, cranial cruciate ligament rupture, breeding selection, tibial tuberosity advancement, dog

**Introduction**

Rupture of the cranial cruciate ligament (CrCl) is one of the most common causes of hind limb lameness in dogs (1). In contrast to humans, the pathophysiology is not explained by trauma, but rather by degeneration (2–4). A review of the literature reveals many theories about the aetiology, among which are immune-mediated arthropathies (5–7), bodyweight (8, 9), breed predisposition (9), abnormal bone conformation (10–14), genetic factors (3, 8, 9) and the tibial plateau slope (15–17).

In 1978, Henderson postulated that two main forces exist between the femur and tibia: one pathophysiology is not explained by trauma, but rather by degeneration (2–4). A review of the literature reveals many theories about the aetiology, among which are immune-mediated arthropathies (5–7), bodyweight (8, 9), breed predisposition (9), abnormal bone conformation (10–14), genetic factors (3, 8, 9) and the tibial plateau slope (15–17). The latter force is generated by the gastrocnemius muscles and is counteracted by the CrCl (15). Slocum (17), re-investigated the forces acting around the stifle joint. He concluded that an increased tibial plateau slope increased the load on the CrCl and promoted degeneration and subsequent partial and complete rupture (17). Many authors confirmed his ideas (18–22), however, contradictory investigations (23, 24) demonstrate that the aetiology and pathogenesis is still not clearly understood. Slocum’s idea concerning the pathogenesis of CrCl rupture led to him to develop the tibia plateau levelling osteotomy surgery (25). In this surgery, the CrCl biomechanics are altered in order to reduce the shear forces to nearly zero, thus making the CrCl redundant.

Another group (26) calculated the stifle forces differently than Slocum did, and proposed an advancement of the tibial tuberosity (TTA). The quadriceps muscle was identified as the main force in the stifle joint. Its insertion on the tibial tuberosity is set to 90° by the TTA, thereby neutralizing the cranial tibial thrust. This fact has recently been demonstrated (27, 28).

The fact that the tibial tuberosity geometry influences the stifle biomechanics, as well as the clinical observation that the tibial tuberosities have individual shapes, led us to the hypothesis that dogs with large tibial tuberosities would have a decreased risk of sustaining a CrCl rupture.

The aim of this study was to detect risk factors for cranial cruciate ruptures in the anatomy of the tibial tuberosity. These risk factors could then be used for breeding guidelines. Furthermore, the study should have the potential to be useful in clinical routine situations. Therefore, the investigation was made on routine radiographs of the stifle joint.

**Material and methods**

**Radiographs**

The medio-lateral radiographs of 219 stifle joints were evaluated. The radiographs were taken between April 2004 and April 2006. All of the radiographs on which the caudal margin of the medial and lateral tibial condyles were separated less than 4 mm were included in the study.

**Radiographic analysis (Fig. 1)**

The following points were identified on the medio-lateral radiographs:

- A: most proximal point of the margo cranialis tibiae

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Clinical data collection

The radiographs were assigned to three main groups: healthy dogs (H), dogs with confirmed partial or complete CrCL rupture (R), and dogs with a TTA treatment (T). The diagnosis of the partial or complete CrCL in the R and T groups was made by clinical testing, or by surgical exploration. Subdivision was made into dogs younger than five years (Y), and dogs five years of age and older (O), resulting in six subgroups. Age and body weight (BW) were noted.

Results

The data collection is given in Table 1 and the Bonferroni/Dunn analysis in Table 2. The most important differences were as follows: the dogs with stifles from Group H (Fig. 2) had a greater rTTW, a lower BW, a lower rBW, a smaller PTTA, a smaller TW/EC and were younger than those patients from Group R (Fig. 3). A comparison of Groups H and T (Fig. 4) revealed that dogs from Group H had a smaller rTTW, a lower BW, a lower rBW, a greater PTTA, a greater TW/AE and were younger.

In each of the comparisons, there was a lack of significant difference in TPA and TW/EC.

Discussion

The identification of the described anatomical landmarks was easy. The only problem was that the medial and lateral condyles were not superimposed in the radiographic views. We chose the mid-point, between the

Table 1: Group assignment and data collection of radiographs of 219 stifle joints.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of cases</th>
<th>BW (kg)</th>
<th>Age (years)</th>
<th>PTTA (°)</th>
<th>TPA (°)</th>
<th>rTTW</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>73</td>
<td>24.5 (4–60)</td>
<td>4.1 (0.7–11.8)</td>
<td>27.6±4.2</td>
<td>33.6±3.7</td>
<td>0.91±0.18</td>
</tr>
<tr>
<td>HY</td>
<td>40</td>
<td>25.6 (4–62)</td>
<td>1.8 (0.7–3.8)</td>
<td>27.1±3.5</td>
<td>33.1±4.0</td>
<td>0.92±0.16</td>
</tr>
<tr>
<td>HD</td>
<td>33</td>
<td>23.2 (4–65)</td>
<td>7.0 (5–11.8)</td>
<td>28.2±4.9</td>
<td>34.2±3.2</td>
<td>0.90±0.21</td>
</tr>
<tr>
<td>R</td>
<td>74</td>
<td>31.9 (4–65)</td>
<td>6.4 (0.7–13)</td>
<td>29.8±3.6</td>
<td>33.7±4.1</td>
<td>0.78±0.14</td>
</tr>
<tr>
<td>RY</td>
<td>21</td>
<td>36.1 (7–65)</td>
<td>3.3 (0.7–4.9)</td>
<td>30.4±4.2</td>
<td>35.1±5.3</td>
<td>0.77±0.16</td>
</tr>
<tr>
<td>RO</td>
<td>53</td>
<td>30.1 (3–53)</td>
<td>7.6 (5–13)</td>
<td>29.5±3.3</td>
<td>33.1±3.4</td>
<td>0.79±0.13</td>
</tr>
<tr>
<td>T</td>
<td>72</td>
<td>34.5 (7.5–65)</td>
<td>6.4 (1.4–13)</td>
<td>24.5±3.1</td>
<td>33.9±4.5</td>
<td>1.07±0.15</td>
</tr>
<tr>
<td>TY</td>
<td>19</td>
<td>38.6 (25–65)</td>
<td>3.5 (1.4–4.9)</td>
<td>24.9±3.5</td>
<td>33.8±4.5</td>
<td>1.06±0.14</td>
</tr>
<tr>
<td>TO</td>
<td>53</td>
<td>33 (7.5–60)</td>
<td>7.4 (5–13)</td>
<td>24.3±2.9</td>
<td>34.0±4.5</td>
<td>1.08±0.16</td>
</tr>
</tbody>
</table>
medial and lateral tibial condyles, in order to determine the caudal point of the tibial plateau.

The method used to measure the TPA in this study differed from other methods employed in the literature (19, 20, 30) as it does not require the determination of the functional axis of the tibia. It was our aim to establish a method to measure TPA that did not require radiograph views of the whole tibia. In conclusion, the TPA was set relative to a horizontal line from the most proximal end of the margo cranialis to the caudal end of the tibial plateau. This angle depends considerably upon the form of the tibial tuberosity and may therefore carry the risk of being influenced by a dependent value. Our conclusion is that the TPA might not be directly comparable to the tibial plateau slope angle as it is traditionally defined (19, 20, 30). We did not find any significant difference in TPAs between the groups. Further studies are warranted in order to validate this method of TPA measurement.

The width of the tibial tuberosity AE was set relative to the distance EC. There were not any significant differences when comparing the quotient of EC:TW. As this quotient can be regarded as constant, the tibial diaphysis and the caudal tibial plateau length are likely to be proportional to one another. The comparison of the

### Table 2  
P-values of the Bonferroni/Dunn variance analysis comparing the groups and subgroups.

<table>
<thead>
<tr>
<th>Category</th>
<th>BW</th>
<th>Age</th>
<th>PTTA</th>
<th>TPA</th>
<th>rTTW</th>
<th>rBW</th>
<th>TW/EC</th>
<th>TW/AE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HY:RY</td>
<td>-0.0012</td>
<td>-0.0013</td>
<td>-0.0009</td>
<td>-0.0605</td>
<td>+0.0004</td>
<td>+0.0253</td>
<td>-0.1305</td>
<td>-&lt;0.0001</td>
</tr>
<tr>
<td>HO:RO</td>
<td>-0.0090</td>
<td>-0.0948</td>
<td>-0.1100</td>
<td>+0.2188</td>
<td>+0.0018</td>
<td>+0.0017</td>
<td>+0.0497</td>
<td>-0.3119</td>
</tr>
<tr>
<td>H:T</td>
<td>+&lt;0.0001</td>
<td>+&lt;0.0001</td>
<td>+&lt;0.0001</td>
<td>-0.5871</td>
<td>-&lt;0.0001</td>
<td>+&lt;0.0001</td>
<td>-0.2535</td>
<td>+0.0001</td>
</tr>
<tr>
<td>HY:TY</td>
<td>-0.0001</td>
<td>-0.0003</td>
<td>+0.0278</td>
<td>-0.4990</td>
<td>-0.0014</td>
<td>+0.0035</td>
<td>+0.0583</td>
<td>+0.3688</td>
</tr>
<tr>
<td>HO:TO</td>
<td>-0.0003</td>
<td>-0.2446</td>
<td>+&lt;0.0001</td>
<td>-0.8191</td>
<td>-&lt;0.0001</td>
<td>+0.0001</td>
<td>+0.4478</td>
<td>+&lt;0.0001</td>
</tr>
</tbody>
</table>

Significant p-values (< 0.0033; Bonferroni correction) are displayed in bold. Positive or negative prefixes indicate whether the first group had higher or lower values.

Fig. 2  
Medio-lateral radiographic view of stifle of a German Shepherd Dog from Group H. (For legend see Fig. 1). This dog underwent surgery because of a patellar luxation. rTTW = 0.99, PTTA = 25°, TPA = 29°, rBW = 0.55.

Fig. 3  
Medio-lateral radiographic view of stifle of a Great Dane from Group R. (For legend see Fig. 1). This dog had a complete CrCl rupture. rTTW = 0.61, PTTA = 26°, TPA = 25°, rBW = 0.43.

Fig. 4  
Medio-lateral radiographic view of stifle of a Great Dane from Group T. (For legend see Fig. 1). This dog had TTA operation because of a complete CrCl rupture. rTTW = 1.04, PTTA = 20°, TPA = 25°, rBW = 0.43.

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distances AE with EC or TW revealed significant differences. This means that the tibial tuberosity width varies between individuals.

The most striking result was that rTTW significantly differed between healthy dogs and dogs with a CrCL rupture. The difference was even greater in the group of dogs that were younger than five years of age. This leads to the conclusion that the tibial tuberosity width is a real risk factor. We propose that the smaller the tibial tuberosity width, the larger the cranial tibial thrust will be, and the earlier the dog will get a CrCL rupture. The fact that we did not find any difference in tibial plateau angles between groups supports the notion of advancing the tibial tuberosity to treat the CrCL deficient stifle. The advancement of the tibial tuberosity following TTA, as shown in our data, results in a tibial tuberosity width that is much greater than that which was measured in healthy dogs. This apparent overcorrection of the tibial tuberosity width makes sense, since when the CrCL is no longer present, the tibial tuberosity must be sufficiently advanced enough in order to counteract cranial tibial thrust.

The special anatomical situation and the differences in healthy and CrCL deficient dogs must not be seen alone in its osseous part. The most important function of the tibial tuberosity is to take the force of the quadriceps muscle. Montavon et al. (26) proposed that the direction of this force be changed to about 90° by doing a TTA. These measurements are normally done on radiographs of stifles in maximal extension. It could be argued that the TPLO procedure (29) would do exactly the same if the tibial plateau were to be reduced to an angle perpendicular to the patellar ligament. However, this explanation was never given by these authors, nor by others who were trying to prove the concept of TPLO (18, 20, 21), although it is possibly more correct than leveling the tibial plateau to an angle of 90° to the long axis of the tibia. Further support for this concept comes from a recently published study which showed that a centered osteotomy position is biomechanically more effective than a distal position (30). When measurement of the rTTW has been completed, the centered osteotomy increases the rTTW, whereas a distal osteotomy decreases the rTTW. We conclude that in a centered TPLO it is not only the tibial plateau angle that leads to biomechanical changes in the stifle joint, rather it is the increasing the rTTW which is also important for the success of this operation.

Body weight was another factor which turned out to be a risk factor. However, we did not determine the risk by absolute body weight. We measured BW relative to TW, by which we got a parameter for either overweight in terms of over nutrition, or overweight in terms of an underdeveloped skeleton. Clinical observations support the results of this investigation, because typically dogs that sustain a CrCL rupture are either large or overweight.

This investigation can also be used to develop an alternative method in order to determine the cage size for the TTA method. The original method uses measurements on medio-lateral radiographs of extended stifle joints. The tibial tuberosity advancement is estimated where the patellar ligament would cross the tibial plateau at 90 degrees. However, this method is dependent upon the relative angulation of femur and tibia and is subject to errors when the extended position is not achieved, or when the stifle is subluxated. Our new method relies on the tibia alone and is not influenced by the anatomy of the distal femur, which also affects the direction of the patellar ligament. The results of the present study indicate that the desired advancement is achieved when the rTTW is 1.07.

Mankind has changed the canine remarkably over the past decades. It could be argued that the selective breeding has resulted in oversized dogs with small rTTWs. Indeed, several large breeds have become larger in a very short period of time. It is possible that parts of the skeleton could not develop as fast as it was needed. One of these anatomical structures might be the tibial tuberosity, which remained smaller than the rest of the structures around the stifle joint, thereby reducing the angle of insertion of the patellar ligament and consequently leading to higher loading of the CrCL. The latter would then partially, or eventually even completely, rupture. This hypothesis helps to explain why a lot of giant breed dogs, whose nature would not have made that large (e.g. Italian Mastiffs, Newfoundlands, Rottweilers) are admitted at a very early age with CrCL ruptures. For breeding purposes, a possible recommendation would be that only dogs with a rTTW of more than 0.90 have a decreased risk of sustaining a CrCL rupture.

This investigation revealed that the TTA method is a suitable treatment for CrCL rupture, because it tends to establish a situation closer to that seen in non-affected dogs. Furthermore, the breeding from dogs that have a rTTW of more than 0.9 may lessen the risk of sustaining a CrCL rupture.

References


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