SURGICAL INDICATIONS

MENISCAL TEARS

The meniscus is wedged shaped structure that act as shock absorber between the femur (thigh bone) and tibia (shin bone). Each knee has two menisci: a lateral and a medial one. Menisci can sometimes tear with twisting or hyperflexion of the knee and become painful, or cause locking and catching. Many meniscal tears get better on their own without an operation. The tear may heal with time or get eroded into a smooth surface and stop hurting. Non operative meniscal tear treatment includes R.I.C.E. (rest, ice, elevation, and compression), anti-inflammatory medication such as Advil (ibuprofen), and physiotherapy plus or minus cortisone injections. Many meniscal tears get better in 3 months or less.

Operative intervention is warranted when significant symptoms have persisted beyond 3 months. Significant symptoms include pain at rest, pain that prevents sleep or work, and pain that interferes with many daily or most physical activities. Significant pain is typically more than 2-3/10 in intensity.

Pain that is only 1-2/10 in intensity or occurs infrequently (ex. occurs only once or twice a month when no activities are avoided) is best left alone as those kinds of symptoms often persist in the operated knee.

In the majority of cases, menisci tear in a region without blood supply so the operation consists in removing the torn piece in a controlled fashion to prevent it from catching and causing pain. Occasionally the meniscus tears in a region that has blood supply and can be repaired if the pieces are in good condition. This tends to occur more often in younger individuals (<40 y.o) as they have better meniscal blood supply. Even in this patient population, however, only a minority of tears are amenable to repair.

A meniscus tear may occasionally block knee motion. This tear should be seen by a physician sooner and treated sooner than a painful tear with normal knee motion. **The blocked knee should be seen within 2-3 weeks and treated within 2-3 months to help prevent knee motion loss.**

KNEE ARTHRITIS

Arthritis signifies thinning of the cartilage in the knee joint. Cartilage acts as a cushion between the bones of the femur and tibia. When the cartilage is thin, the femur and tibia bones feel more of the body's weight and this bone pressure causes pain. This is analogous to sitting in the same position on a chair for prolonged periods. Sitting on a chair with no cushion becomes uncomfortable sooner than sitting on a chair with good padding. In people with excess weight, the first solution to arthritic knee pain is weight loss. In those that have ideal body weight, or cannot lose the weight, artificial joint fluid injections (ex Synvisc or Durolane) or cortisone injections may provide pain relief. Those with misaligned legs due to arthritis may get relief with commercially available braces or even surgeries that realign the leg. Finally those with severe end stage arthritis may only get relief from a total joint replacement. Dr Grondin does not perform this operation. You will be referred to one of his colleagues if you require a total knee.

Medial Collageral ligament (MCL)

MCL injuries respond very well to non operative treatment. Rest, Ice, Compression and Elevation with or without bracing will allow return to normal function in most patients in 4-6 months. Bracing is used when the lower limb has a valgus alignment to help prevent repetitive MCL micro trauma during the healing period.

Anterior Cruciate Ligament (ACL)

ACL injuries are common sport injuries. Surgery is indicated if the knee is unstable with activities the patient wishes to or must engage in. Typically the ACL deficient knee is stable enough to do sports that involve moving along a straight path like running, cycling and swimming without a problem. The ACL deficient knee may however lead to problematic instability when participating in pivoting sports or activities involving uneven terrain. Instability is often a problem with younger patients (<50 y.o.) because they tend to participate in higher intensity sports and tend to have increased knee laxity. Treatment of an ACL injury starts with pain and swelling control with rest, ice, compression, elevation and anti-inflammatory medication. A knee that is operated on while still painful and stiff evolves very poorly. The knee may be immobilized for comfort for 0 t o 5 days. Longer immobilized is not needed in an isolated ACL injury. Crutches may be used for 0-5 days. Range of motion exercises are then practiced followed by controlled strengthening and proprioception exercises. If the knee feels loose or buckles, upon testing the knee in controlled lower intensity sports or in daily living activities, we recommend obtaining an MRI of your knee and obtaining an appointment with an orthopedic surgeon for evaluation and potential surgical fixation. Typically, **Dr Grondin uses the hamstrings to reconstruct the ACL. We strongly recommend surgical fixation if the knee experiences repeated episodes of buckling followed by pain and swelling that can last days to avoid the kind of instability that can cause meniscal and cartilage damage.**