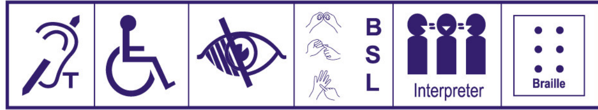

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Knee Arthroscopy

Orthopaedics Department

Patient Information

Knee Arthroscopy

WHAT IS IN YOUR KNEE?

Your knee consists of the following structures:

Cartilage

We refer to 2 common types of cartilage in the knee:

- The first type is the **MENISCUS** - two cartilage cushions (‘menisci’), one on the inner side (medial meniscus) and one on the outer side of the knee (lateral meniscus) between the thigh bone (femur) and the shin bone (tibia). The menisci help the knee to function properly by bearing load and weight, absorbing shock, stabilizing the joint and providing lubrication.

- The second type is **ARTICULAR CARTILAGE** which covers the surface bone ends of the femur, tibia and patella (knee cap) to reduce friction and aid load distribution in the knee joint.

Ligaments

These hold the bones together, therefore stabilising the knee joint.

- The **Anterior Cruciate Ligament (ACL)** is one of the most commonly injured.

FURTHER INFORMATION

If you have any queries regarding the contents of this leaflet please contact Physiotherapy Department (St. Peter’s Hospital) telephone **01932 722547** or **01784 884484** (Ashford Hospital)

Further Information

We endeavour to provide an excellent service at all times, but should you have any concerns please, in the first instance, raise these with the Matron, Senior Nurse or Manager on duty. If they cannot resolve your concern, please contact our Patient Advice and Liaison Service (PALS) on 01932 723553 or email pals@asph.nhs.uk. If you still remain concerned please contact our Complaints Manager on 01932 722612 or email complaints@asph.nhs.uk.

Author: Mr Trikha and J Parker **Department:** Orthopaedics and Trauma
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Exercises

Start as soon as possible. Increase repetitions as able. Repeat several times a day.

1) Lying or sitting with a sliding board under your leg. Bend and straighten your knee by sliding your foot up and down.

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2) Lying or sitting with legs straight. Bend your ankles and push your knee down firmly against the bed. Hold 5 seconds – relax.

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3) Lying or sitting brace your knee straight and lift your leg straight up about 20cm off the bed.

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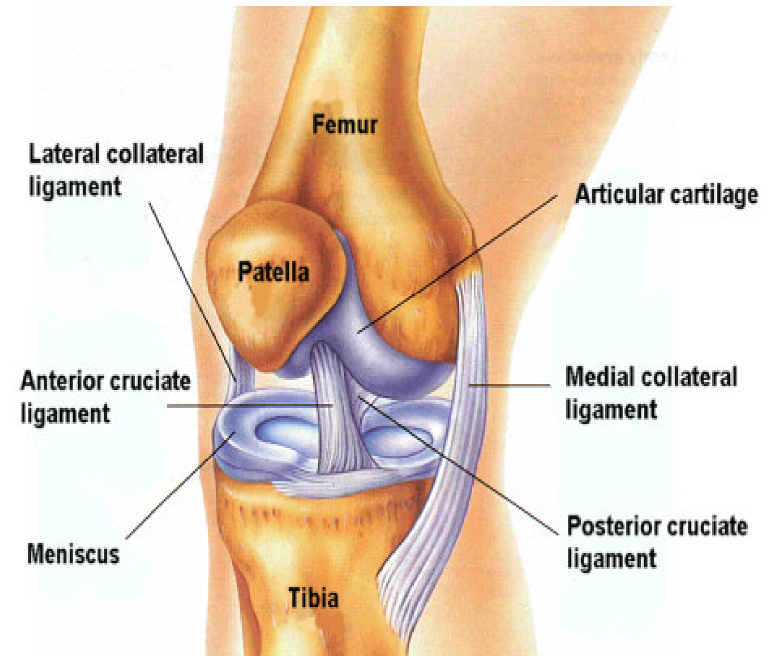
The ACL connects the femur to the tibia. It functions as a stabiliser of the knee joint and it resists forward movement of the tibia on the femur and also acts to prevent the tibia from excessive rotation when pivoting.

- The other major ligaments of the knee are the **Posterior Cruciate Ligament (PCL),** the **Medial Collateral Ligament (MCL)** and the **Lateral Collateral Ligament (LCL).**



COMMON FINDINGS DURING ARTHROSCOPY

The aim of arthroscopic surgery is to correct mechanical problems within your knee joint. The surgeon is able to confirm the nature of the injury and remove or repair the damaged part whilst causing minimal disruption to the knee joint.

Once the structures in your joint have become damaged failure to correct the damage may result in further deterioration of your knee.

In some cases surgery will not be able to reverse the damage which has already occurred. In the majority of cases your recovery will be dictated by the degree of damage and how well you can rehabilitate your knee.

1. TORN MENISCUS / CARTILAGE

A meniscal tear is commonly the result of a twist – a typical injury for someone like a netballer or footballer or from repeated squatting. These tears may cause pain, swelling and a catching or locking sensation.

If not corrected, a meniscal tear, like dirt in the ball bearings of a machine, can irritate the smooth joint surface and damage the articular cartilage. This can lead to more serious problems such as arthritis.

Early treatment can mean less damage to your joint. During meniscal surgery the surgeon can **REPAIR** or remove the torn

Dressings

The small dressings can be removed after 14 days at home or at your first out-patient appointment by your surgeon. Keep your wounds dry for seven days. No stitches need to be removed as your surgeon uses clear absorbable sutures and steristrips (paper stitches).

Painkillers

You will be prescribed simple painkillers which you should take as required.

Rehabilitation

After surgery, you should care for your knee by resting, elevation, icing and simple exercises.

Ice and Elevation

To reduce swelling, elevate and apply ice to your knee for at least two days post operatively, two to ten times a day. Apply ice on your knee for 20 minutes (make sure you wrap the bag of ice in a damp towel to protect your skin). Continue daily until the swelling subsides. When resting have your leg straight and not in a bent position. If you want to rest the leg on a pillow, make sure it is placed under the heel and calf, this ensures the leg is straight.

surgeon is able to confirm the nature of the injury and remove or repair the damaged part.

Complications

These are rare but include infection and deep vein thrombosis (DVT - a blood clot in the leg). Other complications include numbness around the scars, bleeding, residual pain and stiffness. Arthroscopic surgery is generally used to correct mechanical problems within the knee. If osteoarthritis is causing your problem, an arthroscopy may not be of benefit as surgery will not be able to reverse the damage which has already occurred.

AFTER ARTHROSCOPY

In most cases your recovery will be dictated by the degree of damage and how well you can rehabilitate your knee. Every injury is different and your recovery may be different from other people.

TED Stockings

Leave the above knee TED stocking on over the bulky bandage for 48 hours. The bulky bandage can then be removed at home leaving the small dressings underneath. Reapply the above knee TED stocking over these small dressings. The TED stocking will stay on for 3 weeks in total and help minimise swelling and prevent DVT.

unstable piece of cartilage (meniscus) **(PARTIAL MENISCECTOMY)** leaving as much of a stable rim of meniscus behind as possible.

2. ARTICULAR CARTILAGE DAMAGE

- **Chondroplasty:**

A procedure which smoothes over loose damaged articular cartilage flaps from the surface of the bone. If the damaged articular cartilage is severe (all the way down to bone) any bare bone can be drilled or pinned to allow bleeding and thus allow new cartilage type material to fill in any defects left.

This technique is called **MICROFRACTURE.** Follow up clinical examination and MRI scans are required to assess any new cartilage.

- **Removal Of Loose Bodies**:

Torn flaps of articular cartilage can become detached and calcify with time leading to loose bodies within the knee. They can also be formed by some conditions causing inflammation of the lining of the knee (the Synovium). Loose bodies can cause jamming or locking of the knee. Sometimes extra portals or key-holes are required to help remove these.

3. RUPTURED (TORN) ANTERIOR CRUICATE LIGAMENT (ACL)

ACL tears are common injuries in footballers and other athletes where turning and pivoting are important parts of the game.

The diagnosis of an ACL tear can be based on history and knee joint examination. Patients may hear a pop as the ACL ruptures. The knee is very painful and swollen early on. The pain subsides over several days in isolated ACL injuries.

When the ACL is torn, the knee has a tendency to slip, buckle or give way leading to **knee instability**. **Patients may lose confidence in their knee.** Some will have instability during simple daily activities like climbing steps and turning suddenly.

ACL injured knees have an increased incidence of both articular cartilage injury and meniscal tears over time. Injury to either type of cartilage may be the reason for ongoing pain and in theory may be associated with the development of osteoarthritis. Surgery may cure the pain and prevent further long term damage to the knee.

The treatment of an ACL injury is individualised based on many factors including severity of instability, activity level, and associated injuries.

Treatment approach ranges from simple strengthening exercises, arthros-copic surgery to address any cartilage damage or reconstruction of the ACL to provide stability.

4. ARTHRITIS

Osteoarthritis or degenerative joint disease is the most common type of arthritis often due to 'wear and tear.' The knee joint becomes inflamed causing pain, swelling, stiffness, instability and often deformity.

The smooth articular cartilage surface which covers the bone wears out or is damaged and becomes irregular, fissured and may fall off revealing the underlying bone.

If this happens the underlying bones can rub together, producing the pain typical of arthritis. Severe arthritis can interfere with activities of daily living and limits lifestyle. If osteoarthritis is causing your problem, an arthroscopy may not benefit you as surgery will not be able to reverse the damage which has already occurred.

THE ARTHROSCOPY PROCEDURE: KEY-HOLE SURGERY

What is involved in having arthroscopic surgery?

In most cases arthroscopic surgery is performed as a day case under general anaesthetic. Arthroscopy is used to look inside the knee joint with a small camera. The knee joint is filled with fluid to allow the camera to be moved through the joint causing minimal disruption to the knee joint. The camera is inserted through a small 'key-hole' incision, less than 1 cm long, near the knee cap. One or two further small 'key-hole' incisions are made to insert the small instruments to carry out any surgical procedure. The