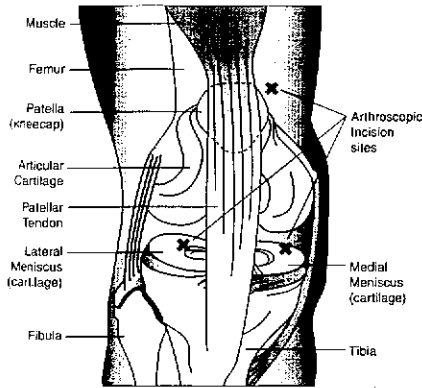
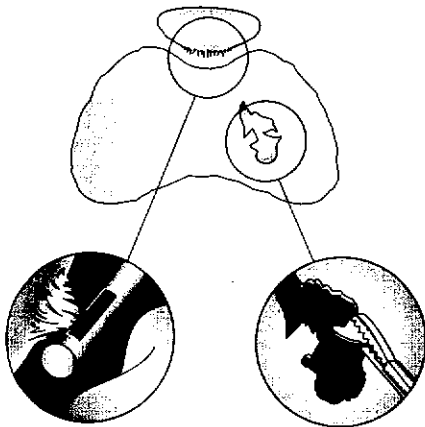


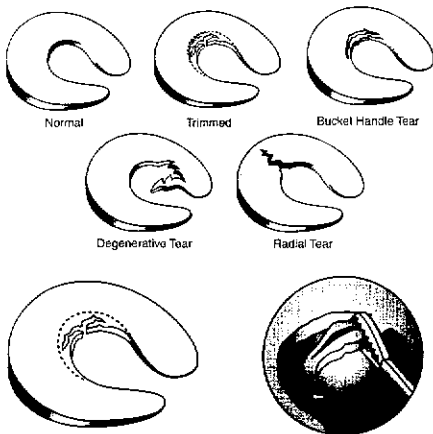
KNEE ARTHROSCOPY



Arthroscopic incision points



Debridement



Trimming the torn meniscus

After a general anesthesia is given, the knee is prepped. Three 1/3-inch incisions are made—one on either side of the kneecap and one just above it on the inside (medial) of the thigh. A scope attached to a closed circuit TV and instruments can be inserted into these portals to view and treat various problems.

If the smooth cartilage covering the bone of the joint is worn, frayed or chipped, it can be trimmed using power or hand held instruments. Between the bones, two "C" shaped "shock absorbers", called *menisci* can be inspected and, if torn or weakened, trimmed and re-shaped to eliminate any sharp edges.

The inside (medial) area is viewed first by pulling the lower leg out sideways while a post braces the upper leg. After inspection and repairs in the medial compartment, the leg is allowed to "dangle" over the side of the table, and the middle part of the knee including one of the main ligaments (*Anterior Cruciate, ACL*) is inspected.

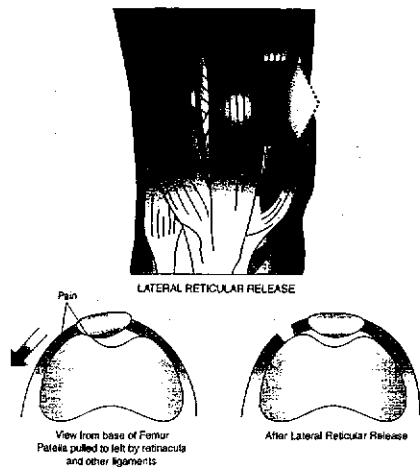
The foot is then brought across to the opposite knee, which "opens up" the outside (*lateral*) compartment of the knee. This allows an inspection of the structures on the lateral side of the knee.

The knee is then returned to a "straight out" position and the spaces on either side of the knee above the kneecap are inspected for loose pieces of tissue that can roll into the joint and cause damage.

The kneecap is then inspected while the knee is bent and straightened in a variety of positions. Ideally, the kneecap centers in the groove on the femur when the knee is bent 30 degrees. If it appears that the kneecap stays on the outside of the knee instead of dropping into the groove, an electric probe may be used to cut the ligament that tethers the kneecap to the side. This allows the kneecap to slide towards the inside of the knee and center better in the joint. This is called a "*lateral retinacular release*" (*LRR*). There are two arteries near the top and bottom of the kneecap, and if they are bleeding, it might be necessary to make an

continued on back

Knee Arthroscopy, *continued from front*



Lateral Reticular Release

incision on the front of the kneecap to repair them. These arteries are very small, and there is no risk of blood loss that would require a blood transfusion. However, the knee joint is a small, contained area, and blood in the joint that could cause pain and stiffness might need to be removed.

Trimming the articular cartilage and menisci and “releasing” the kneecap requires about one hour. Immediately following arthroscopy, the patient recovers from anesthesia and rests in the recovery room for about an hour to make sure it is safe to go home.

Unless told not to, the patient is allowed to place full weight on the knee immediately after surgery. He or she should remain a “couch potato” for the first 48 hours and limit walking. After that time, he can walk as much as is comfortable, working up to normal daily activities. Physical therapy is required for about 1/3 of the patients.

How soon the patient is able to return to work depends on the patient and their occupation. The following are some general guidelines following a simple trimming of the cartilage:

Desk job – four to seven days

Standing/sitting for an eight hour day – four weeks

Walking/standing for an eight-hour day (like a postman or meter reader) – six weeks.

Scaling ladders, walking on heights and working in awkward positions (like a plumber or framer) – ten to twelve weeks or more for full workdays on a regular basis

F. Ray Nickel, MD is an orthopedic surgeon/sports medicine specialist who focuses on knee and shoulder problems. He joined Ventura Orthopedic and Sports Medicine following his fellowship training in 1985 and has practiced in Ventura County ever since.

If a lateral retinacular release was also done, it could require an additional month of recovery to the times listed above.

Although complete healing may take several months, it is usually possible to determine how helpful the surgery was within four months, and often earlier.

Hopefully, this information has been interesting and helpful to you. As with any general information, some of it may not apply to your case and it is not intended to take the place of an orthopedic evaluation and personalized treatment plan. If you still have questions, please do not hesitate to discuss them with Dr. Nickel.

