Arthroscopic debridement of the osteoarthritic knee

Dr. A.M. Dissi.
Orthopaedic Surgeon, Consultant Knee Surgeon, Arthroscopy & Sport Injury.

Is there any good chance?

In recent years there has been renewed interest in depriving and irrigating the osteoarthritic knee arthroscopically. This is quiet similar to an open procedure advocated by Magnusson at least 60 years ago. Results then and now: are defined as the degree to which patient's symptoms are relieved regardless of the state or possible progression of the osteoarthritic process.

There was an understandable reluctance on the part of many patients to undergo the earlier version of this version of this surgery due to the often prolonged period of recovery. No such reluctance is evident by patients who are offered an Arthroscopic outpatient debridement.

Recently and after doing about 300 patients, I did debridement. 3Questions came to my mind in considering the statistics:

1. Can we justify the cost and effectiveness of such a procedure?
2. Is there a proper selection of patients?
3. Do we really explain enough to the patients about the expectations of the surgery?

At present there is little doubt that Arthroscopy is among the most commonly performed orthopedic surgical procedure, perhaps the most commonly performed. When one considers all the joints that are now being investigated arthroscopically.

Though the cost of surgery in Jordan is relatively much less then the nearby Gulf States or Europe.

There is no evidence thus for that irrigation, debridement and/or abrasion, Arthroplasty produce relieve for more than a few months or at most several years, which brings us to the second question regarding the proper selection of patients.

Its very important to explain to the patient that TKP will be the final solution ifArthroscopis shaving fails.

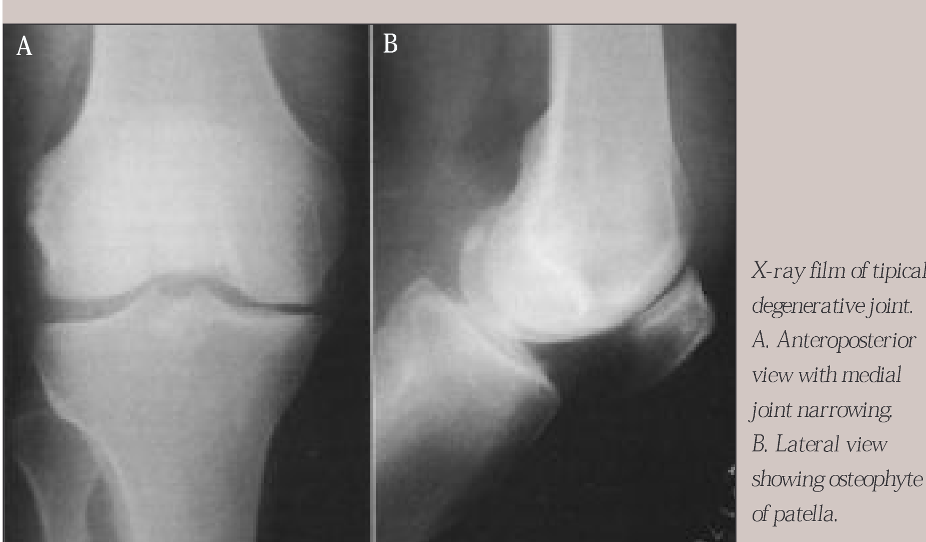
The procedures have been used on patients between 30 and 65 years with knee pathology vary from mild to severe osteoarthritis. In most articles the pathology is categorized according to the outerbridge scale, which is less than satisfactory. According to this, the grades 1 to 4, depends on the diameter with the bone exposed or the articular cartilage lesion. A lesion, 3 or 4 cm in diameter, in which bone is exposed, would also fall into grade 4.

Although the prognosis of these 2 lesions are hardly the same, although other systems of classifications have been advised, the outerbridge is the most popular, although scarcely the most precise.

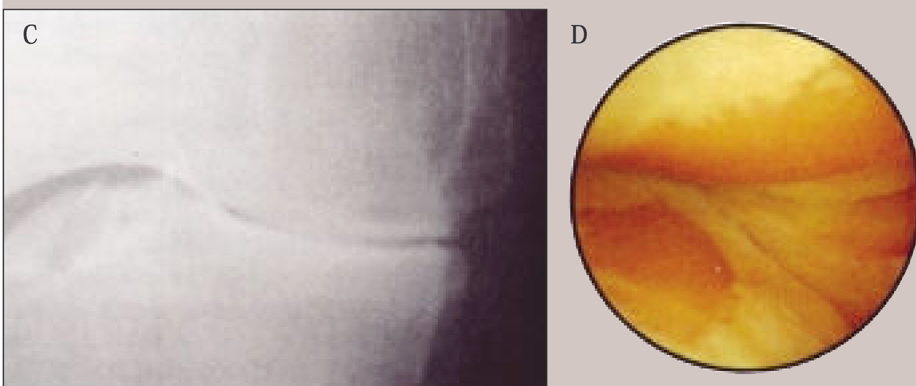
Information on the axial weight bearing

alignment of these extremities is rarely, if ever given, despite the fact that it is more relevant to the prognosis of the patient's disease than any other bit of information.

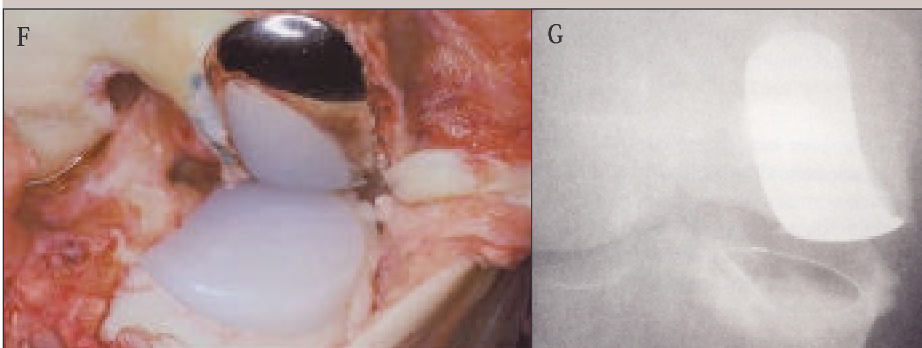
Unless surgeons measure and record information on the alignment of extremities, the results of Arthroscopic debridement are in scientific and in some cases hardly worth reporting.



X-ray film of tipical degenerative joint.
A. Anteroposterior view with medial joint narrowing.
B. Lateral view showing osteophyte of patella.



Patients have both alignment and surface problems
C. X-ray film showing alignment problem.
D. Arthroscopic close-up shows loss of normal articular surface



Prosthetic replacement
F. Prosthetic replacement of medial compartment.
G. Postoperative x-ray film.

The fact that many patients experience symptomatic relieve following Arthroscopic irrigation and debridement is something that has been known since the days of Burman in the early 30's and it has been the observation of the Arthroscopies since that time.

In choosing patients, for this procedure, the age of the patient is often ignored although age ranges are recorded; the results are often not tabulated in terms of the patient's age. A 45-year old patient with a moderate varus deformity of the knee is probably not a good candidate for Arthroscopic debridement regardless of the fact that he or she may receive several years of symptomatic relieve.

During this time the patient's disease will slowly progress, despite the lack of symptoms and most, if not all, Orthopaedic surgeons agree that the best results of Osteotomy are obtained when the disease is relatively mild.

There have been a few reports by conventry and others that there has been some resurfacing of these cartilegeneous defect following osteotomy.

In the patient 50years or older, standing x-rays usually provide all the information that is needed to make an accurate diagnosis. Such patients might be better candidates for irrigation of the knee.

But unfortunately there are no published results of this procedure and probably it is done infrequently.

Enthusiasm for Arthroscopic procedures appears to know no limits at the present time. We must carefully select patients for Arthroscopic debridement as well as other Arthroscopic procedures and be more scientific in our approach to the problem

If we fail to do so. It will be done for us regardless of our wishes.