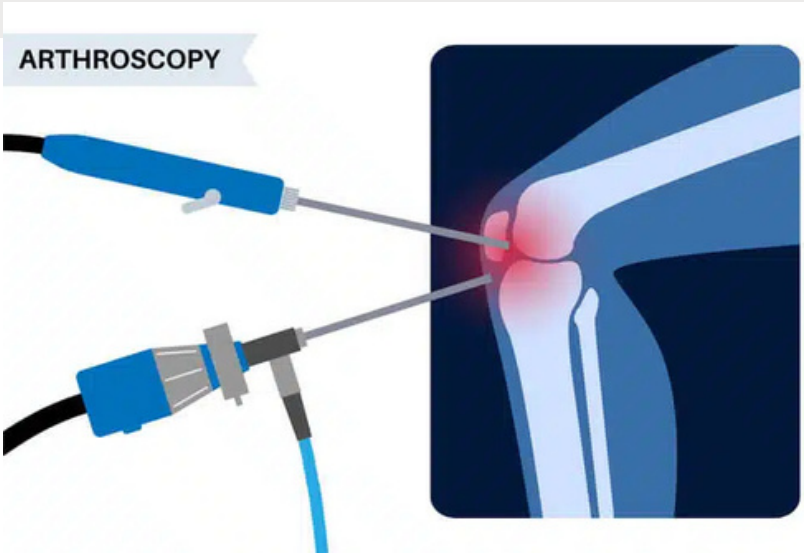
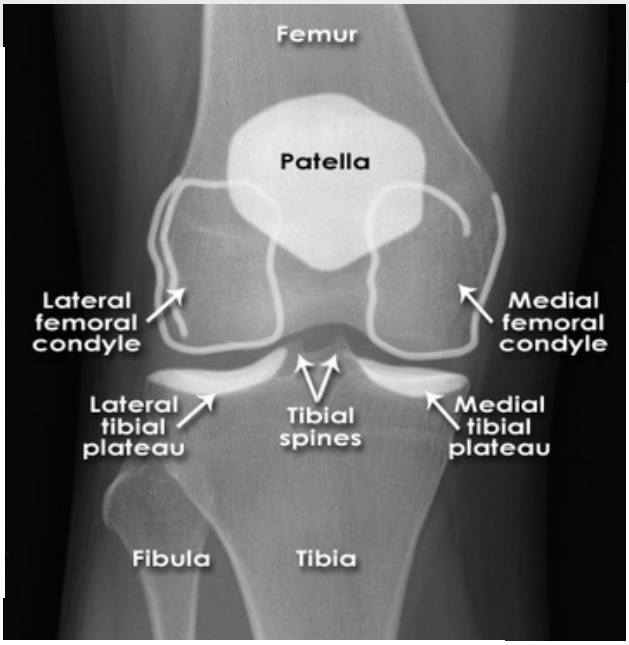
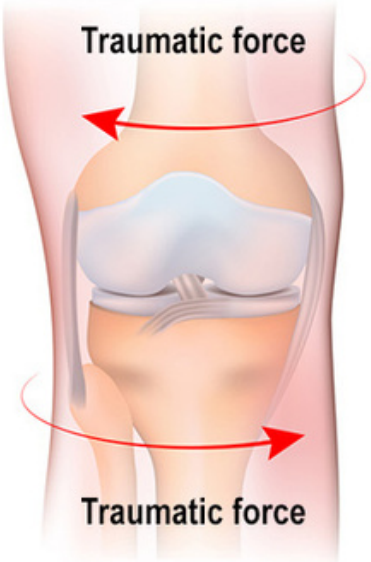
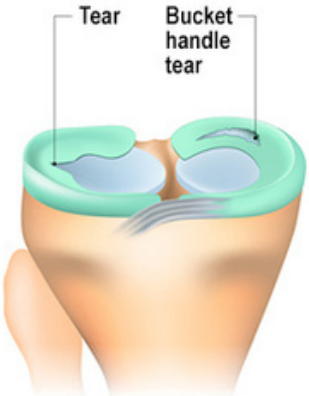
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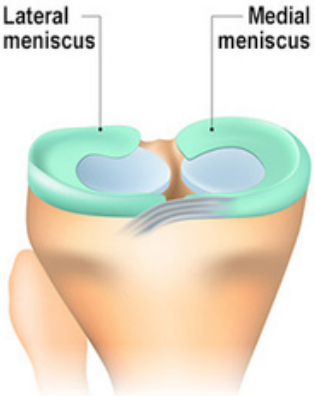
Knee Arthroscopy











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WELCOME



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DR. CHAD CONNER

AMG PROVIDENCED ORTHOPEDICS &
SPORTS MEDICINE

Dr. Conner specializes in sports medicine and arthroscopic and reconstructive surgery of the shoulder, hip, knee, and ankle. He is board certified in orthopedic surgery by the American Board of Orthopaedic Surgery with a subspecialty certification in orthopaedic sports medicine. He grew up in Dallas, Texas and attended Lake Highlands High School. Beginning at age five, he practiced gymnastics and went on to compete for the University of Minnesota gymnastics team in Minneapolis, Minnesota.

Dr. Conner attended The University of Texas Medical Branch for his medical school training and subsequent orthopedic surgery residency training. Following this, he completed a fellowship at the world renowned Southern California Orthopedic Institute. There, he specialized in sports medicine, arthroscopy, and reconstructive surgery of the shoulder, hip, knee, and ankle. He helped care for athletes from the high school level to the professional level. His training also included specialization in total/reverse shoulder replacement surgery.

Dr. Conner currently practices at AMG Providence Orthopedic & Sports Medicine in Waco, Texas and is a team physician for a local high school team. He is a member of the Arthroscopy Association of North America, the American Orthopedic Society for Sports Medicine, and the American Academy of Orthopaedic Surgeons.

He has done extensive research on treatment of massive rotator cuff tears, ACL reconstruction, hip arthroscopy and ankle arthroscopy. He has also been involved in teaching hip arthroscopy as an associate master instructor at the Arthroscopy Learning Center in Chicago, IL. With Baylor University, he gives lectures for pre-health student information courses and is involved in the Baylor Health Science Studies internship program mentoring students interested in orthopedic surgery.

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Conner also volunteers and helps lead a monthly orthopedic and rehabilitation clinic at a community outreach organization called Mission Waco, which strives to provide Christian-based holistic, relationship-based programs that empower the poor and marginalized and was named Business of the Year by Mission Waco for 2013.

Outside of the office, Dr. Conner enjoys his wife and children, church, work outs, mountain biking, wake surfing, and the outdoors.



MEMBERSHIPS

SPECIAL SOCIETY

AMERICAN ORTHOPAEDIC SOCIETY FOR SPORTS MEDICINE
ARTHROSCOPY ASSOCIATION OF NORTH AMERICA
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

STATE MEDICAL SOCIETY

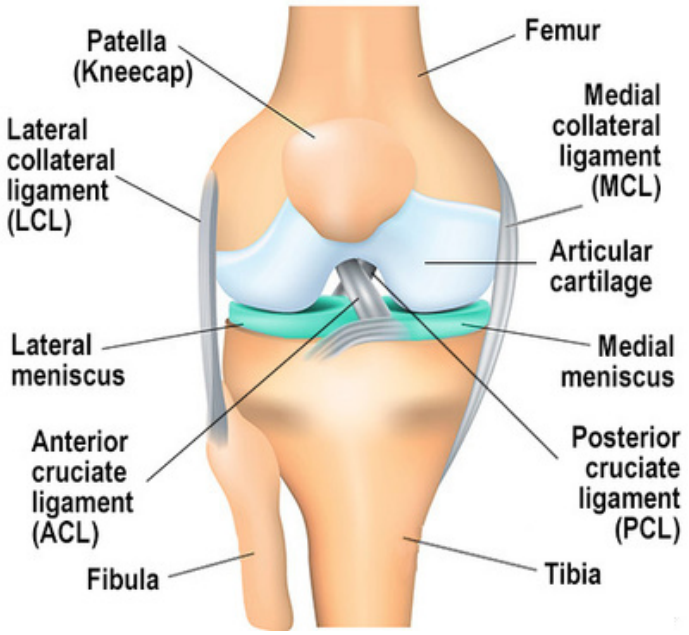
TEXAS MEDICAL ASSOCIATION

INTRODUCTION

This booklet will provide a general guide to the common indications for knee arthroscopy, what to expect if undergoing the surgery, the significant risks, and a general guide to the expected recovery pathway. This document is not by any means fully comprehensive, and any specific questions should be addressed with your surgeon. The development of the techniques has improved dramatically over the last two decades and this has allowed surgeons to improve the treatment of knee injuries.

Normal Knee Joint

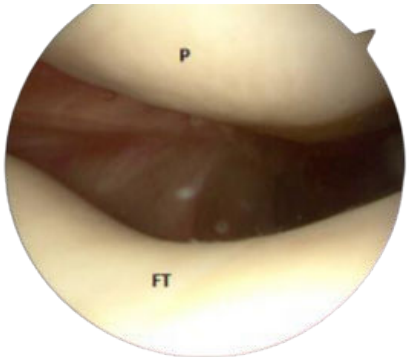
The knee joint acts like a hinge, with the end of the femur articulating with the top of the tibia. The knee joint is a natural shock absorber as well as stabilizer and consists of several components.



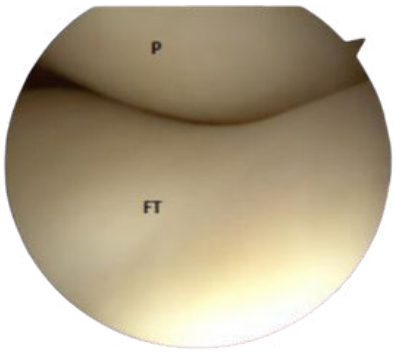
Key Structures

· Bones: Femur, Tibia, Fibula and patella
· Supporting structures: articular cartilage on tibia and femur, lateral and medial menisci.
Ligaments: lateral collateral (LCL), medial collateral (MCL), anterior cruciate (ACL), and posterior cruciate(PCL), posterolateral corner and medial patella femoral ligament
· Associated muscles: Quadriceps, hamstrings, iliotibial band, gastrocnemius, and popliteus.

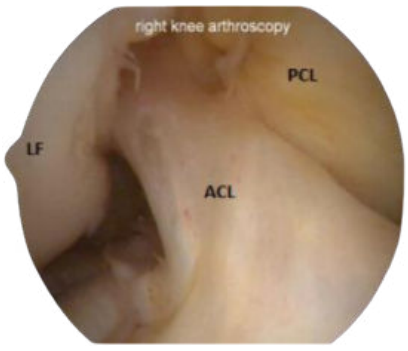
Joint stability is maintained primarily by the main four ligaments including the ACL, PCL, MCL and LCL. The joint capsule as well as the meniscus and other structures provide secondary stability.



Normal patella (P) and femoral trochlea (FT) with knee straight and arthroscopic fluid in the knee



Normal alignment of the patella (P) and femoral trochela (FT) with the knee bent 20° and arthroscopic fluid removed



Normal view of ACL and PCL ligaments which stabilize the front and back motion and knee rotation. Lateral femur (LF) is also shown

INDICATIONS FOR ARTHROSCOPY

Knee arthroscopic techniques and instruments have improved over the past two decades, resulting in many surgeons reducing the number of open joint surgeries preformed. Knee arthroscopy provides the surgeon with a direct visualization and accurate evaluation of the joint. Currently, there are many reasons for recommending knee arthroscopy. Some of the more common problems are:

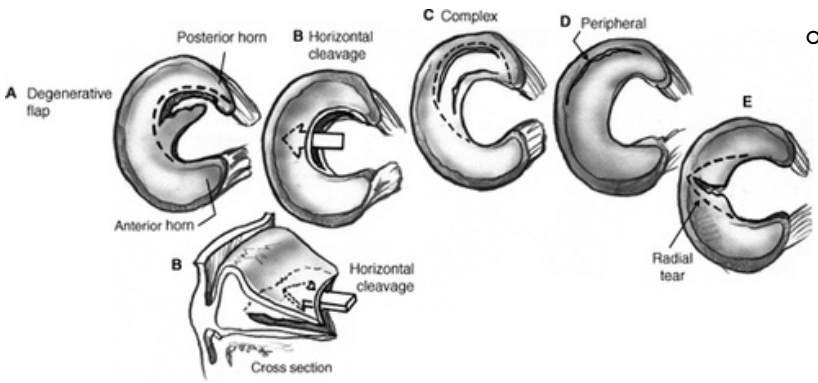
1. Meniscus tears
2. Damage to cartilage
3. Fragments of cartilage in the joint (Loose bodies)
4. Injury to ligaments
5. Plical Band
6. Patella tilt or instability
7. Stiff knee
8. Painful Total Joint Replacement
9. Arthritis of the Knee
10. Synovitis of the Knee

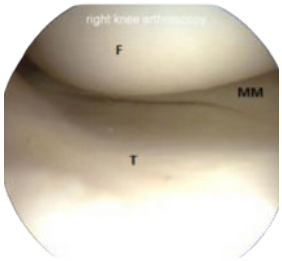
The most common current indication for knee arthroscopy includes injuries to the meniscus. This problem as well as arthritis is discussed in more detail below.



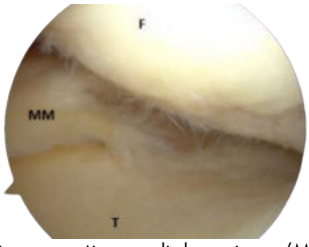
INJURIES TO THE MENISCUS

The knee joint contains two menisci, one on the inside of the knee (medial) and one on the outside of the knee (lateral), which look like semicircles with raised edges. The function of the menisci is to act as a shock absorber for the knee and help stabilize the femur (femoral condyles) on the tibia (tibial plateau). The menisci are made out of fibrocartilage and have a poor blood supply that prevents them from healing on their own effectively.

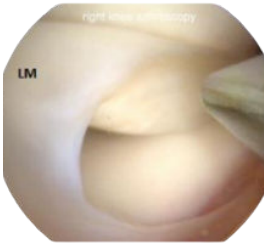




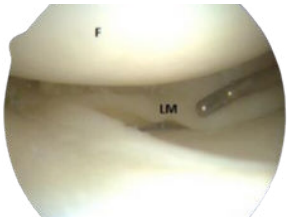
Normal medial meniscus (MM) and articular cartilage on femur (F) and tibia (T).



Degenerative medial meniscus (MM) tear with the degeneration of the cartilage surfaces (arthritis) to the femoral (F) and tibial (T) surfaces



Lateral meniscus (LM) bucket handle tear with the probe pointing to the flipped out meniscus between the femur and tibia



Arthroscopic repair of lateral meniscus (LM) bucket handle tear with the probe pointing to the lateral meniscus. Note how the lateral meniscus is wider than the medial meniscus

Damage to the meniscus can be from an acute injury or from degeneration over time. A twist while the knee is bent is a common injury mechanism. Individuals 40 years old and older are more likely to experience a degenerative tear.

When a meniscus is damaged, a variety of issues can arise:

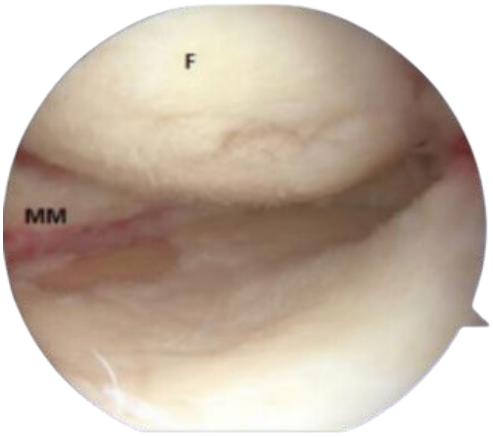
- Pain in the knee joint
- Stiffness and swelling
- Catching or locking of the knee due to loose pieces of either menisci or cartilage moving between the joint surfaces
- Knee giving way from instability of the knee
- Decreased range of motion

As technology and techniques have improved, treatment to repair meniscus tears has advanced so that most meniscus tears can now be repaired (sewn back, not removed) with advanced arthroscopic techniques. Preservation of the meniscus has been shown to decrease the chance of advancing arthritis that typically occurs with a meniscus tear or resection (removal) of the meniscus. Other options for treatment can include conservative management with physical therapy and injections, especially if there is advanced arthritis. During a meniscus repair, the meniscus tissue that is torn can be repaired with suturing devices and suture. Not all tears are repairable and sometimes resection of the torn part of the meniscus is required for treatment. Various arthroscopic biters and shavers are used by the surgeon to remove the damaged tissue. In these cases, care is taken to try and preserve healthier meniscus to act as a residual cushion and stabilizer of the knee.

ARTHRITIS OF THE KNEE JOINT

When dealing with knee arthritis studies have shown that arthroscopy for simple arthritis has not been proven beneficial for long term symptom relief. Along with a meniscus tear, if a patient has significant arthritis the studies have shown that there is less certainty as to whether the arthroscopic surgery will have beneficial effects.

There are several conservative management techniques to help treat knee arthritis including physical therapy, injections, bracing, anti-inflammatories, and lifestyle behavioral modifications. Physical therapy has been shown to be effective in increasing range of motion and strengthening the muscles of the knee to allow the knee to function better and then decrease pain. Some lifestyle behavioral modifications include weight loss (if overweight) and avoiding excessive impact activities or stairs as these can place increased strain on the knee. Water aerobic activity or therapy is a recommended way to provide a total body work out that is low impact on painful arthritic joints.



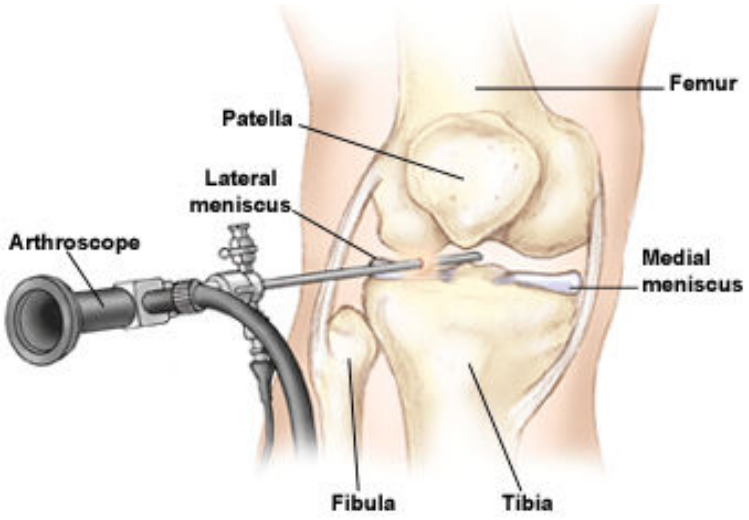
View of the knee following chondroplasty or debridement of the cartilage surface to smooth the irregularities and partial medial meniscus (MM) removal "meniscectomy."

WHAT IS KNEE ARTHROSCOPY?

KNEE ARTHROSCOPY IS A PROCEDURE THAT ALLOWS YOUR ORTHOPAEDIC SURGEON TO INSPECT YOUR KNEE FROM WITHIN AND THEN DIAGNOSE, AND TREAT PROBLEMS INSIDE THE JOINT.

Once anesthesia has been provided in the operating room you will be positioned carefully on your back and then the nurse will prepare your leg with a sterile prep. Sterile drapes are then placed around the leg to create a sterile operating field.

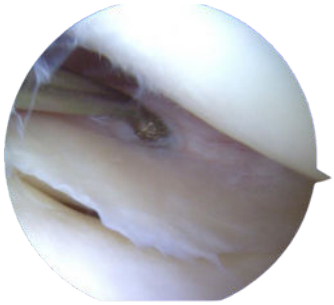
During knee arthroscopy, typically two or more small incisions are made at the front of your knee to allow the surgeon to visualize your knee and work with small instruments to repair and treat your knee problems. A 4mm camera called an arthroscope is placed into the knee joint to begin the operation. The camera displays pictures in high definition onto a television screen. Saline (water balanced for your body) is pumped into the knee joint to allow the surgeon to see clearly and remove debris from the joint.



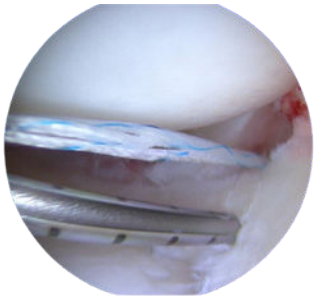
The first procedure performed is a systematic view looking at all of the important structures of the knee joint to evaluate for any damage. Once the injured tissues have been assessed, the surgeon begins working to repair and/or treat as possible all of the pathology thought to be causing pain. This typically correlates with the preoperative imaging and evaluation.

When the meniscus is able to be repaired, the meniscus and capsular tissue are prepared to create a good healing surface for the tissue. A small arthroscopic rasp and the shaver are used to clean the tissue to remove any fibrous layer and stimulate the tissue for a healing response. Following this, the tissue is sewn to the capsule or to back together with an arthroscopic device/suture designed to secure the meniscus back to the capsule (surrounding knee joint tissue) or together. In root (where the meniscus attaches to the bone) tears the meniscus is secured back to the bone.

KNEE ARTHROSCOPY CONT.

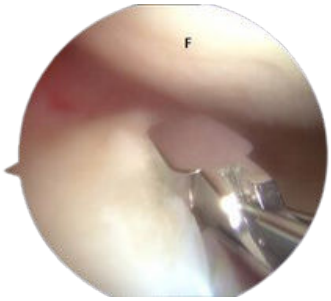


Arthroscopic rasp used to help prepare the meniscus and capsular tissue for meniscus repair.

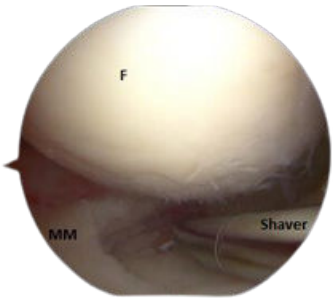


Meniscus repair device used to repair the torn meniscus to the capsule. The first stitch has been placed and the second stitch is about to be placed.

If there is a non-repairable tear then an arthroscopic biter is placed into the knee joint and the torn meniscus tissue is resected. Following this a shaver is used to further debride the meniscus tissue and leave the remaining meniscus smooth and well contoured. The remaining functional meniscus can still work to cushion and stabilize the knee joint.



Arthroscopic biter used to remove and resect a torn meniscus. (F) femur.



Arthroscopic shaver used to smooth the resected medial meniscus (MM) and the irregular cartilage surfaces (arthritis).

Other procedures as noted earlier in the text may be performed as well.
Once the procedures have been completed, the small incisions are closed beneath the skin with an absorbable suture and further secured with small white band-aids called steri-strips. These are left on until removed and replaced with new ones at your first post-operative appointment.

RISKS ASSOCIATED WITH KNEE ARTHROSCOPY

Most patients do not experience complications from knee arthroscopy. As with any surgery, however, there are some risks. These are usually minor and treatable. Potential risks with any surgery include pain, bleeding, infection, damage to surrounding structures like nerves or blood vessels, failure to heal or cure, need for additional procedures, fluid complications, and any medical or anesthetic complication. Loss of limb or death would be exceedingly rare with knee arthroscopy surgery. Your surgeon will discuss the possible complications with you before your operation and you should ask any questions that you may have.

WHICH PATIENTS SHOULD CONSIDER KNEE ARTHROSCOPY?

Patients with symptoms of a painful condition that have not responded well to nonsurgical treatment and/or have a significant injury to the knee. Your surgeon will help you understand and decide when surgical treatment is needed verses treatment without surgery.





Nonsurgical treatment includes rest, physical therapy, and medications or injections that can reduce inflammation. Inflammation is one of your body's normal reactions to injury or disease. In an injured or diseased knee joint, inflammation causes swelling, pain, and stiffness.

Injury, overuse, and age-related wear and tear are responsible for most knee problems. Knee arthroscopy may relieve painful symptoms of many problems that damage the menisci, ligaments, articular cartilage, and other soft tissues surrounding the joint. X-rays and a preoperative MRI can help to confirm the diagnosis of these problems prior to the arthroscopy.

PREPARING YOURSLEF & YOUR HOME BEFORE SURGERY

Recovery is a gradual process and will take time after surgery. Plan for your return home before you enter surgery. Most patients return home the same day of surgery.

- Ask your spouse, children, or friends if they can assist you with activities of daily living for about two days.
- Before surgery, it maybe helpful to practice daily activities that will be affected by surgery.

If you're interested in assistance from a home healthcare agency, select the agency before your surgery. Your doctor's office can help you with these arrangements. Most of the time, your insurance will cover the cost of home health care following surgery if it is a taxing effort to leave the house. It can be arranged that you have a nursing assistant come to your house and help with day to day things you may need as well as help with physical therapy exercises also.

- Anticipate temporary changes to your activity level.
- Plan to leave your home clean and in order.
- To prevent falling, remove throw rugs and excess clutter from traffic paths.
- Place a sturdy armchair in your living room near a table so that magazines, hobby supplies, TV remote, phone charger or other items you want to be within reach.
- Prepare some meals in advance and freeze them.





BEFORE SURGERY CHECKLIST

SLEEP



A good night's rest is important before surgery.

NO FOOD/DRINK



Before surgery, do not eat or drink anything after midnight. Your stomach must be empty before you receive the anesthetic. This helps prevent nausea, vomiting and other complications during and after anesthesia.

SUPPLEMENTS



Supplements: in general, you should discontinue all herbal over-the-counter supplements one week before surgery. You may continue multivitamins and Vitamin C, but nothing else. Some supplements affect bleeding tendencies and may cause problems with wound healing.

POST-OP MEDICATIONS

Please make sure you have picked up your post-op medications **PRIOR** to your surgery. Failing to do so can lead to delays in receiving the medications and pain relief.

SHOWER



Take a shower or bath the evening before surgery. This will help decrease the amount of bacteria on your skin.

OTHER MEDICATIONS

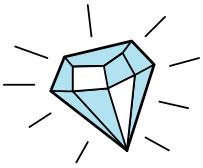


You should stop all medications that have a potential to cause bleeding before surgery. The most common medications that fall into this category include aspirin (14 days prior), anti-inflammatories (such as Advil, Motrin, Naprosyn) (7 days prior) and blood thinners such as Plavix, Eliquis or Coumadin. (ask your PCP or refer to the surgery medication sheet you were given by Dr. Conner's office)

DAY OF SURGERY CHECKLIST

You will be provided a time to come and check into the surgery center or hospital. It is important to follow these instructions:

☐ NO VALUABLES



Leave your valuables at home.

☐ SHOES



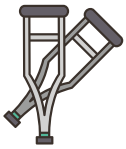
Comfortable, non-skid walking or athletic shoes. Elastic laces are available, eliminating the need to tie your shoes. Athletic shoes are available with hook and loop fasteners. Another option are slip on shoes or slippers.

☐ CLOTHES



Clothes that are soft and loose fitting. Bring comfortable clothes that open in the front with buttons or a zipper. Women can bring pants with elastic waistbands. For men, gym pants are easiest.

☐ CRUTCHES/WALKER



Please remember to bring your crutches or walker!

☐ MAKEUP



Do not wear makeup the morning of surgery. This includes nail polish.

☐ USUAL MEDICATIONS



Take only the medications your physician or nurse tells you to take on the morning of your surgery. (with a small sip of water)

Do **NOT** bring your medications that you usually take. It is important to have a list with the appropriate dosages. This will be requested from you at the time of registration.

☐ KNEE BRACE



IF APPLICABLE: Please bring the post op brace you received in our office.

YOUR SURGERY CENTER OR HOSPITAL STAY

You will be provided a time to come and check into the surgery center or hospital.

MORNING OF SURGERY

- After admission, the nursing staff will take your temperature, pulse, respiration rate, and blood pressure.
- The anesthesiologist will discuss the types of anesthesia to be used.

GOING TO SURGERY

- You will be asked to empty your bladder.
- Remove all jewelry (including rings), dentures, and contact lenses.
- You may wear your glasses/hearing aid if necessary.
- You will be taken to the operating room on a hospital bed.
- An intravenous (IV) line will be started before surgery.
- The affected knee may be shaved and scrubbed to prepare for surgery.

ANESTHESIA

The surgery is most commonly performed under general anesthetic. Often times the anesthesiologist may not even have to place a tube down your throat and may use an apparatus called an LMA, which goes in your mouth and allows you to breathe on your own during the surgery. Alternatively, your anesthesiologist may determine that it is best to place a breathing tube into your trachea. In either case there may be a sore throat after the surgery which is normal.



WHAT TO EXPECT AFTER SURGERY

POSTOPERATIVE:

After surgery, you will stay in the recovery room for 1 to 2 hours before being discharged home. Nurses will monitor your responsiveness and provide pain medication, if needed. You will need someone to drive you home and stay with you for at least the first night.

WOUND CARE:

The knee dressing may be removed 48 hours after surgery for showering. The small tapes (steri-strips) covering the incisions should be left in place. Bandaids should be placed over the incisions.
Avoid prolonged sun exposure and/or use adequate sun block once the wounds have healed to promote a better healing scar for one year.

SHOWERING:

Showers are acceptable after the dressing has been removed. No use of bathtubs or Jacuzzi. When showering, apply a clear plastic wrap (Saran wrap) to keep the knee dry. This should be applied around the knee until your first postoperative visit. You need to keep your incisions dry. After showering, make sure that you dry the knee area. Your sutures are usually removed at your first post op appointment.

SWELLING:

Swelling is common to experience especially around the knee joint. This will cause stiffness and discomfort. This may last for several weeks after surgery. To minimize the swelling, utilize ice on the knee for 20 minutes every 2-4 hours as desired.

BLEEDING:

In some cases, oozing at the point of incision can persist for several hours. If this should persist with the continued use of the compression dressing, contact our office. If the steri-strips covering the incisions are removed, this sometimes does remove the clot covering the wound, which is why we ask that you leave the steri-strips on until your first post op appointment.

DIET

After surgery, drink lots of fluids and eat a bland, nutritious meal when you return home from the hospital and or surgery center.

WHAT TO EXPECT CONT.

NAUSEA & VOMITING:

Although unusual, both can be experienced after anesthesia in surgery. If you have a tendency for this, please discuss this with the anesthesiologist. Otherwise, it is usually alleviated with a clear liquid diet. You have also been prescribed an anti-nausea medicine such as phenergan (promethazine) or zofran (odansetron). You may take this as directed, If you are having constipation then make sure you are taking a stool softener (Colace or other) and consider taking an over the counter laxative such as Bisacondyl 10 mg.

DROWSINESS:

After anesthesia, drowsiness may persist for up to 48 hours.

PAIN MEDICATION:

You will be prescribed pain medication (typically oxycodone) to be used at home after your surgery. This is a narcotic pain reliever. Take 1-2 tablets every 4-6 hours as needed for pain. It is usually recommended to take the pain medicine every 4 hours for the first 24-48 hours, and then take it as needed. Keep in mind that the medication will cause drowsiness and should not be used with alcohol. Also, taking this medication on an empty stomach may result in nausea. It is common to feel discomfort when lying down to sleep at night, so you may find it beneficial to take the pain pill at bedtime. If unusual side effects occur, please discontinue the medication and contact our office. We recommend taking 1000mg of Tylenol every 6-8 hours for pain around the clock to help get ahead of the pain. NSAIDs (Aleve, Ibuprofen) are usually not taken for 3 months after the surgery if a repair was performed in order to not slow healing of the tissue. It is recommended to take an over the counter stool softener such as colace each day to help prevent constipation while taking the narcotic medicine.

You can expect the acute surgical pain and discomfort for at least a week after surgery. If you have had a more extensive surgery, however, it may take several weeks before the initial acute surgical pain subsides.

SIGNS OF INFECTION:

With any surgery it is important to be aware of signs of infection, which can include: unusual looking incision such as increased redness or smell, drainage to be green or yellow, and increased fever. It is normal to have a slight temperature post operative, but above 101 degrees; you may need to contact our office immediately.

WHAT TO EXPECT CONT.

PHYSICAL THERAPY:

Patient's are typically scheduled for their physical therapy to begin 2-3 days after their surgery. If you do not have an appointment scheduled for after the surgery, please call our office to make sure a post op appointment was made for you.

POST-OP VISIT:

Patient's are typically given a post op appointment with the surgeon's PA or NP at the time their surgery is scheduled for 5 to 10 days after surgery. If you do not have an appointment scheduled for after the surgery, please call our office at 254-752-9638 to make sure a post op appointment was made for you. Please make the scheduler aware that this is your first post op appointment. At this appointment, we will change the steri-strips, and examine your knee. Typically, you will be seen again approximately 6 weeks after the surgery.

RETURN TO WORK:

The decision to return to work is made depending on your job requirements. With most occupations that involve office and/or computer work, you may be able to return to work in a few days.
If you job requires significant manual labor and lifting, the return to work may be prolonged to 6 to 12 weeks to 6 months for complete release depending on the procedure.

EXERCISES:

Please do the exercises discussed in the following section to speed the rehabilitation of your knee.

RETURN TO SPORT:

Typically, return to sport will vary depending on the specific knee procedure performed and sport. Partial menisectomy typically requires 3-6 weeks verses 5-6 months for meniscus repair and up to 1 year for cartilage restoration procedures. Your therapist and/or trainer will be following and directing your progressive preparation for return to your sport under our guidance.

QUESTIONS:

Please feel free to contact our office at any time if you have any questions or concerns,
254-752-9638.

POST-OP KNEE EXERCISES

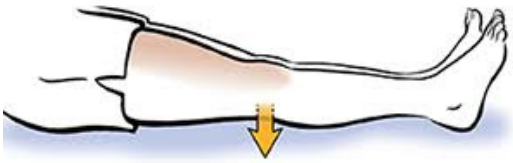
Repeat each exercise 10-30 times and repeat each set 3-4 times daily.

Exercise and movement are important following surgery. Muscle contractions through exercise release nitric oxide, which decreases inflammation, aid wound healing and help prevent stiffness. You should begin these exercises when you return home from your surgery the same day. You should begin in a gentle manner and then progress under the guidance of your therapist.

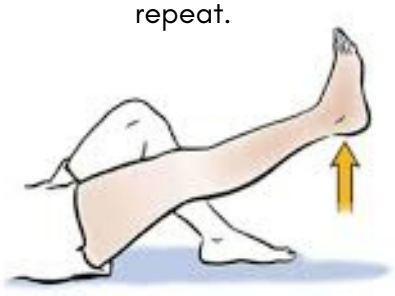
1. **Ankle Pumps:**
Point your foot down like pushing on the gas pedal of a car and then move your foot back to the starting position.



2. Quad Sets
Either lying down or sitting straighten your leg tightening up your quadriceps muscle making it as straight as possible and hold for 3-5 seconds then relax.



3. Straight Leg Raises:
Either lying down or sitting bend the unaffected leg and keep the leg that has been operated on straight. Tighten thigh muscle of the straight leg and slowly raise the leg keeping it perfectly straight. Hold the leg in the air for 3-5 seconds. Relax the leg and repeat.



4. Range of Motion:
Gently work on regaining the motion of your knee by working to fully straighten your knee and then fully bend the knee.



FREQUENTLY ASKED QUESTIONS



1. HOW LONG IS MY SURGERY?

About 1 hour, but complex repairs may be longer

2. HOW LONG WILL I BE KEPT AT THE FACILITY?

Patients can typically leave to go home within 1-2 hours following surgery.

3. HOW MUCH WEIGHT CAN I PLACE ON MY FOOT?

If a meniscus repair is performed, then typically no weight is allowed for 4-6 weeks. If the meniscus is trimmed out, then weight is allowed as tolerated.

4. IS IT NORMAL TO HAVE SWELLING OR POPPING FOLLOWING THE SURGERY?

It is normal to have swelling in the knee the first week after surgery as this is from the surgical fluid. Swelling after this may be indicative that the knee is not fully healed yet and is becoming irritated from excessive use. Occasional popping can occur while the knee is healing from readjustment of the muscles while the strength returns to the knee.

5. WHEN CAN I DRIVE?

Usually, you can drive within a few days once you are off of the narcotic pain medicine, and can ambulate well. You should feel comfortable moving the leg quickly to hit the brakes in case of an emergency situation.

6. WHAT ELSE SHOULD I DO TO PROTECT MY KNEE AS IT HEALS?

Avoid over exerting the knee in the first few weeks. This can cause swelling and irritation to the lining of the knee joint and prolong your recovery. If you get swelling in the knee then you are probably doing too much.



Ascension