Degenerative Meniscal Tears

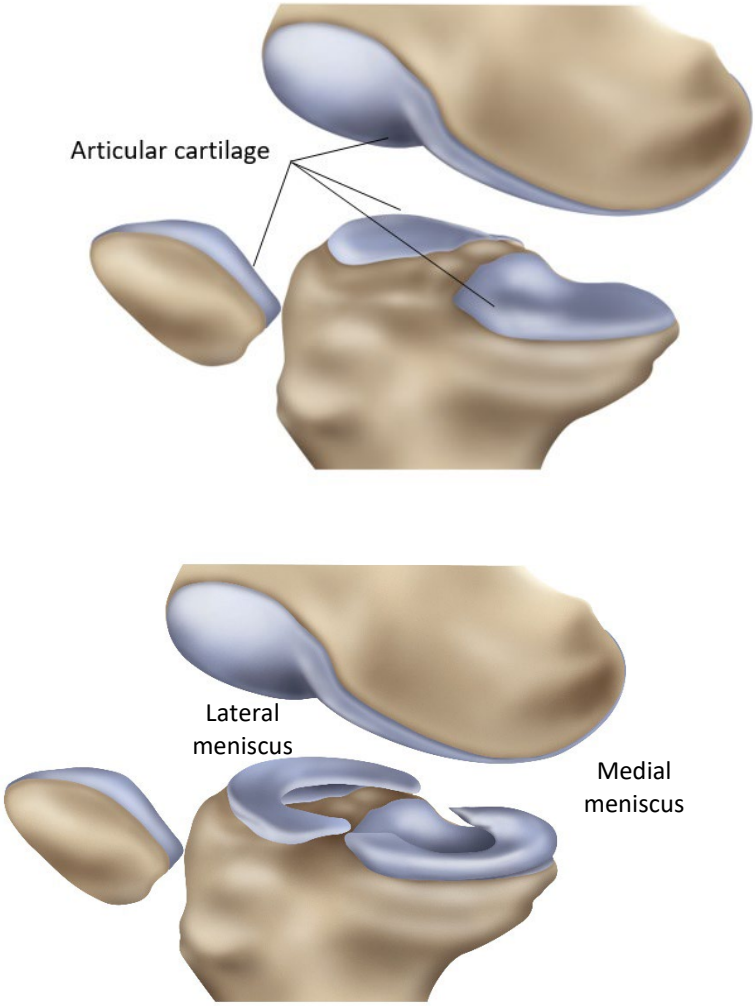
Information for patients

The menisci are the shock absorbers that sit within the inside (medial) and outside (lateral) compartments of the knee joint. The articular cartilage covers the end of the thigh bone (femur), top of the shin bone (tibia) and back of the kneecap (patella), Figure 1. The menisci help to transfer load across the joint and act as shock absorbers.

Meniscal tears can result from an acute injury (traumatic meniscal tear) or from a 'wearing out' process in a middle-aged or older person (Degenerative Meniscal Tear) and are considered part of the ageing process of a knee. Meniscal injuries increase with age, ranging from 16% in the knees of 50 to 59 year-old women to over 50% in the knees of men aged 70 to 90. However, over 60% of these meniscus lesions/injuries are not symptomatic for the patient.

For those who do have symptoms, these can include pain at a particular side of the knee, locking, feelings of instability and a reduced ability to exercise or be active.

Figure 1. Menisci and Articular Cartilage in a Knee



Research has concluded that surgery is **not** recommended as first line treatment for Degenerative Meniscal Tears in patients over the age of 35. It is advised that 3-6 months of non-operative management should be performed before consideration of surgery in the non-locked, non-arthritic knee. Non-operative treatment includes activity modification (e.g. avoid football or tennis for a period if it hurts), painkillers and/or anti-inflammatories, avoidance of squatting, kneeling and lunging activities, structured physiotherapy, strengthening plans and potential corticosteroid injections to reduce pain and help rehabilitation.

Keyhole surgery (Arthroscopy) to remove the torn piece of meniscus can be an option in some patients whose symptoms are not responding to 3-6 months of non-operative management with significant pain and locking.

Keyhole surgery in knees with advanced osteoarthritis is **not** beneficial and in those who have moderate level osteoarthritis, removal of any part of the meniscus is unlikely to help.

The evidence shows that some people improve with keyhole surgery in the short term but in the longer term, the benefit compared to non-operative management is less clear. Defining who benefits from surgery can be difficult and requires individual assessment, discussion and shared decision making with your orthopaedic specialist. Appropriate imaging may be arranged if clinically indicated.

If surgery is considered suitable, there are risks including knee joint infection, Deep Vein Thrombosis (DVT), scar thickening, minor numbness at the site of scars, persistent post-operative swelling, pain and stiffness and potential future development of osteoarthritic changes at the side of the knee where the meniscal tear has been trimmed. The surgery is carried out as a Day Case procedure (in and out on the same day) under general anaesthetic (asleep). Initial recovery will take 2 or 3 weeks, at which point most people will have returned to work though those in more manual jobs may take longer.

Physiotherapy is not routinely arranged after your operation, but you will be given an information booklet with advice and exercises to follow. Strengthening and rehabilitation can take up to 3 months (or longer) before return to impact exercise and sports. Ongoing strengthening is essential in the longer term to maximise knee function.