Frequently Asked Questions

Meniscus Questions

Q. What is a "meniscus"?

A. The meniscus is a "C" shaped shock absorber in your knee joint. There are two menisci or cartilage. The terms may be used interchangeably by your doctor. The meniscus has several different functions. It is a shock absorber, stabilizer, and helps with joint lubrication.

Q. What does it mean to "tear" a meniscus?

A. You can tear the meniscus in many different ways. As we get older the water content of the meniscus which is similar inconsistency to a piece of "gristle" loses water content and becomes more brittle. With twisting activities the meniscus can be pinched between the femur and tibia and it can rip, tear, or degenerate.

Q. What are some activities that can result in a torn meniscus?

A. We see patients who tear their meniscus doing many different activities. Usually there is some form of a twisting activity. It does not necessarily have to occur from a sports injury. We see patients who injure the meniscus while kneeling or squatting while gardening, or who are on the floor playing with their kids or grandchildren and tear the meniscus arising from a kneeling, seated or squatting position. Sometimes patients may "tweak" their knee while walking on a treadmill. Occasionally someone will twist their knee stepping off a curb or slipping on ice. Of course sports is the most common mechanism. Menisci can be torn in association with knee ligament injuries, particularly tears of the anterior cruciate ligament. Perhaps 40-50 % of patients who acutely tar their ACL may have an associated meniscal tear. In chronic ACL deficient knees this can in fact be higher.

Q. What are some of the symptoms of a torn meniscus?

A. Patients may have pain associated with **twisting** activities. The pain is usually localized along the inside or outside of the knee. It is not localized about the kneecap region. For example, rolling over in bed, getting in an out of a car, torqueing the leg on the carpet while walking, crossing your legs while seated, sitting "Indian" style, squatting or some of the activities which may cause symptoms**. Swelling** of the joint is another coming complaint. **Instability** or "giving way" is another symptom. Sometimes patients will feel like something is **catching** or pinching in the joint and give a transient **locking** sensation.

Q. What might the doctor detect on his examination?

A. The doctor will examine you for localized joint line tenderness, swelling, and will bend and rotate your knee to see if these symptoms are reproducible. Your doctor will also exclude any underlying knee ligament problem.

Q. Will an Xray detect a meniscal tear?

A. No! The purpose of the Xray is to make certain that you do not have any underlying arthritis in your knee. Also a loose bone chip "loose body" may mimic a meniscal tear. The Xray give your doctor information about the "boney" anatomy of a joint, whereas the MRI gives more information about the soft tissues (cartilage, ligaments) of the knee.

Q. Does every patient require a MRI?

A. No! Sometimes patient s have such classic symptoms that the diagnosis can easily be made without the MRI.

Q. Does every meniscal tear require surgery?

A. No! The decision to perform surgery is based on your symptoms. Sometimes a meniscal tear is picked up as an incidental finding and is not the source of the patient's complaints.

Q. So who needs surgery?

A. The patient who has meniscal tear symptoms confirmed clinically who is not getting better is a candidate for arthroscopic surgery.

Q. If I have arthritis in my knee and I have a meniscal tear should I have surgery?

A. There are many patients who have an abnormal meniscus on MRI and have arthritis on Xrays. The patients who most predictably will benefit from an arthroscopic partial meniscectomy are those individuals with short duration symptoms that are mechanical in nature. For example if the patient recalls a specific event that occurred less than 3 months earlier and is mechanical (catching, locking) that person usually will benefit from surgery. If the patient has longstanding diffuse pain he/she is far less likely to benefit from arthroscopic partial meniscectomy.

Q. What is done surgically?

A. Three or four small ¼ inch incisions are made about the knee under an anesthetic. The surgery is performed in the Rush Surgicenter or at hospital. A fiberoptic "telescope" is inserted into the knee joint which allows us to maneuver through the joint looking at the normal and abnormal joint surfaces. A variety of instruments can be inserted to perform the surgery. A probe can be used to palpate the joint surfaces and feel the menisci. Miniature cutting instruments and or a motorized shave is used to remove the torn fragment or portion of the meniscus. In general approximately 15-20% of the meniscus might be removed. At the end of the surgery an anesthetic is injected into the knee joint, the "poke holes" (portal) are closed with a single suture, and sterile dressings are applied along with an ice wrap. The procedure usually takes 30-45 minutes and is performed on an outpatient basis.

Q. What is the difference between a meniscectomy and a meniscal repair?

A. A meniscectomy is the medical term for a partial removal of the meniscus. This is done over 90% of the time, and almost always in patients over the age of 40. There are certain patterns of meniscal tears that are

amenable to repairing with sutures. The periphery of the meniscus has a blood supply, the inner two thirds does not have a blood supply. A meniscal repair is frequently performed in conjunction with ACL surgery because of the specific pattern of tear. Meniscal repairs are more extensive surgical procedures and take longer to recover and return to sport. A meniscal repair frequently requires making a 1- 2 inch incision along the inside or outside of the knee as part of the procedure.

Q. What happens after surgery?

A. You can expect to be released from the surgery center approximately two hours after your surgery. Immediately after your surgery you will be in the "recovery" area for about one hour. When you are wide awake a family member can visit you. You will be encouraged to move your knee, perform straight leg raises to activate the muscles (quad sets and straight leg raises), and move you rankles up and down (ankle pumps). Most patients will be discharged with crutches.

Q. What can I expect in the first week?

A. You may need to use some pain medications for the first few days after surgery. You will be given a prescription for pain medications. We want you to move your knee as tolerated during the first week. You might need crutches for 1 to 2 days. You should ice for the first week. By one week we like to see about 90 degrees of knee bending (flexion). You will be seen between 7-10 days postoperatively to check your knee, remove the stitches, and assess your range of motion. At that time you will be referred to physical therapy?

Q. When can I expect to see a difference in my preoperative pain?

A. Many patients with meniscal tears can tell that there is a difference in the character of their pain within one week postoperatively. If the patient also has some component off arthritis it may take up to 6 weeks to discern a difference.

Q. How long will I be in physical therapy?

A. Most patients are in supervised physical therapy for 4-6 weeks postop.

Q. When can I return to sports?

A. Most athletes are returning to sport in a 4-6 week time period. If you have a meniscal repair the time period to return to sport is longer –3 to 4 months.

Q. What risks are associated with arthroscopic surgery?

A. In general the risks are extremely low. The chances of getting an infection blood clot, or pulmonary embolus---the major concerns we have are all less than 1 %. You will sign a surgical consent form that list many of the other RARE complications reported in association with knee arthroscopy. It is also important for patients to realize that although arthroscopy is a highly successful low morbidity procedure, that I there is associated

"wear" or early arthritis than the patient may have incomplete relief of pain after surgery. Fewer than 2% of our patients will retear the meniscus within one year after surgery.

Q. How quickly can I fly after surgery?

A. We generally recommend that patients not fly on an airplane for at least one week after surgery because of the concerns of leg swelling and blood clots.