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#### INFORMATION REGARDING KNEE ARTHROSCOPIES FOR PATIENTS

NOTE: Knee arthroscopy is a minimally invasive i.e. keyhole surgery of the knee performed for a variety of reasons. I tend to undertake them both as a diagnostic procedure to establish and confirm a meniscal tear or loose body or confirm a cruciate disruption in combination with examination under anaesthetic. In most cases the pathology can then be treated in the same procedure, its main advantage over MRI scan.

Usually done under either a General or spinal (*needle in back to numb the legs*) anaesthetic, it usually takes less than an hour with the patient going home the same day. With or without a tourniquet ( the latter makes the procedure slightly easier in more difficult cases but has a slightly greater risk of a clot in the leg or the development of transient nerve paralysis) a camera on the end of a light tube (*arthroscope*) is inserted into the knee so that the operation can be performed through key holes. A second key hole is inserted to allow instruments to enter the knee and permit manipulation/ surgical intervention.



Whilst it is a safe and effective method of treating such conditions, they do have risks and the patient needs to be aware of this.

First of all, any anaesthetic has risk, people have a chance of having a complication of the general anaesthetic, either unexpected and rare complication of the anaesthesia

or chest infection/heart attacks that are associated with the stress of an anaesthetic. These risks are present in everyone although the fitter they are, the less risk there is, and for the average healthy person the risk is extremely low.

Then there are specific risks to the operation, first of all, the operation can be tricky and on some occasions, may need to be abandoned for a procedure done on another day, (more likely when a meniscal (*cartilage tear is identified which needs a repair for which the equipment is not available- a rare event*))

Secondly, there is a risk of infection (*this is present in any operation and is rare in a standard knee arthroscopy*) **chance of less than 1/1000**, but when it does occur, can make the patient very unwell, and may take up to 3 -6 months to fully recover- increasing the risk of later degenerative arthritis. The knee, which has improved following arthroscopy, which then flares up becomes more painful, which shall always be reviewed by immediately by a medical person. If there is any concern then a needle may need to be placed into the knee to take fluid off and if this is confirmatory then a knee arthroscopy to wash out the knee may be required. The patient may need to be readmitted to hospital, who then may need to undergo one or more knee arthroscopies to get infection under control and remain on antibiotics for at least six weeks. Such complication which can occur out of blue and is not always associated with the index operation, can lead to continuing pain and early arthritis and obviously the decision to undergo an arthroscopy with this risk in mind should always be taken into consideration.

Other risks that need to be mentioned are the scars (usually 2) that are required. These usually heal very small but sometimes they can be painful for a period of time. Also, the knee is tender for several weeks even up to a month and therefore, people with manual duties may require two to four weeks off work.

Following surgery, I usually close the wound with Steri-Strips (*tapes*) or occasionally on the bigger wounds sutures (*stitches*) are required. I then dress these with Mepore (*sticky dressing*) and a wool and crepe dressing. Following discharge, the patient is given a TubiGrip (*elastic bandage*) dressing to change from the wool and crepe to the TubiGrip the following day. They must keep the wound entirely dry for five days and on five days they can have a shower having taken the TubiGrip off the leg, get the Mepore dressing wet and then remove it, tap the Steri-Strips dry or sutures dry and replace the tubigrip. If the Steri-Strips fall off and the wound is still fresh, the patient needs to replace them with Band Aids. If the Steri-Strips fall off and the wound is fully healed then no dressing required other than the TubiGrip dressing. Sutures are removed at 10 days.

Finally, in the post-operative period there is incidence of deep vein thrombosis, this is low but it can occur, particularly associated with a tourniquet. Consequently, I recommend that the patient move the leg and foot as quickly as possible in the post-operative period to mobilise and to take half a soluble Aspirin every day for the first two weeks following surgery (*if there are no contraindications*). Should the leg or calf become suddenly swollen or painful then an ultrasound may be required. I would emphasise the emphasis of latter is very low but the above precautions can help reduce this as well.