British Orthopaedic Association

MR ELLIS PATIENT INFORMATION FOR INFORMED CONSENT

KNEE ARTHROSCOPY

With meniscal resection or repair, washout, removal of loose or foreign body, closed lateral release, microfracture, chondroplasty with or without radiofrequecy ablation or other procedure as required by your condition

PROCEDURE: An arthroscopy means "looking into a joint" with a camera. It allows Mr Ellis to examine the knee joint and perform some operations without having to open the knee completely.

You will be visited by Mr Ellis before your operation. Mr Ellis will mark the correct leg with a felt pen. This is to make sure the correct leg is operated on. If you have any questions, this is a good time to ask them.

Anaesthetic will be administered in theatre and a tight inflatable band (tourniquet) will be placed across the top of your thigh to limit the amount of bleeding.

Your skin will be cleaned with anti-septic solution and clean towels (drapes) placed around your knee. Mr Ellis will make up to four small incisions (cuts) around the knee cap. These are generally no more than 1 centimetre in length and are usually secured after surgery with steristrips (butterfly stitches).

Through the first incision, Mr Ellis can pass a telescope with a camera. This shows pictures on a nearby television screen. The second or third incision may allow tools or drains to be passed into the joint. The tools include probes, shavers, scissors and punches.

Mr Ellis might not be able to say exactly what needs to be done until he is looking inside the knee. Therefore the consent form is non-specific. It allows Mr Ellis to treat most abnormalities found during the operation.

When finished, the wounds are dressed and local anaesthetic and usually painkillers will be injected into the knee.

When you wake up, you will have a padded bandage around your knee. Later the same day, when you feel well enough, and you have been shown how to use crutches, you may go home. You should not drive for 48 hours following surgery if it is your left leg and you have an automatic and a week if not.

The padded bandage should be removed after 2-3 days but the plasters beneath should remain for around 14 days and the wounds be kept clean and dry. Do not be alarmed if you see small dried spots of blood through the bandage. Any continuing fluid discharge should however be reported to Mr Ellis through the hospital or his practice manager.

Exercises will be given before your discharge. The most important of these are the straight leg raising drills and working knee bend as comfort allows. You will be allowed to put full weight through the leg unless Mr Ellis or his team advises otherwise

You may return to work as soon as walking long distances is comfortable. Returning to work naturally depends upon your profession. In general you will need to keep your knee moving and as a result you may need to vary your way of working to accommodate this for up to a month.

You should avoid sport following your surgery initially. It is reasonable to return to straight line excercises such as the use of a cross trainer, exercise bike and light treadmill work after 2 weeks and most sports after 6 weeks although twisting is likely to remain uncomfortable at that stage. It is likely to take up to 3 months to reach an endpoint in recovery. If you have any questions please talk to Mr Ellis after the operation.

ALTERNATIVE PROCEDURE: Usually an MRI scan will have been carried out and Mr Ellis will have discussed the results with you. This will however only aid diagnosis of a problem and not treat it. Physiotherapy may also be of great benefit and if so Mr Ellis would recommend this first..

The procedure may also be done purely as an open procedure (an arthrotomy). This involves making a larger cut (incision) and opening the knee joint. This is rarely done now because arthroscopy is so successful and has much fewer complications (in/ by comparison).

BENEFITS

Arthroscopy is generally a very successful produre at dealing with mechanical problems within the knee joint such as locking (where the knee suddenly gets stuck). In general terms the procedure will help knee pain and function and allow you to return to a higher level of activity

RISKS

As with all procedures, this carries some risks and complications.

COMMON (1-5%)

Swelling: The knee may fill with fluid or rarer, blood. This usually resolves on its own however may occasionally require a second operation or draining of the fluid.

Persistent pain: the symptoms may carry on despite the procedure. A repeat arthroscopy or other knee operation may be required.

RARE (<1%)

Infection: the wound sites may become red, painful and hot. There may also be a discharge of fluid. These are signs of infection and can usually be treated by antibiotics. Very rarely, the infection may spread to the knee joint itself (requiring a washout) and/or the blood (sepsis) requiring intravenous antibiotics.

Damage to structures within or around the knee: this is rare, but may cause further injury and

symptoms. This may need further treatment including operation.

Damaged instruments: these may break within the knee and require an opening of the joint to remove them.

Abnormal wound healing: the scar may become thick, red and painful (keloid scar). This is more common in Afro-Caribbeans and Asians. There may also be some oozing of clear fluid.

Numbness: the skin around the knee and shin may be temporarily or more permanently numb due to damage of small superficial nerves.

Blood clots: a DVT (deep vein thrombosis) is a blood clot in a vein. These may present as red, painful and swollen legs (usually). The risks of developing a DVT are greater after any surgery (and especially bone surgery). Although they are painful, a DVT can also pass in the blood stream and be deposited in the lungs (a pulmonary embolism –PE). This is a very serious condition which affects your breathing.