Osteoarthritis of the knee

Information for patients considering surgery

Osteoarthritis of the knee is common, affecting approximately 10% of the population. It is arthritis from wear and tear.

It can occur with no obvious cause but can be related to previous trauma often decades earlier and sometimes not memorable.

Treatment

Osteoarthritis of the knee is never life threatening. The main aim of treatment is therefore symptomatic for pain.

Treatment is usually a progression from simple measures to major surgical intervention. The inflammation and pain associated with arthritis commonly runs a fluctuating course and can settle despite a period of increased symptoms.

Simple measures

Exercise

Non-impact exercises to keep strength and tone in the thigh muscles. This will help to improve your feeling of stability and security, especially for stairs and hills. It does not fundamentally change the arthritis in your knee. A consultation with a physiotherapist for education and a home exercise program can be useful.

Footwear

Shock absorbing footwear and walking/exercising on soft surfaces such as grass rather than concrete can make a big difference. Air or gel trainers and sorbothane shoe inserts provide the ultimate cushioning and reduce jarring. These can be sourced in sports shops.

Walking stick

Using a walking stick in the same hand as the affected knee can increase your walking distance and decrease pain. A strong stick of correct length with a non slip rubber end is best.

Paracetamol

A simple but safe analgesic when used correctly. Often needs to be used 3 or 4 times a day (2 x 500mg tablets on each occasion). This can be safely used by most people at prolonged periods at these doses.

Natural Remedies

Often not proven but some people gain relief from various naturopathic potions, magnets, acupuncture and the like. This affect may be placebo but some plant substances have proven anti-inflammatory effects. You should check the use of these with your local Doctor as some may react with other medicines or be dangerous.

Fish Oils

Have been associated with some improvement in cartilage quality and may be beneficial.

Anti-inflammatories (NSAID's)

Several types of Non steroidal anti-inflammatories are available. They can be very effective in reducing pain and

swelling associated with Osteoarthritis. The most common effects are: exacerbating asthma, stomach upset (ulcers etc), increased blood pressure and ankle swelling.

Weight loss

There is no doubt that if you are above ideal weight, weight loss can have a significant impact in reducing pain from osteoarthritis. Weight loss can also reduce the risk of anaesthetic complications and wound healing. Many people after loosing weight no longer need surgery for their Osteoarthritis. You may be given an ideal weight to attain prior to consideration for surgery. Consulting your practice nurse may be beneficial.

Injections

Cortisone injections into the knee can be helpful for a couple of months but do not provide long term relief. They have some negative effects and cannot be used repetitively. They may be very helpful in specific circumstances such as to reduce fluid in the joint.

Before you consider surgery

- Ensure you have considered all simple methods to control your pain
- Remember surgery has significant risks attached
- Surgery can be painful
- Patients have to work hard with physiotherapy to achieve optimal results
- Smoking greatly increases the risk of complications during and after surgery. For support with stopping smoking contact your GP, pharmacist or the North Yorkshire Stop Smoking Service on 0845 8770025
- Not all patients are entirely satisfied with surgery

About surgery

Surgery is only considered when previous options have been exhausted.

Arthroscopy (key hole surgery)

Should only be considered in patients with symptoms of a cartilage (meniscal) tear. Arthroscopy has a limited effect if any on Osteoarthritis.

Osteotomy

This involves cutting the thigh bone (femur) or leg bone (tibia) and changing the alignment of your leg. It is most common in patients with arthritis at a younger age (less than 60 years). It has the advantage that there is no replacement in the knee joint to wear out or come loose and does not lead to restrictions in activity. An osteotomy is aimed to provide functional relief for 5-10 years at which time a knee replacement can be performed.

Uni-compartment or partial knee replacement

This is an artificial knee, replacing only the worn inner half of the knee. It is a smaller operation and maintains better bend than a full or total knee replacement but has all the other potential negatives associated with a full knee replacement. Statistically these knees are likely to fail earlier than full knee replacements.

Total Knee replacement

Involves resurfacing the knee with a metal and plastic artificial joint. It is excellent for relieving pain and stability within the knee. They rarely bend fully usually reaching

up to 120 degrees. Two percent of knee replacements fail within the first 10 years, some quite early with infection or other complications. The other 98% last between 10 and 20 years.

The wear and loosening rate increases with high levels of physical activity. When they fail a revision procedure or 'redo' operation can be performed to put in another knee but in general terms these are not as successful as first time replacements. This is why people are told they are too young for a knee replacement. Artificial joints are not suitable for impact or twisting sports such as tennis or running but golf, walking and swimming are encouraged.

In summary

Start with a regular exercise / walking program and good shoe wear. Take simple pain killers and by all means try 'natural remedies' if you wish. If and when 'something needs to be done' your GP can guide you through the options available.

If you would like this document in a different format, for example large print, audio CD or Braille, or in another language, please call 01423 859618