PRIMARY CARE CONFERENCE
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“I Don’t Want a Total Knee”

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LEARNING OBJECTIVES

- Understanding the natural history of osteoarthritis of the knee
- Recognizing the signs and symptoms of knee osteoarthritis
- Become familiar with the knee physical exam
- Learn what studies to order to help diagnose knee osteoarthritis
- Understanding the treatment algorithm for knee osteoarthritis

Knee Osteoarthritis

- 52 million Americans suffer from arthritis
- Most common joint disorder in the US
- Knee OA affects 37% of Americans >60 yo
  - 42% Females: 31% Males
- Estimated costs due to hospital expenditures of total knee replacements $28.5 billion (2009)
KNEE ARTHRITIS

• Arthritis is a degenerative joint disease
• Knee arthritis is one of the most common joints affected
• Results in destruction of cartilage progressing to bone on bone in moderate/severe disease

General Principles

• Knee is composed of three joint compartments
  – Medial, lateral and patellofemoral compartments
• Normal knee functions as a complex hinge allowing
  – Flexion, extension, rotation, and gliding
• Weight distribution across the knee with normal alignment
  – 60% through medial compartment
  – 40% through lateral compartment
Zones of Articular Cartilage

- **Superficial** (tangential or zone I)
  - Forms the gliding surface
  - Collagen fibers parallel to the articular surface

- **Middle** (transitional or zone II)
  - Thicker with oblique collagen fibers
  - Constitutes most of the cartilage depth

- **Deep** (radial or zone III)
  - Collagen fibers perpendicular to articular surface

- **Calcified cartilage** (zone IV)
  - Radially aligned collagen fibers

PATHOPHYSIOLOGY
(Degenerative Cascade)

- **Articular Cartilage**
  - Increase water content
  - Collagen orientation lost
  - Loss of chondrocytes

- **Synovium**
  - Inflammation (increased thickness & vascularity)
    - Type A (phagocytosis)
    - Type B (produce synovial fluid)
    - Type C (multi-potent precursor cells)
PATHOPHYSIOLOGY
(Degenerative Cascade)

- **Meniscus**
  - Increasing congruency
    - Increases contact area leads to decreased point loading
  - Shock-absorption
    - Meniscus is more elastic than articular cartilage, and therefore absorbs shock

- **Synovial fluid**
  - Decrease of hyaluronin and lubricin

In summary:
- Articular cartilage degeneration
- Meniscus degeneration
- Synovial inflammation
- Synovial fluid with diminished lubrication
- Kidney failure, Heart failure, why not Joint failure?
Presentation

• Patients c/o knee pain worse with walking up or down steps

• Patellofemoral articulation reaction force
  – 2-3x body weight while descending stairs

• Tibiofemoral articulation reaction force
  – 3x body weight with walking

Presentation

• Symptoms may wax & wane often in correlation with recent activities or body stressors (illness)

• Not uncommon for OA exacerbation to occur during hospital admission for unrelated event
  – Surgery, CHF, COPD, pneumonia, viral illness
Physical Examination

- Joint line tenderness to palpation
  - Degenerative compartment will often correlate to overall alignment
  - Varus deformity = medial joint space narrowing
  - Valgus deformity = lateral joint space narrowing
- Effusion
  - Persistent large/tense effusion may represent degenerative meniscus tear (without specific event)

Physical Examination

- McMurray’s test
  - Flex knee & place one hand on medial side of knee
  - Gently externally rotate leg & bring knee into extension
  - Palpable click is a positive test (medial meniscus tear)
- Lachman’s test
  - Most sensitive exam to detect ACL tear
Physical Examination

- Flexion contracture
  - Persistent synovitis and progressive immobility will lead to tight hamstrings
- Joint widening
  - Osteophyte formation is the body’s attempt to heal the progressive destruction of cartilage
- Crepitus
  - Patella should glide smoothly over femoral trochlea

Radiographs

- AP, lateral, and sunrise (merchant) view
  - Osteophyte formation
  - Sclerotic joint margins & subchondral cysts
  - Joint space narrowing
  - Loose bodies
Radiographs

- A clinical pearl is to always order weight bearing AP radiographs of the knee
- Following images is non weight bearing X-ray and weight bearing X-ray of the same knee

MRI

- MRI can be useful in the workup for osteoarthritis of the knee if a degenerative meniscus tear is suspected
### MRI

- Degenerative tears in older patients are most commonly found in the posterior horn of the medial meniscus.
- Correlation to physical exam findings and/or mechanical symptoms is critical to confirm diagnosis.

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### MRI

- MRI has been shown to find asymptomatic degenerative meniscus tears in over 60% of patients > 65 y.o.
- Diagnosis of symptomatic meniscus tear becomes difficult in the setting of concomitant OA.
- Articular cartilage destruction may be the root cause of the patients symptoms.
MRI

- Adjacent bone marrow lesions can be identified in osteoarthritis
- Representing bone marrow edema of subchondral bone
- BML: Bone marrow lesions

Common Clinical Situation in Knee

- X-ray does not match patient symptoms
- Chronic pain, gait abnormality, worsening QOL

- Clinical picture ≠ radiographic evaluation
  - patient 1: bone on bone but no pain
  - patient 2: preservation of joint space, severe pain
MRI Changes the Picture

- Bone damage not appreciated on radiographs
- As MRI technology improves - helps us better understand this scenario
- MRI demonstrates:
  - Soft tissue causes of pain (meniscal tear, synovitis, etc.)
  - The primary reported source of pain: *chronic* subchondral bone marrow lesions (BML)

Rothman/Cohen Retrospective Case Series

Retrospective Review of 1st 66 Consecutive Patients

General Study Protocol

**Patient profile**
- Chronic, aching pain (VAS ≥ 4/10)
- ↑ pain with load bearing
- Pain localized to compartment of subchondral bone defect
- **Failed conservative care**
- Typical candidate for knee replacement

**Clinical diagnosis of BML bone defect could be in combination with**
- Meniscal tear / extrusion
- Cartilage thinning / fraying / loss
- Mechanical symptoms / loose bodies

**Surgical care**
- 1 surgeon, 1 center
- SCP® procedure + arthroscopy

**Postop management**
- WBAT w/ crutches 1 wk
- PT started 10-14 d post
- Full activity 4-8 wk post

Cohen Clinical Series – Results

**Patients followed ≥ 2 years**
- Regular follow up visits
- Data points collected
  - VAS Pain
    - Change from baseline
    - Duration of change (years postop at final VAS)
  - IKDC
    - Change from baseline
    - Duration of change
  - Kaplan-Meier survivorship
    - Not converted to TKA/UKA
Conservative Treatment

- Ice application
  - 20 minutes on / 20 minutes off for 2 hours
  - May allow patients to continue exercise programs
- Ambulation aids
  - Use in opposite upper extremity
Conservative Treatment

• Weight Loss
  – Indications: symptomatic OA and BMI > 25
  – Improvement in joint pain and function
  – Reducing the risk of progression of OA
  – Each pound of weight loss results in a fourfold reduction in the load exerted on the knee per step during daily activities

Conservative Treatment

• Exercise / Physical therapy
  – First line treatment for all patients with symptomatic arthritis
  – Low impact aerobic exercise
    • Swimming
    • Bicycling
  – Improving flexibility and strengthening muscles improve functional outcome and pain scores
Conservative Treatment

• Exercise / Physical therapy
  – Quadriceps strengthening
    • Improve stability of joints and lessens pain
  – Hamstring stretching
    • Prevention of flexion contracture
  – Combination of supervised exercises and home program show the best results
  – Benefits often lost after 6 months if exercises are stopped

Conservative Treatment

• Viscosupplement intra-articular injections
  – Hyaluronic acid (HA) forms the backbone of aggrecans
  – The macromolecule that makes up cartilage matrix
  – HA at low load speeds acts as a lubricant and faster movements as a shock absorber
  – In OA the concentration of HA is reduced by half to one third of normal
Pharmacologic Treatment

- Acetaminophen at doses of up to 4 g per day have demonstrated to be superior to placebo in relief of pain resulting from OA
- Acetaminophen less effective than NSAIDs
- Tramadol
  - Strongly recommended by AAOS

Pharmacologic Treatment

- NSAIDS
  - First line treatment for all patients with symptomatic arthritis
  - Risk factors for adverse reaction
    - Age > 60
    - Multiple medical comorbidities
    - H/o PUD
    - H/o GI bleeding
    - Concurrent corticosteroid use
    - Anticoagulant use
Pharmacologic Treatment

• NSAIDS
  – Cox-2 inhibitors limit inflammation without interfering with normal production of protective prostaglandins and thromboxane
  • Decrease the potential gastric toxicity of NSAIDs
  – Cox-2 inhibitors along with all NSAIDs may cause cardiovascular and renal side effects to varying degrees

Conservative Treatment

• Unloader brace
  – Used less frequently
  – Designed to reduce reactive forces in involved compartment
  – Provides 3 point bending force
  – $ 800-1000
Orthotics

- Padded shoe inserts
  - Decrease in joint impact forces to joints
  - $8-22

- Varus knee deformity
  - Lateral heel wedges

Hyaluronic Acid vs Corticosteroid Injections

- Meta-analysis, Randomized trial
- Reported effects of intra-articular hyaluronic acid vs corticosteroids on knee osteoarthritis
- 7 eligible trials included 606 patients
- 0 – 4 weeks:
  - Intraarticular corticosteroids appear to be more effective for pain than intraarticular hyaluronic acid
- 4 – 8 weeks:
  - The 2 approaches have equal efficacy
- > 8 weeks:
  - Hyaluronic acid has greater efficacy
Conservative Treatment

- Intra-articular corticosteroid injection
  - Limits inflammation of the joint
  - Injections given typically no closer than Q3 months
  - Useful in controlling acute exacerbation of OA
  - Often injection given in combination with Lidocaine

Microsphere Technology: Background

Pain relief associated with IA corticosteroid administration to patients with knee osteoarthritis (OA):

- Can diminish within 1-6 weeks following injection1-4
- Is transient due to efflux of drug from the joint within hours of injection5

TA-ER is an extended-release formulation of the corticosteroid TA6-7

- Small crystals of TA are embedded in a PLGA co-polymer matrix
- Designed with the goal to extend TA joint residency time and reduce systemic exposure to TA following IA injection

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TA-ER Microsphere Characteristics

TA-ER is prepared as an injectable suspension of ~45 μm microspheres¹

- **Active Ingredient:** TA
  - FDA-approved for use via multiple routes of administration (including IA)²
  - FDA-approved for several diseases/conditions (including OA)²
  - One of the most prescribed IA corticosteroids³
- **Microsphere Scaffold:** PLGA⁴
  - Biodegradable polymer
  - Used in several FDA-approved extended-release therapeutics (>20-year history)

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TA-ER Microsphere Function

PLGA microsphere technology allows for extended-release of TA¹

- **Initial TA release:** TA crystals near the surface of the microsphere dissolve upon contact with synovial fluid
- **Extended TA release:** TA crystals that are more deeply embedded within the microsphere are slower to dissolve
  - Small pores on the surface of the microsphere are created by the dissolving TA crystals
  - ~500 nm channels appear throughout the microsphere; enable TA release from the interior through the surface pores
  - PLGA eventually degrades into lactic acid and glycolic acid, which ultimately metabolize into CO₂ and H₂O

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¹ Data on File. Flexion Therapeutics, Inc.
³ Data on File. Flexion Therapeutics, Inc.
⁴ Makadia HK and Siegel SJ. Polymers. 2011;3(3);1377.
Patients with knee OA received a single IA injection; synovial fluid TA concentrations were measured¹:

- **TA-ER 32 mg**: most patients had quantifiable TA through Week 12
  - Week 1: 231,328.9 pg/mL
  - Week 6: 3590.0 pg/mL
  - Week 12: 290.6 pg/mL

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TA-ER Microsphere Characteristics in a Pharmacokinetic Study: Plasma TA Concentrations

Patients with knee OA received a single IA injection; blood plasma TA concentrations were measured¹:

- **TA-ER 32 mg**: plasma TA
  - Gradually increased to peak (836.4 pg/mL) over 24 hours
  - Slowly declined to <110 pg/mL over Weeks 12-20

- **TAcs 40 mg**: plasma TA
  - Peaked at 4 hours (9,628.8 pg/mL)
  - Decreased to 4,991.1 pg/mL at 24 hours
  - Was 149.4 pg/mL at Week 6*

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Please see Important Safety Information on slides 21 and 22 and full Prescribing Information available at Zilettalabel.com.
Patients with knee OA and T2DM received a single IA injection; blood glucose levels were measured.

• Change CGM\textsubscript{days1–3} was significantly lower following TA-ER vs TA\textsubscript{cs}:
  
  * 14.7 vs 33.9 mg/dL - LSM-difference [95% CI] = –19.2 [–38.0, –0.4] P=0.0452

TA-ER: Phase 3 Pivotal Trial

\textit{ADP Intensity}

• Primary endpoint met: TA-ER pain relief vs saline-placebo at Week 12
  
  * LSM difference [95% CI]: -0.98 [-1.47, -0.49]; P<0.0001

• Key secondary endpoint not met: TA-ER pain relief vs TA\textsubscript{cs} at Week 12
  
  * LSM difference: -0.26; P=-0.2964

• Exploratory endpoints: TA-ER pain relief vs saline-placebo and TA\textsubscript{cs} at each week
  
  * Favored TA-ER vs saline-placebo at each week through Week 16
  
  * Favored TA-ER vs TA\textsubscript{cs} at each week from Week 2-12 (not statistically significant)

Please see Important Safety Information on slides 21 and 22 and full Prescribing Information available at Zilrettalabel.com.
**TA-ER: Phase 3 Pivotal Trial**

**Exploratory endpoints: WOMAC**

- **WOMAC-A (Pain)**
- **WOMAC-B (Stiffness)**
- **WOMAC-C (Function)**

| LSM, least squares mean; SE, standard error; TAcs, triamcinolone acetonide crystalline suspension; TA-ER, triamcinolone acetonide extended-release injectable suspension; WOMAC, Western Ontario and McMaster Universities Osteoarthritis Index. |


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**TA-ER: Phase 3 Pivotal Trial**

**Exploratory endpoints: KOOS QoL Subscale**

<table>
<thead>
<tr>
<th>LS Mean AASB Change from Baseline, KOOS QoL</th>
<th>Weeks Post Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>TA-ER (N = 136)</td>
<td>Saline-placebo (N = 144)</td>
</tr>
<tr>
<td>TAc (N = 134)</td>
<td></td>
</tr>
</tbody>
</table>

| KOOS QoL, Knee Injury and Osteoarthritis Outcome Score: Quality of Life; LSM, least squares mean; SE, standard error; TAcs, triamcinolone acetonide crystalline suspension; TA-ER, triamcinolone acetonide extended-release injectable suspension. |

Arthroscopy

• Debridement
  – Synovectomy (plica removal)
  – Removal of loose bodies
  – Chondroplasty
  – Resection of torn/damaged meniscus

Arthroscopy

• Direct Visualization of articular cartilage

| Outerbridge Arthroscopic Grading System |
|-------------------------------|------------------|
| Grade 0 | Normal cartilage   |
| Grade I | Softening and swelling |
| Grade II | Partial thickness defect, fissures < 1.5cm diameter |
| Grade III | Fissures down to subchondral bone, diameter > 1.5cm |
| Grade IV | Exposed subchondral bone |
Evidence Based Medicine for Arthroscopic Debridement of Knee Osteoarthritis

- 180 patients with knee OA who received arthroscopic débridement, arthroscopic lavage, or placebo surgery (skin incisions)
- Outcomes were assessed at multiple points over a 24-month period
  - Use of 5 self-reported scores for pain, function, walking, and stair climbing
- The outcomes after arthroscopic lavage or arthroscopic debridement were no better than those after a placebo procedure

Arthroscopy

- Partial meniscectomy
  - >80% satisfactory function at minimum follow-up
  - Predictors of success
    - Age <40yo
    - Normal alignment
    - Minimal or no arthritis
    - Single tear
Arthroscopy

- **Total meniscectomy**
  - 70% have arthritic X-ray changes 3 years after surgery
  - 100% have arthrosis at 20 years
  - Severity of degenerative changes is proportional to percent of the meniscus removed

Unicompartmental Knee Arthroplasty

- **Indications**
  - Isolated unicompartmental noninflammatory arthritis
  - Deformity of less than 10 degrees
  - Intact anterior cruciate ligament (ACL)
  - Little or no joint subluxation
  - Little or no patellofemoral disease
  - Weight < 90 kg
Unicompartmental Knee Arthroplasty

- Data suggests that only 6% of patients meet the criteria for whom knee arthroplasty is indicated
- Indications for this procedure have been expanded for younger patients
- 10 year survival rates range from 87 to 96%
- 15 year survival rates range from 79 to 90%
  - Survivorship declines rapidly in the second decade
- Late failure
  - Opposite compartment degeneration
  - Component loosening
  - Polyethylene wear

### Table 1

<table>
<thead>
<tr>
<th>Therapeutic Modality</th>
<th>AAOS Position</th>
<th>Strength of Supporting Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening exercises with neuromuscular education</td>
<td>Recommend</td>
<td>Strong</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>Recommend</td>
<td>Strong</td>
</tr>
<tr>
<td>Total knee arthroplasty</td>
<td>Recommend</td>
<td>Strong</td>
</tr>
<tr>
<td>Appropriate weight loss (body mass index &gt;25 kg/m²)</td>
<td>Recommend</td>
<td>Moderate</td>
</tr>
<tr>
<td>Vagal-producing proximal tibial osteotomy</td>
<td>Might recommend</td>
<td>Limited</td>
</tr>
<tr>
<td>Intra-articular corticosteroids</td>
<td>Cannot recommend for or against</td>
<td>Inconclusive</td>
</tr>
<tr>
<td>Acetaminophen (oral) or opioids (oral or transdermal patch)</td>
<td>Cannot recommend for or against</td>
<td>Inconclusive</td>
</tr>
<tr>
<td>Manual therapy</td>
<td>Cannot recommend for or against</td>
<td>Inconclusive</td>
</tr>
<tr>
<td>Physical agents, including electrotherapeutic modalities</td>
<td>Cannot recommend for or against</td>
<td>Inconclusive</td>
</tr>
<tr>
<td>Arthroscopic partial meniscectomy</td>
<td>Cannot recommend for or against</td>
<td>Inconclusive</td>
</tr>
<tr>
<td>Intra-articular hyaluronic acid</td>
<td>Cannot recommend</td>
<td>Strong</td>
</tr>
<tr>
<td>Braces (to unload medial compartment)</td>
<td>Cannot recommend</td>
<td>Strong</td>
</tr>
<tr>
<td>Arthroscopic intervention (eg. lavage, débridement)</td>
<td>Cannot recommend</td>
<td>Strong</td>
</tr>
<tr>
<td>Osteotomy and chondroplasty</td>
<td>Cannot recommend</td>
<td>Strong</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Cannot recommend</td>
<td>Strong</td>
</tr>
<tr>
<td>Insettes (eg. lateral wedge)</td>
<td>Cannot recommend</td>
<td>Moderate</td>
</tr>
<tr>
<td>Needle lavage</td>
<td>Cannot recommend</td>
<td>Moderate</td>
</tr>
<tr>
<td>Bone/soft tissue interpositional device</td>
<td>Cannot recommend</td>
<td>Consensus (no reliable evidence)</td>
</tr>
</tbody>
</table>
What treatment options exist?

- Activity Modification
- Weight loss
- Self-help/assistive devices
- Heat and Cold Treatments
- Physiotherapy
- Over-The-Counter Medications
- Prescription Medications
- Injections

Joint replacement is the final option, once all conservative methods of treatment have been tried.

When is someone a suitable candidate for an Oxford?

- 48 out of 100 patients have been shown to be a candidate for an Oxford Partial Knee\(^2\)
Oxford Microplasty Instrumentation

Phase 1
1976 - 1987
- Difficult to balance due to femoral prep
- A lot of eyeballing

Phase 2
1988 - 1997
- Introduction of milling
- Improving reproducibility

Phase 3
1998 - 2011
- Improving milling technique
- Continued focus on reproducibility

Microplasty
2011 - current
- Focus on reproducibility

Tibial Preparation

- More reproducible tibial resection using²
  - Sizing Spoons – reference intact cartilage
  - G-Clamp
  - Removable Shims

² Hurst, et al. 2014 (JOA)
Globally Published Oxford Partial Knee Survivorship

Non-designer results

<table>
<thead>
<tr>
<th>Author</th>
<th>Year Published</th>
<th>Cohort</th>
<th>Follow-Up</th>
<th>Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Svard⁶</td>
<td>2001</td>
<td>124</td>
<td>10-year</td>
<td>95%</td>
</tr>
<tr>
<td>Rajasekhar⁷</td>
<td>2004</td>
<td>135</td>
<td>10-year</td>
<td>94%</td>
</tr>
<tr>
<td>Yoshida⁸</td>
<td>2013</td>
<td>1279</td>
<td>10-year</td>
<td>95%</td>
</tr>
<tr>
<td>Jones⁹</td>
<td>2012</td>
<td>1000</td>
<td>10-year</td>
<td>91%</td>
</tr>
<tr>
<td>Lim¹⁰</td>
<td>2012</td>
<td>400</td>
<td>10-year</td>
<td>94%</td>
</tr>
<tr>
<td>Faour-Martin¹¹</td>
<td>2013</td>
<td>416</td>
<td>10-year</td>
<td>95%</td>
</tr>
<tr>
<td>Price¹²</td>
<td>2011</td>
<td>682</td>
<td>20-year</td>
<td>91%</td>
</tr>
</tbody>
</table>

• Traditionally focus has been on
  – Survivorship
  – Functional Scores
  – Pain Relief

• Still important, but shifting towards
  – Patient Satisfaction
  – Activities of Daily Living
  – Happiness with Joint Replacement
Closing the Revision Gap
PKA Candidacy

- Kozinn & Scott (1989) indications\(^\text{24}\) → 5% of patients are PKA candidates\(^\text{25}\)
- Globally only 8% of Primary Knee Arthroplasty is a PKA\(^\text{26,27}\)

- 2015 publication Scott\(^\text{28}\) revisits 1989 publication, and removes the following contraindications
  - Obesity
  - Age
  - PFJ damage limited to the medial facet
  - Chondrocalcinosis

- Study of 200 knees found 47.6% are PKA candidates\(^\text{30}\)

- Anteromedial Osteoarthritis
  - Bone-on-bone in the medial compartment
  - Full thickness cartilage in the lateral compartment
  - Functionally intact ACL
  - Functionally normal MCL

Oxford Radiographic Decision Aid

- Helps surgeons identify whether or not a patient is a candidate for an Oxford Partial Knee

  - Blinded to final device, found w/ pre-op x-rays, 92% sensitivity in predicting suitability for Oxford PKR
  - In patients meeting Decision Aid criteria and receiving PKR, 99% survivorship @ 5 years

- Available via Zimmer Biomet
  - Printed and Digital
  - X-Ray Protocol also available
  - Provides an overview of how to perform the required x-rays

26. EU Millenium 2013
27. US Millenium 2014
28. Berend, et al. 2015 (JSOA)
30. Willis-Owen, et al. 2009 (Knee)
**Benefits of PKA compared to TKA**

**Benefits**
- Better range of motion\(^{32-34}\)
- Preserving more healthy bone than TKA\(^{34}\)
- More physiological functionality\(^{34}\) and near normal gait\(^{32}\) than TKA
- Faster return to a more functional level and shorter hospital stay than TKA\(^{32}\)
- Fewer and less severe postoperative complications including less morbidity compared with TKA\(^{36,37}\)

**And for society...**
- Substantial cost savings over TKA\(^{32}\) ($3,261 per knee)
- Registry data reports that TKAs are 2.6 times more likely to have risk of reoperation for infection\(^{37}\)
- Average reduction in length of stay, at least 0.8 days in favour of PKA (variation between 0.8 – 4 days)\(^{36-41}\)
- Additional cost savings when associated with an accelerated recovery protocol\(^{42}\)

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\(^{32}\) Willis-Owen, et al. 2009 (Knee)
\(^{33}\) Amin, et al. (2006)
\(^{34}\) Deshmukh, et al. (2001)
\(^{35}\) Wiik, et al. (2013)
\(^{36}\) Brown, et al. (2012)
\(^{37}\) Robertsson, et al. 1999 (AOS)
\(^{38}\) Shakespeare, et al. 2003 (Knee)
\(^{39}\) Yang, et al. 2003 (SMJ)
\(^{40}\) Xie, et al. 2009 (EJHE)
\(^{41}\) Koskinen, et al. 2008 (AO)
\(^{42}\) Reilly, et al. 2005 (Knee)

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**Lifetime Warranty**

- Every Oxford Partial Knee implanted on or after April 29, 2013 is covered under the only Lifetime Knee Implant Replacement Warranty in the US*.

- If a patient receives an Oxford Partial Knee, and it has to be revised for any reason, Zimmer Biomet will cover the cost of the Zimmer Biomet replacement knee implant.

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*Subject to terms and conditions within the written warranty.

- Applies to Oxford Partial Knees implanted on or after 4-29-2013
- Covers the replacement of Oxford Partial Knee components for any reason, to any extent.
- Covers the cost of the replacement implant only; does not cover hospital costs, co-pays, or other related expenses.
- Limited to no more than one complete replacement of the product.
- Any additional costs associated with surgery or follow-up are not covered – only the implant components.
DO NOT TOUCH MI-EYE!!

Associated Clinical Laboratories

THE END
References


Question 1

Which of the following non-operative treatments for osteoarthritis has the best evidence to support its use?

• 1. Combination of supervised and home exercise programs
• 2. Hyaluronic acid injections
• 3. Lateral heel wedge
• 4. Acetaminophen
• 5. Glucosamine
Question 2

A 62-year-old female undergoes an uncomplicated primary total knee replacement. Her knee range-of-motion pre-operatively was 0-135 degrees of flexion. Which of the following is true regarding the immediate post-operative use of a continuous passive motion machine in this patient?

- 1. Reduced risk of venous thromboembolism
- 2. No long-term difference in ROM compared to patients not using CPM
- 3. Increased passive knee flexion at 6 months
- 4. Increased length of hospitalization
- 5. Decreased risk of surgical site infection
Question 3

The following are risk factors for developing knee osteoarthritis EXCEPT:

• 1. Knee articular trauma
• 2. Metabolic syndrome
• 3. Female gender
• 4. Increased age
• 5. Participating in physical fitness
Question 4

• All the following are common complaints associated with knee osteoarthritis EXCEPT?

• 1. Knee pain at night
• 2. Knee pain while climbing stairs
• 3. Knee stiffness
• 4. Instability, clicking, or locking sensation
• 5. Numbness in the ankle or foot
Question 5

Which radiographic images are most commonly used to identify the degree of degenerative joint disease caused by knee osteoarthritis?

1. Knee MRI to identify meniscal pathology
2. Knee CT scan
3. X-ray images of knee with patient lying down
4. Ultrasound images of the knee joint
5. X-rays: Standing AP, lateral, and sunrise views of the knee