Connecticut Orthopaedics

Osteoarthritis

My knee is killing me but I don't want surgery what can I do?

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The bottom line is that osteoarthritis of the knee is not an acute problem and there is no "urgent" or "emergency" surgery needed to treat knee arthritis. Degenerative disease of the knee can be painful, debilitating and certainly affect patient quality of life; but, as I tell my patients, "arthritis is not a blocked heart artery, it's not cancer, and it not going to kill them." Total knee replacement surgery can wait as long as they can, and the symptomatic patient determines if and when knee replacement is right for them.

Patients delay knee arthroplasty for various reasons. Poor medical health, pre-existing commitments and fear of surgery are common reasons to postpone knee replacement. In the meantime, there are ways to temporarily avoid the likely inevitable knee replacement in patients with symptomatic degenerative joint disease who are otherwise unable to or unwilling to undergo this definitive and highly successful procedure. The symptomatic DJD (degenerative joint disease) patient should understand, however, these treatments are not going to "cure" the underlying problem, the loss of cartilage from their arthritis. Once the cartilage is worn away in their knee as a result of degenerative joint disease, there is no way to get it back. Smaller lesions typically from trauma or localized cartilage injury may be treated with cartilage transplant or synthetic cartilage grafting. However, in the arthritic joint, these are not viable options at this time.

Patients should be informed that these alternative treatments act as temporary measures to relieve the discomfort through various methods but are only "band-aids" and by no means are they going to guarantee long-term relief, nor will they "grow" the protective cartilage back. In fact, as time goes on, despite attempts at conservative measures, the clinical and radiographic signs of arthritis will likely worsen over time. Pain relief may improve in the early stages of conservative treatment, but will last variable amounts of time and, if enough time goes by, the arthritis will usually win out in the end. Conservative measures that may be initiated by the patient include activity modification to avoid painful activities (squatting, stairs, etc.), the use of ambulatory aids like a cane or walker and weight loss if they are overweight.

The use of NSAIDS on a regular basis rather than intermittent use for several weeks should be attempted early in the treatment. Shoe inserts such as medial or lateral heel wedges or an off loader heel brace can be effective in transferring weight away from the more severely arthritic knee joint surfaces (medial/lateral) and placing more on the side with more undamaged and

intact cartilage. OTC Glucosamine / Chondroitin tablets can be used with variable results. Finally, injections can be used and are particularly helpful in the more acute arthritic knee pain setting. Corticosteroid injections (2cc /4cc /4cc, kenalog /marcaine/ lidocaine) can be performed.

As a personal observation, initially these injections work well but as the number of injections increases, each one seems to last less time. In addition, the relief that they obtain from the anesthetics in the corticosteroid injection is likely the type of relief rhat they will experience after TKA (Total Knee Arthroplasty). Viscosupplementation injections (Synvisc, Hyalgan, Supartz, etc.) are also available and are usually performed after attempts at corticosteroid have failed. Typically, the less disease (i.e. more cartilage) in the knee, the better they work.

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