

Internal Fixation of Unstable Cahill Type-2C Osteochondritis Dissecans Lesions of the Knee in Adolescent Patients

ANDREAS H. GOMOLL, MD; KYLE R. FLIK, MD; JENNIFER K. HAYDEN, MSN; BRIAN J. COLE, MD, MBA; CHARLES A. BUSH-JOSEPH, MD; BERNARD R. BACH, JR, MD

abstract

The treatment of osteochondritis dissecans lesions remains controversial. Twelve adolescent patients, with average 6-year follow-up, underwent compression screw fixation of unstable Cahill Type-2C osteochondritis dissecans lesions. Postoperatively, patients were evaluated with several functional tests and scoring systems, including Lysholm, IKDC, and KOOS. All lesions healed, and no clinical or radiographic evidence of degenerative disease was noted. No significant differences in thigh girth, range of motion, stability, or single-leg-hop distance was observed when compared to the unaffected, contralateral extremity. This technique is appropriate and efficacious for the treatment of unstable osteochondritis dissecans lesions.

The specific pathophysiology of osteochondritis dissecans remains controversial. Originally thought to be an inflammatory phenomenon, various investigations point to vascular insufficiency,¹ repetitive microtrauma,² and genetic factors³ as playing a role in the etiology of this disease. Prognosis and treatment recommendations are primarily determined by the patient's bone age, and secondarily by characteristics of the lesion (ie, location, fragmentation, and stability).⁴ Osteochondritis dissecans lesions of the knee have an estimated incidence between 0.02% and 1.2%,^{5,6} are more common in boys than girls by a factor of 2, and typically manifest between ages 10 and 15 years. Both knees

should be routinely imaged as bilateral presentation occurs in 15%-30% of cases.⁷

A large, controlled trial has not been conducted to investigate different treatment modalities for osteochondritis dissecans lesions. Therefore, treatment recommendations often are based on smaller case series and personal experiences of treating physicians. However, a consensus exists that nondisplaced, smaller lesions (<2 cm), in the classic location on the lateral aspect of the medial femoral condyle have a better prognosis—especially in children with open growth plates.⁷ Conversely, unstable or displaced lesions after physeal closure have little potential for healing and should therefore be treated surgically, preferably by fixation

of the fragment in its original bed.⁸ Several authors have reported on their experience with compression screw fixation of unstable osteochondritis dissecans lesions.⁹⁻¹¹ These reports mostly consisted of small case series with comparatively short follow-up, but reported >80% good and excellent results with this technique.

This article presents a case series of 12 adolescent patients who were treated with internal fixation of unstable osteochondritis dissecans lesions of the knee. Patients were observed with clinical and radiographic examination for ≥ 2 years.

MATERIALS AND METHODS

Through a retrospective, IRB-approved

Dr Gomoll is from the Department of Orthopedic Surgery, Brigham and Women's Hospital, Boston, Mass; Dr Flik is from the Department of Sports Medicine, Northeast Orthopaedics, LLP, Albany, NY; Ms Hayden and Drs Cole, Bush-Joseph, and Bach are from the Division of Sports Medicine, Department of Orthopedic Surgery, Rush University Medical Center, Chicago, Ill.

Correspondence should be addressed to: Bernard R. Bach, Jr, MD, Division of Sports Medicine, Dept of Orthopedic Surgery, Rush University Medical Center, 1725 W Harrison St, Ste 1063, Chicago, IL 60612.

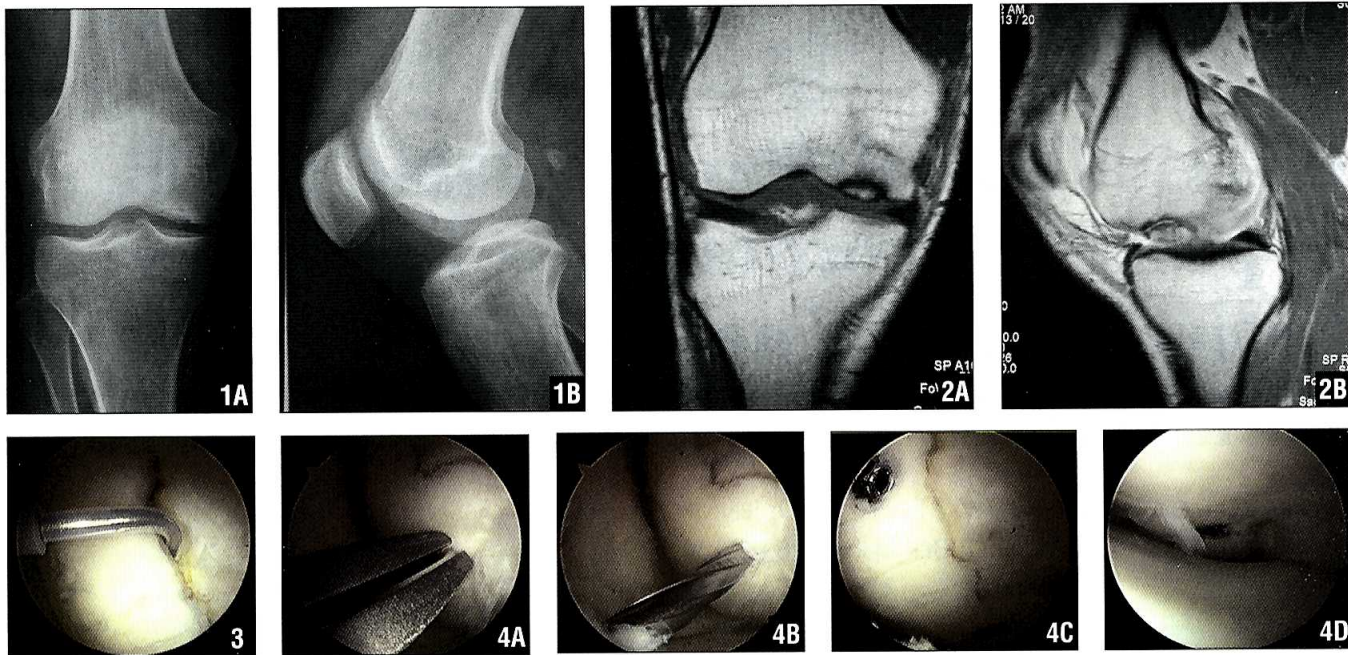


Figure 1: AP (A) and lateral (B) radiographs of an osteochondritis dissecans lesion in the medial femoral condyle. **Figure 2:** Coronal (A) and sagittal (B) MRI cuts depicting an osteochondritis dissecans lesion in the femoral condyle. Note the sclerotic appearance of the defect bed, and presence of a bright fluid signal behind the fragment. **Figure 3:** The fragment is carefully mobilized, often requiring a release of superficial fibers of the PCL. **Figure 4:** Compression screw fixation. A guide wire is drilled through the fragment into the femoral condyle (A), the guide wire is overdrilled (B), the screw is placed, compressing the fragment into the bed (C), and at the end of the procedure, the knee is taken through a range of motion to ensure that the screw head is seated under the articular surface and does not abrade against the opposing surface (D).

review of the surgical logs of three senior surgeons at our institution (B.R.B., C.A.B.-J., B.J.C.) from 1990 to 2002, 22 adolescent patients were identified as meeting the following inclusion criteria: unstable osteochondritis dissecans lesion; classic location; treated with internal fixation; minimum 2-year follow-up. Although patients were identified retrospectively, data collection had been performed in a prospective manner with regular radiographic and functional evaluation. Of 22 patients, 9 patients were lost to follow-up, and 1 patient was unwilling to return for a follow-up examination, leaving 12 patients for inclusion into the study. These patients were evaluated by a single surgeon (K.F.) who was uninvolved in the patients' prior surgical care in an attempt to minimize surgeon bias.

All patients had undergone preoperative evaluation with conventional radiographs (Figure 1) as well as magnetic resonance imaging (MRI) to classify the lesion (Figure

2). Based on the system described by Cahill and Berg,¹² all defects were described as 2C lesions located in the classic, eccentric position in the lateral aspect of the medial femoral condyle. Magnetic resonance imaging demonstrated a high signal consistent with fluid behind the fragment (Figure 2B)—a finding characteristic of unstable osteochondritis dissecans lesions. However, lesions were not displaced out of their bed.

Patients presenting to our facility with a symptomatic, nondisplaced osteochondritis dissecans lesion undergo an initial nonoperative treatment course aimed at decreasing joint inflammation and achieving union of the lesion. The program consists of short-term immobilization, followed by a period of ≥ 6 weeks of nonweight bearing. Subsequently, patients are asked to modify their activities to avoid impact-loading of the lesion. Persistent pain for > 3 -5 months and apparent nonunion on radiographs and/or MRI are indications for surgical fixation. All patients in this study participated in this pro-

cedure, and elected for surgical intervention due to failure of conservative management. One patient with a concomitant anterior cruciate ligament tear was treated acutely.

No patients had undergone prior surgical procedures for this, or any other pathologic entity of the ipsilateral knee.

All patients underwent arthroscopic or mini-open internal fixation of the osteochondritis dissecans lesion with a compression screw. Initially, the lesions were localized through a standard diagnostic arthroscopy of all three knee compartments. If found to be not amenable to arthroscopic fixation, a mini-arthrotomy was performed to expose the defect. The lesions then were opened to expose the often sclerotic bed. This was performed by superficially releasing fibers of the posterior cruciate ligament insertion to expose the lateral margin of the lesion (Figure 3) that then was hinged open slightly on a medial cartilage bridge. Thereafter, the bony bed was prepared with a curette and microfracture awl as needed to re-

move or perforate the sclerotic surface. The lesion was reduced back into its bed, and fixated either with one or two conventional 3.5-mm AO compression screws, or standard Acutrak headless screws (Acumed, Beaverton, Ore), based on surgeon preference (Figure 4).

Patients were kept nonweight bearing on crutches for 6-8 weeks. Physical therapy with range of motion (ROM) exercises as tolerated and straight-leg-raising-quad-strengthening was instituted on postoperative day 1. Patients returned for follow-up after 7-10 days for suture removal. Radiographs were obtained at this visit (Figure 5), as well as after 6 weeks. Based on surgeon preference, screws were removed between 8 and 10 weeks, either arthroscopically or through a mini-arthrotomy. Postoperatively, patients were rapidly advanced to full-weight bearing, but were restricted from impact activities for 4 to 5 months. They were observed clinically and radiographically every 3 months for 1 year.

ASSESSMENT

At follow-up, patients were assessed with several well-established and validated scoring systems. In addition, the following parameters were recorded in both legs: thigh girth, alignment, knee ROM, presence of effusion, and single-leg-hop distance. Standard anteroposterior, flexion posteroanterior, and flexion lateral weight-bearing radiographs were obtained at final follow-up (Figure 6).

Findings in the operated extremity were compared to the uninvolved, contralateral extremity using Student's *t* test. The level of significance was set at 0.05.

RESULTS

Twelve patients (10 males and 2 females) were evaluated at an average of 6 years (range: 24-184 months) after surgical fixation of an unstable osteochondritis dissecans lesion. Average patient age at the time of surgery was 16 years (range: 12-19 years) (Table 1). At the time of secondlook arthroscopy for hardware removal, all le-

Table 1

Epidemiologic Characteristics of Study Population	
Gender	10 males, 2 females
Average age (y)	16 (range: 12-19)
Affected side	8 left, 4 right knees
Average lesion size (cm ²)	4.85 (range: 1.8-7.5)
Fixation technique	Acutrak screw (8); 3.5-mm AO screw(4)
Average time from symptoms to surgical fixation (mo)	17 (range: 0.5-84)
Average follow-up (mo)	72 (range: 24-184)

Table 2

Results				
Scoring System	Average	Standard Deviation	Minimum	Maximum
Noyes Activity Scale	86.7	14.9	55	100
Tegner Activity Score	8.2	2.1	4	10
Lysholm	82.1	17.9	46	100
IKDC	82.8	15.3	58	100
KOOS				
Pain	89.9	10.4	75	100
Symptoms	87.5	10.7	71	100
ADL	96.8	3.7	88	100
Sports participation	80.4	16.2	50	100
QoL	79.7	17.1	50	100
SF-12				
PCS	44.7	2.6	41	50
MCS	55.5	6.1	46	62

Abbreviations: ADL=activities of daily living, IKDC=International Knee Documentation Committee, KOOS=Knee and Osteoarthritis Outcome Score, MCS=mental component score, PCS=physical component score, and QoL=quality of life.

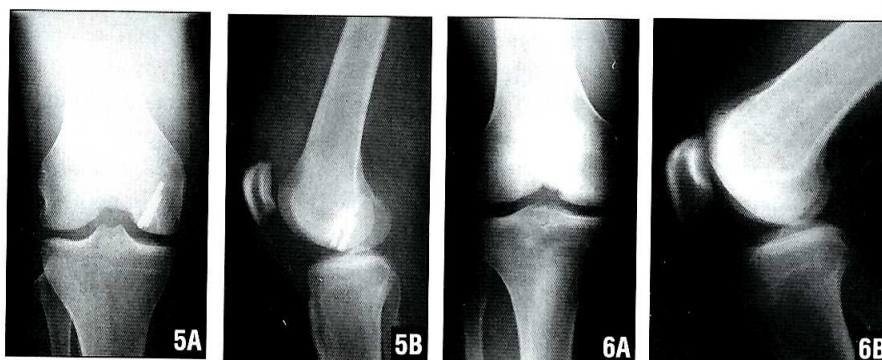


Figure 5: Postoperative AP (A) and lateral (B) radiographs showing fragment fixation with two compressive screws. **Figure 6:** AP (A) and lateral (B) radiographs 6 years after osteochondritis dissecans fixation and subsequent screw removal showing a well-healed lesion and no degenerative changes.

