**Before the Blade**

**Meniscus Injury Recovery- Do you really need surgery?**

**Non-Surgical Options That Work**

It’s funny how dramatically things can change in a short time during your career. I used to have patients pinpoint their pain by stating, “Use one finger to point to where your pain is.” Understandably, patients had a very hard time with this. Pain changes and is not just in one spot. I did this to see if their pain corresponded to the abnormality seen on MRI. Now I know that abnormal MRI findings don’t always indicate the source of pain. This has been confirmed in research studies. There is not a good correlation between the level of “severity” on an X-Ray or MRI and the level of pain someone experiences or vice versa. This is not to say imaging is not important. Imaging such as X-ray, CT, MRI, and diagnostic US are very useful tools, but they are just that, tools. Imaging should be used to help guide a treatment plan for the individual patient.

I have figured out that you need to have patients use their hands to show you where their pain is and listen. As I have changed my approach, I’ve noticed how many patients have become just as fixated on their MRI as the physicians have. A good example of this is a recent patient of mine, a 58-year-old male with right knee pain. I asked, “Tell me about your pain?” Patient “Well, my MRI says I have a meniscus tear.” Me: “I see that, but tell me about your pain?” Patient: “My XR showed some arthritis, but the MRI said I have another meniscus tear.” Unfortunately, we have treated patients so long based on imaging findings they have come to think the same. Imaging is a tool, part of our assessment, but treatments should not be the basis for this. “Treat the patient, not the image.” This was drilled into us during medical school unfortunately in a busy practice, with EMR requirements, time constraints, etc it has been pushed to the side.

When I was finally able to get this patient to tell me his story, we were able to sort through the source of pain. He did manual labor and spent much of his day kneeling, going up and down ladders, and carrying heavy things. When his knee pain started about 10 years ago, he had an MRI that showed a meniscus tear. He tried over the counter medications and a cortisone injection. When this did not allow him to continue working, he had surgery to fix it. He felt good for about a year, and the pain gradually worsened since that time. When I asked him what his understanding of the surgery was, he stated, “They fixed it. I think that means they cut out the part causing me pain.” Unfortunately, like many others, the fix was cutting out something that is vital to the function of our knee and lower legs. The meniscus are C-shaped cartilage rings inside the knee. Each knee has two menisci, medial and lateral. The menisci are shock absorbers and help the knee to move smoothly. When a part is cut out, even a small part, this dramatically changes how the knee functions, the alignment, and dynamic of that knee joint and surrounding structures. This progression of degeneration, pain, and dysfunction that occurs after is related to how the rest of the knee, and eventually the body responds to compensate. A study showed that 80% of those who had a meniscectomy had worsening arthritis of that knee one year later.

This patient, his pain was worse some days, better others. He could not pinpoint what made his pain better or worse. He also could not localize his pain. At times it felt like his whole knee, other times pain was in his thigh and sometimes the knee felt unstable. When asked, he noted intermittent back pain.

After a thorough exam and review of his imaging, we discussed he did have a meniscus tear on MRI and arthritis. The meniscus tear is degenerative, meaning it was not an acute injury and has worn away with time contributing to further cartilage loss. Osteoarthritis is a degenerative condition where cartilage is worn away. In addition, inflammation in the joint creates an unhealthy environment. Over time this can lead to breakdown of the surrounding stabilizing structures such as ligament and tendons. Nerves can be irritated and cause further pain and dysfunction.

The thigh pain he sometimes had was related to irritated nerves in his back. The instability was due to the loss of strength in his leg. Even though he did a physical labor job, he still had smaller muscles of his right leg, ie: atrophy, compared to the left. This is a combination of the back nerves being irritated, compensation for pain in the knee, and altered gait and biomechanics related to the abnormal wear pattern in his knee.

How do we begin to heal someone like this? Like many, this patient had years of breakdown happening. We need to work together to help rebuild and heal. A combination approach is needed for optimal results. We can use products such as PRP (platelet rich plasma) from his own body to help heal and rebuild the knee structures that have broken down. We use other treatments to help treat the irritated nerves. We use bracing, physical therapy, and a graded return to activity to rebuild the muscles. We educate the patient and give him the resources and support he needs to make healthy lifestyle changes, improve his diet, adequate sleep, and stress management. Many times, this includes being seen to help optimize hormones and labs that could block the body’s ability to heal.

We can no longer have a point-and-fix approach to medicine. I think we should reconsider what is normal findings. Meniscus tears are a great example. Studies have shown that for middle aged and elderly patients, meniscus tears seen on MRI are just as common in those with knee pain as those without. So, what is normal? An abnormal finding on an image may or may not be the source of pain. It may or may not cause local pain. It may or may not be contributing to the pain and dysfunction someone is having. Pain is complex. The more we understand the more complex it becomes. So, how do you determine if the finding on an image is the source of your pain? You need a physician who one has time with their patient. More than just the average seven minutes a physician has with their patient right now. Seeking out a physician with good clinical exam skills, meaning they take a good history, do a comprehensive exam, use imaging as a tool, and understand the body as a whole. We need to start healing structures when they are first injured and try to prevent the chronic breakdown that happens. This is an exciting new approach to medicine and a journey I am happy to go on with my patients.