



# ACL and Meniscal Tears: When to Treat, When to Refer – Ref288

*with Ian McDermott*

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## **TRANSCRIPT**

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**Steven Bruce**

Good afternoon. Welcome back to the Academy of Physical Medicine. Got a great one for you this afternoon. I'm talking to orthopaedic consultant Ian McDermott, who's been on the show three times before to talk about his particular area of expertise, which is knees, and if you want to look back at those recordings, they're all in our archive as you can imagine. Today we're looking at something which is really relevant to you clinically, we're going to be looking at ACL tears and meniscal tears. And I know that Ian has got a lot to tell us about the current evidence about those things and about the current arguments, the debate that goes on about arthroscopy and otherwise, but of real value is his advice on when you should proceed and treat conservatively and what are the indicators for you that mean, yeah, you need to refer this one on to someone more expert, to an orthopaedic consultant for example. Now Ian works in London for, I think, Orthopaedics... Ian, remind me of the name of the company? Orthopaedic Sports?

**Ian McDermott**

Yeah, it's London Sports Orthopaedics.

**Steven Bruce**

London Sports Orthopaedics. Sorry about that. London Sports Orthopaedics. And obviously, I will share the details of Ian's practice with you with the handout that comes out after the show. I'll also be including quite a few more slides, than you will likely see during the show, which will back up the sort of evidence and information that Ian gives us and hopefully, given the stresses and strains on the NHS at the moment, that could be very helpful to you and your patients. But anyway, Ian, thanks for coming back for a fourth time. And I'm sorry, we put you through all the hassle of trying to get your slides to work today. That's all down to our use of the technology. No problem with your slides, of course. How are you?

**Ian McDermott**

Yeah. All good here, Steve. Just busy, as usual.

**Steven Bruce**

More busy because of the NHS's problems or less so?

**Ian McDermott**

I think so. It certainly feels like it. Yeah, we're hearing quite upsetting stories from people about how they just can't get access to anything nowadays. So I think there is a lot of overspill into the private sector, unfortunately.

**Steven Bruce**

I have to say my father, I think I might have mentioned to you, he fell over recently and broke his hip at the age of 90. And I was very impressed given what we hear in the media of the response time of the ambulance, they were with him within a couple of hours. And given that it was only a fracture, that's probably quite a good response time anyway. And he was in surgery within, I think within 48 hours and is now back home and recovering. Although he fell over again this morning, the silly old duffer and fell onto the injured side. So he was complaining about that when I spoke to him on the phone. But yeah, the NHS certainly served him well in this particular instance, what have you got to tell us about ACLs and this menisci?

**Ian McDermott**

Okay. Well, the topic we were going to discuss was really very much about when to operate or when not to, so it's conservative management versus surgery. And it seems to have generated a fair amount of contention recently. So should we just plunge straight in?

**Steven Bruce**

Yeah, sure. Is that contention within your circles or across the healthcare media as it were?

**Ian McDermott**

Yeah, healthcare media, for sure. I think any decent knee surgeon already knows the appropriate indications for surgery. I mean, that's our job, if you don't know that you shouldn't be doing the job. So I think there's been a lot of misinformation put out there over the last few years by people who, well, the way I would put it is armchair experts. They think they know what they're talking about. And a little bit of information can be quite dangerous.

**Steven Bruce**

Yeah. Having said that, though, one of the slides, which we took out of your deck, for this lunchtime part of the show, was one I think, I can't remember what the qualifications of the particular doctor concerned, but he was saying that arthroscopy should never be carried out. So it's a medical expert coming up with this opinion.

**Ian McDermott**

Yes, Fauci is a medical expert. What's your point?

**Steven Bruce**

Yeah, but it's not just the healthcare editor for The Daily Mail that's saying this, there are people who've got MD after their name or whatever, which people are inclined to believe.

**Ian McDermott**

I couldn't agree with you more. There's a lot of stupid people, and especially people with Dr. in front of their name. Yeah. Doesn't mean they're an expert, doesn't mean they know what they're talking about. Medical qualifications are a very, very basic thing, I'm afraid. And if you want to be a doctor, you've just got to be able to learn stuff by rote and regurgitate it by rote. It doesn't mean that actually you've got any ability for critical thinking, unfortunately. But I think most people realise that about doctors by now.

**Steven Bruce**

Well, let's hope so. Anyway, menisci.

**Ian McDermott**

Right. Let's see whether these slides work. Has that moved on, because I can't see my slides. I can see this one centimetre square at the top of my, my phone.

**Steven Bruce**

We've got your first arthroscopy slide showing here.

**Ian McDermott**

Right. So that should be a video. Is it moving?

**Steven Bruce**

Yeah. Can we run the video?

**Ian McDermott**

Brilliant. Okay, so that's the meniscal tear. This is me looking into somebody's knee. This is a left knee, that's the medial meniscus posterior horn. And when you look on the MRI scan, you may see a line, it may be slightly unimpressive. But if you do an arthroscopy, you actually look inside, and you can probe so you can see it for real, you can probe it, you can see whether it's, you can feel and see whether it's unstable and how bad it might be. Now, that particular meniscal tear was a tear in somebody who was an older patient. The reason I'm poking and prodding it for a while is to get a really good feel for how extensive that tear is, whether it's a simple tear or whether the tissues degenerate, whether it's likely to be repairable. And that's largely an intra operative decision, you can get a pretty good idea beforehand, as to the probability as to whether a tear's repairable. A lot of the time, you don't actually know for certain till you get in there. So that was irreparable in a patient with a very symptomatic knee, complaining of sudden sharp pain, painful clicking, catching, giving, locking, those kinds of symptoms. And so that's what the knee looks like once you've trimmed the meniscus. So you've trimmed away the torn tissue, you've got it back to smooth, stable tissue. Now all that does is get rid of the pain from the meniscal tear, because the meniscus has got nerve fibres in it. So it doesn't restore the volume of function back to that meniscus. You know, once it's torn, normally the damage has been done, depending on what type of tear it is, because some tears defunction the meniscus more than others. So if you trim a torn meniscus, it will get rid of the symptoms. So if you've got no symptoms, there's no point in trimming it. Or if you've got minimal symptoms. And now the definition of a minor operation is an operation that someone else is having. If you're having it, there's nothing minor or trivial about it. And if you think about pain, hassle, risks, time off work, time to do the rehab, and the risk of infection, nerve or blood vessel damage, blood clots, those risks are all very, very low with an arthroscopy, but low risk does not mean no risk. So if you tot up all the potential negatives of surgery, the symptoms are up here. It's a no brainer, go ahead, get it done. The symptoms are down there, well don't bother. And that's a judgement call. So if you've got a symptomatic meniscal tear, the symptoms are not getting better and if those symptoms feel bad enough to justify the pain, the hassle, the risk, well then surgery can be really good for you. If you don't need surgery, and you have surgery that you don't need, knowingly so as a patient, well, then you're a little bit of a nutter, at best. And if you're a surgeon, and if you perform an operation on somebody who doesn't need it, well then you're not just a butcher, you're a criminal because that's GBH.

**Steven Bruce**

Can I just put a question to you about meniscal tears before you go on? In the early stages in the diagnostic stage, in your experience, what proportion of meniscal tears will result in locking?

**Ian McDermott**

Locking? A small percentage.

**Steven Bruce**

Because I mean, a lot of patients and maybe a lot of practitioners will be thinking, well this is a common sign in meniscal tears. And, as I understand it, there's also a difference between the sort of the timing of inflammation between an ACL rupture or a tear and a meniscal tear, one will flare up straightaway, the other later, is that correct?

**Ian McDermott**

By inflammation, do you mean swelling?

**Steven Bruce**

Yes. Swelling. Sorry.

**Ian McDermott**

Yeah, because both will hurt at the time of the tear, normally. With an ACL tear, what tends to happen is ligament tears, the ends bleed, so the knee fills up with blood. So you get a hemarthrosis in the joint. So the knee will swell up, often massively, or certainly large, and it'll happen quickly. So within half an hour to an hour, or certainly within a few hours. With a meniscal tear, you may get the pain suddenly, but the knee will tend to swell up less because it's an effusion, not hemarthrosis and it'll tend to swell up later. So later that day or by the following day.

**Steven Bruce**

Okay, thank you. Sorry, I interrupted you.

**Ian McDermott**

No, that's all right. Difference between an effusion and hemarthrosis. So, yeah, back to the slides. Very importantly, the meniscus is important. It's only in the 1970s that people began to realise that they actually had a function. Up to then they thought the meniscus was just a vestigial remnant in a knee like an appendix. So we now know they're very important and if you lose your meniscus, then you decrease the contact surface areas in the joint and increase the peak contact pressures and therefore increase the peak loads on the articular cartilage, which means the cartilage is more likely to wear away quicker. So it leads to degenerative changes. So if you lose your meniscus, well then you're roughly speaking, roughly, 15 times more likely to develop arthritis in your knee 20 years later. Now, when I say lose the meniscus, a lot of it depends obviously on how much. If you lose a little bit, if it's a small tear and a small trim, it may be trivial. If you lose the whole thing, then obviously it's more significant. So when we talk about meniscectomy, it's rarely a total meniscectomy we're talking about, it's nearly always nowadays a partial meniscectomy. So the important thing is, if you can preserve the meniscus then you should. So if a meniscal tear is repairable, and these tend to be tears in younger people, so under the age of 40, with an acute traumatic tear, and that's quite different, a very different thing from an older person with a spontaneous degenerative meniscal tear, two different things. Although there is crossover in the middle, there's that if you pardon the pun, there's that grey zone in the middle. If you have a younger person with a sports injury, and they've torn what was otherwise previously a normal meniscus, then you should do your very best to repair them. But even in the hands of somebody who's really into knee surgery, and really into arthroscopic repair, which is like my practice in London, I'm lucky that I, a) have a lot of younger patients, b) a lot of patients with sports injuries and c) they get to see me quickly. So even in the hands

of an enthusiast and I've done plenty of research into meniscal repair, meniscal transplantation, still only roughly a third of the meniscal tears that I operate on, only about a third are repairable, that means two thirds are not. If you can repair it, then it's a crime or it's a little bit silly not to repair it, you should, because of the long-term consequences of trimming, but if it's not repairable and if it's too symptomatic to leave alone, and that's a very important caveat. Well, then you're going to trim it and if you trim it, you take away as much as you need to to get the remaining tissue smooth and stable. Leave behind as much as you can.

**Steven Bruce**

Can I ask a silly question, the image that we just saw of a repaired meniscus, I mean, it looks as though that it's been sewn up into a sort of a rolled-up bunch along the edge of the meniscus there, does that affect its ability to absorb shock evenly?

**Ian McDermott**

No, what happens with these stitches when you put them in, they're non absorbable stitches, they stay there forever, but you always get creep, you get creep of the knot, you get creep of the tissues. So if you stitch something you want it to be slightly bunched up initially, not too bunched up but slightly bunched up and it will relax out as it were, so you don't want a loose sloppy knot.

**Steven Bruce**

I got a question from one of the audience if I may as well. It is about a younger patient, Sally says, she has a nine-year-old girl with a nine month history of knee pain. MRI shows discoid lateral meniscus in the right knee, no mention of a tear, intermittent catching, clicking and pain, otherwise normal activities of daily life. Left one subsequently developed pain and consultant has asked for it to be included in MRI scanner when we go back for a six month follow up scan. The question is, should the symptomatic knee undergo some form of surgery or treatment, do you think?

**Ian McDermott**

Probably, yeah, sadly, probably yes. And you got to be very careful on an MRI scan of a discoid meniscus. Because often, what you get is you get peripheral detachment of the meniscus. So a tear around the edge. If you've got a young person, if they've got a discoid meniscus, if it's symptomatic, then you're probably better off dealing with it sooner rather than later. But you need to see somebody who is a dedicated sports knee surgeon who's used to doing meniscal repair, because these discoid lateral menisci can be incredibly difficult.

**Steven Bruce**

Okay, I take it that is something that you're good at.

**Ian McDermott**

I would be good at if I did kids, but where I work, my main hospital only does 18 plus, so I've never bothered kind of keeping my paediatric level 2 training etc. So I only do 18 plus.

**Steven Bruce**

So in this case with Sally, with her patient there, how would she find an appropriate surgeon to refer to, is it obvious who is a paediatric meniscal expert?

**Ian McDermott**

Be very, very careful. Depends where she is geographically. And she got to do some careful research. Most of us, most knee surgeons know who the good guys and the bad guys are. And most of us know who we would want to be seen by if it was somebody in our family. So it really is word of mouth.

**Steven Bruce**

So if she sends me that information, could I ask you for an opinion on who she should see?

**Ian McDermott**

Well, yeah, depending on her geography, depending on where it is, yeah. And if I don't know, then we've all got mates that we can ask and we can find out. Yep.

**Steven Bruce**

Sarah has actually followed up with perhaps the obvious question, she says is it very different doing surgery on children?

**Ian McDermott**

Yes and no. Children have got growth plates in their knee, which is very relevant when it comes to things like ACL tears.

**Steven Bruce**

Of course, yeah.

**Ian McDermott**

Or can be relevant. And I would say it is not very different, but it is different because it's smaller. It's more delicate. Yes, they got better healing potential, but the big no, is the consequences of damage or anything going wrong in a child are massively higher. I'm actually, call me a chicken, I'm quite relieved that I only see 18 plus, I think paediatric surgery is scary. And it's a really big deal.

**Steven Bruce**

Right. Okay. Well, I've just heard, Sally's in Basingstoke. If that helps.

**Ian McDermott**

Yeah, I know some very good guys there. So if you email me, I'm happy to give you their details.

**Steven Bruce**

Yeah, thank you. Martin says, can a full thickness tear in a 60-year-old man be repaired? And if not, should they continue to exercise symptom free or rest?

**Ian McDermott**

That's a big question. Depends on what type of tear. Now what we've talked about so far is predominantly I focused on those meniscal repair pictures on younger patients. Once you've got somebody who's 60, then that means that in all probability that is a degenerate tear. It depends on what type of tear. I mean, full thickness is a partial description. Is it a vertical, peripheral, circumferential tear? Is the meniscal tissue stable or unstable? Or is it a horizontal degenerative cleavage tear, which tend to be stable? You know, what type of tear? If you're 60, it's probably not going to be repairable. And if it's asymptomatic, well, then you're going to leave it alone. Simple as that.

**Steven Bruce**

Yep. Okay, I got another question waiting, but shall we move on? Otherwise, we might not get to answer the question that you posed us.

**Ian McDermott**

So when it comes to the kind of contentious discussions, everything kicked off after this paper, and it's so small on my screen, I can't see the date. Can you see the date on that?

**Steven Bruce**

I'm not sure it shows me the date.

**Ian McDermott**

Okay, it was a few years ago.

**Steven Bruce**

22nd of April 2015. It was accepted.

**Ian McDermott**

Okay, so, yeah, roundabout then. So 5, 6, 7 years ago, this paper came out. And from this point onwards, everything kicked off. And this was a very interesting study where they looked at the papers that have been published about meniscal tears, and meniscal trimming, and from several thousand papers that were potentially eligible, they whittled them down, and they only studied about nine, and they excluded all of the evidence of the others. And those nine papers they studied included some really strange studies, like the psychological impact of meniscal tears. This is one of the most flawed papers I've seen in a long time. And yet, unfortunately, people refer to it, you have to read it and analyse it carefully to see the actual flaws in it.

**Steven Bruce**

You actually have to be very competent to do that, don't you? It's one thing to look at a paper and read the conclusions. But to understand the flaws in research is a very skilled thing.

**Ian McDermott**

You've got to understand the subject. I think, abstracts and titles are deeply, deeply dangerous. I've seen a few papers recently where you read the title, and then you read the abstract, but when you read the paper, the actual data contradicts their abstract, which is just shocking. I mean, I have no idea what's



going on with the quality of some of these editorial boards of some of these journals. But yeah, I think headlines are deeply, deeply dangerous, have the potential to be dangerous and misleading.

**Steven Bruce**

If it's a Cochrane review, are we more likely to be able to believe the summary?

**Ian McDermott**

Cochrane reviews are interesting, but they have their own dangers, which is rubbish in, rubbish out. So if you have 100 studies and 100 studies are poor quality, well, you're going to have a conclusion or summary of 100 studies that's also poor quality. And the other thing is that when you average out data, what you lose is, you lose the granularity. So you may get a good answer in terms of what's appropriate for the average, but you're going to potentially lose out on your ability for subgroup analysis. So what may be right and appropriate for one, may be terrible for another person. Group analysis is critically important. And when you come up with a Cochrane Review, that's a meta analysis that says, best analogy I can give you is what colour are flowers? Well, if you average them all together, flowers are grey. Well, how many grey flowers have you seen? So you gotta be very careful about averaging things out. But Cochrane are very useful, but they're a part of the overall jigsaw puzzle. So then yeah, what we had is headlines like this on this next slide, which is arthroscopy doesn't work and that's just absolute bunkum. Nearly swore.

**Steven Bruce**

Well, at the top of your slide there you've got shorthand for bunkum, I think. It says Mail Online.

**Ian McDermott**

Yeah, yeah.

**Steven Bruce**

But the public will look at this and say that a leading surgeon has said this, and he's leading, so therefore, he must be right.

**Ian McDermott**

Yeah, just like the public over the last three years has listened to the chief medical officer, say, it's safe, it's effective. Mail Online, not very useful when you get to try and discuss medical issues or scientific issues in magazines. Now, saying that arthroscopy doesn't work is as stupid a statement as saying a telescope doesn't work when you're trying to look for a bacteria or saying a microscope doesn't work when you're trying to look for the moon. Arthroscopy is not an operation, arthroscopy means arthro, joint, scopy, look. If you want to be pedantic about it, arthroscopy is a surgical approach, it means the way to look into a joint with a camera through little holes. It's not actually a procedure, it doesn't tell you why you're doing it, why you doing the operation, what you find when you get in there, what you do when you get in there, it's just a broad reaching term. So again, another analogy it's like saying cars don't work, because they're rubbish for ploughing fields, they get stuck. Well, that's because you know, cars are not designed for ploughing fields you need a tractor. Cars are designed for driving to the shops. So arthro, joint, scopy, look. And saying that looking inside a knee with keyhole surgery doesn't work is utterly stupid. It shows you have no idea what you're talking about. The genuine summary, if you want to look

at the research, and the research about conservative management and meniscal tears is incredibly important and very useful. The genuine summary is that in two thirds of cases of degenerate meniscal tears, very important, degenerate meniscal tears, this is in older people, the symptoms with time will settle down on their own, and the patient's knee will feel good enough to leave alone and they therefore won't need surgery. In 1/3, the symptoms will persist. And if those symptoms feel bad enough to justify the pain and the hassle, the risk of surgery, they end up needing a partial mastectomy. So you've got to know your patients, you've got to analyse your patients, you got to treat them like they're an individual, not treat them like they are an average. And also, you've got to understand that the big, big difference between a spontaneous or minimally traumatic degenerative meniscal tear versus a traumatic meniscal tear in a younger person with what was otherwise previously before the trauma, a normal meniscus.

### **Steven Bruce**

Ian, why do those symptoms settle down in the older patient, do they just stop doing things and therefore stop aggravating it?

### **Ian McDermott**

No, I think what happens is the pain fibres probably just shrivel up. They probably just shrivel up and it just stops hurting. Meniscal tears do not heal. Like the large majority of meniscal tears do not actually heal on their own. And certainly with a degenerate tear, they don't regenerate. They don't become healthier, grow a blood supply, like my hair is not gonna grow back, sadly. That's life, things get weaker and lose their elasticity and become more friable, more liable to tear as you get older. So no, they don't heal, what happens is, they cease to be symptomatic. And it's all about the symptoms and how it affects the patient when it comes to that decision making process as to whether or not to operate. So what else have we got here, so if you really want the best advice about when to operate on a degenerate meniscal tear, BASK, the produce association for surgery for the knee published their professional guidelines. And these guidelines are really sensible, really useful. And I think the positive that's come out of this big argument about whether or not surgery is appropriate, the positive is, undoubtedly in the past, there were surgeons out there who were doing too many operations, who you know, they were trigger happy on the scalpel, and their threshold for operating was too low. And they were rushing in too soon, and they were doing too many arthroscopies. I think that's probably fair to say that's correct. Also, there were surgeons in the bad old days who were doing arthroscopic washouts for arthritic knees, and that's also inappropriate. So it's all about appropriate case selection. If you can select the right patient at the right time for the right reason, do the right operation, you'll get good outcome.

### **Steven Bruce**

These wash outs were quite common, weren't they? I mean, was that according to the best medical knowledge at the time, and that's now changed, or was that just bad practice?

### **Ian McDermott**

Today's bad practice was yesterday's trying to do your best, wasn't it? In 100 years time, we'll look back and think what the hell were we all doing for almost everything we're doing now. So in the past, I believe that the vast majority of surgeons were hopefully acting in goodwill and trying to do a good job and trying to do the best they could for their patient to try and delay knee replacement. But washing out an arthritic knee, we now know it's a pointless thing to do. So that shouldn't be happening.

**Steven Bruce**

Just a quick word for the audience. Obviously, you saw the guidelines slide a moment ago, and it will be difficult to read on anything other than a full-size desktop screen I imagine. Don't worry, you will get that as part of the handouts after the show, they will be sent out probably this afternoon.

**Ian McDermott**

And on those guidelines, if we can get the slide back up. Personally, I think the most important thing in that entire guideline is at the bottom, NB, patient treatment preferences must always be considered. These guidelines support, do not substitute shared decision making. That's critically important. There's a huge difference between a guideline and a protocol. Protocols are for monkeys, who don't have the faintest idea what they're doing. They're just acting like an automaton, learning by rote and just following simple instructions. Guidelines are useful. Protocols are dangerous. Guidelines are useful, because they make you think about what you're doing. But a guideline is not a protocol. So what else we got on here? So yeah, this is just simple logic. If the symptoms are bad, you're more likely to need surgery. And it's not really black and white, yes, no answers, it's more likely to need surgery. If the symptoms are mild, you're more likely to manage conservatively. If the symptoms are improving, well, wait, wait and watch because you don't know how good the knee is going to end up if it's still improving. If the symptoms are not improving or if they're getting worse, well, you're more likely to go for an arthroscopy, for surgery. And then mechanical symptoms, this is the painful clicking, catching, giving away, locking, those kind of mechanical symptoms. Again, if you're suffering, then you're more likely to end up needing surgery. If you don't, if it's more of a deep, dull, achy pain, then you're less likely to need arthroscopic surgery. And again, these are just broad guides. And again, very important, there's a big difference between meniscal pain, which sorry to say again, that is the sudden sharp pain, sharp stabbing pains, painful clicking, catching, giving away, locking, versus arthritic pain, which is that deep, dull, aching, nauseating pain. Okay, if it's the former, you're more likely to need an arthroscopy. If it's the latter, well, it's arthritic and an arthroscopy is much less likely to help you. And if you have an arthritic knee, well, then no, an arthroscopic washout, and just a bit of a tidy up is very, very, very unlikely to help you. So, yeah, as we said, if you've got a brain, use your brain, if you haven't got a brain, well, protocols were designed for you.

**Steven Bruce**

So before we move on, if I may, I have got a couple of other questions which are about menisci. Vanessa says, do you have any dietary or supplementation suggestions to help knees collagen, ligaments, menisci as we age?

**Ian McDermott**

No. If you look at the meta-analysis, I'm being a hypocrite now because I'm quoting a meta analysis that has been published in the BMJ, in the British Journal of Sports Medicine, about supplements. Chondroitine sulphate, probably pointless, glucosamine, probably pointless, collagen tablets, utterly stupid. Collagen is the stringy bit in meat. So if you eat a collagen tablet, you're going to digest it, well, eat some meat. In terms of, I think the only supplement that has got some weak evidence to support it is omega three oils. And then the only supplement that probably everybody in the UK should be taking is vitamin D.

**Steven Bruce**

Okay, so that echoes a lot of what we've heard on previous shows as well which is good. Jolene says, is there a role for steroids hyaluronic acid and PRP injection?

**Ian McDermott**

Thank you. Who was that Jolene,

**Steven Bruce**

Jolene? Yep.

**Ian McDermott**

Thank you so much for on give me an opportunity to answer that one. The most injections in the knee are utterly pointless, at best, they do nothing and at worst, they cause more damage. If you look at the proper studies, PRP, platelet rich plasma, injected into a knee joint utterly pointless. Hyaluronic acid injected into a knee joint utterly pointless. The American Academy of Orthopaedic Surgeons have removed these from their treatment algorithms for arthritic knees. So pointless, no evidence to do them whatsoever for things like meniscal tears, the best thing you can inject into a knee is also the worst thing, which is steroid. The reason it's the best thing is it's quick, it's cheap, it's very, very low risk, it acts as a powerful anti-inflammatory. So it will mask your symptoms. The reason it's the worst is that it will mask your symptoms. And if you mask the symptoms, you're fooling somebody into thinking their knee's better when it's not, which encourages them to do more. So by the time the injection's worn off the damage and the symptoms are worse than they were beforehand. Very good study published a couple of years ago showed that for every steroid injection, you've give into a knee joint, you increase the likelihood of that patient ending up with a knee replacement by 10% per injection. So if you've got a reason to inject somebody's knee with steroid because you want, let's say they want to go on around the world trip, or they want to walk their daughter down the aisle in a month's time. Well, as long as you discuss the pros and cons, so the patient has fully informed consent, and they understand the negatives, where then there's an argument for going ahead. But would I ever inject steroid for a meniscal tear? No, I think is utterly stupid. It shows a complete lack of understanding of the pathology, the physiology. I think it's a daft thing to do. Pain is there as your friend, it's your body's way of saying don't do this. Best analogy again, I do like my analogies, but best analogy is let's say you put your finger on something that's burning hot, like a hot plate, and your fingers like "Ow!" and you say, Oh, don't worry, I can cure that, I'll put local anaesthetic on your finger. So you put your finger on the hot plate, you go, Oh, yeah, that's feels fine, doesn't hurt at all. Your finger's going sizzle, sizzle sizzle. So there's a lot of people out there, a lot of doctors who love injecting joints and love injecting knees with all kinds of stuff. And what people really need to ask themselves is from the patient's perspective is this kind of naivety and wishful thinking predominating over common sense. And from the doctor's perspective, you've got to really question their motivation, because they should know better, they shouldn't be that stupid or gullible to the marketing from the companies selling this stuff. Or, and this is an awkward thing to say, why are they doing it? Are they doing it for their benefit and the fee? Or are they really doing it for the patient? So I'm totally not a fan of intra-articular joint injections. And then don't even start me off on the crooks out there who are injecting stem cells into knees. It's quackery, and they are criminal.

**Steven Bruce**

Right, I think you were quite clear on that. No fence sitting there, was there, Ian? I think we're halfway through and we've got 10 minutes left. So we better move on to ACLs, hadn't we?

**Ian McDermott**

We'll go fast through ACLs. ACLs are easy. All right. It's exactly the same logic. Good old days, when I was younger, when I had a full head of hair, we were told it's the rule of thirds: If you rupture your ACL a third of people will need surgery, a third of people won't and a third maybe? Well, if you look at that, maybe group and say, Well, okay, let's call it 50/50. But that means overall, 50% of people will, 50% of people won't. And that's been borne out exactly. There's a very important paper by Frobell et al. And that's exactly what they showed. If you try and manage ACL tears conservatively, 50% end up not needing surgery. And if you don't need surgery, don't do it. You've gotta be nuts to have surgery if you don't need it. But if you've got a wobbly, unstable knee, well, the longer you leave it, the worse it's going to get, the more damage. And quite apart from the fact that you won't be able to do cutting and pivoting manoeuvres if your knee is unstable, and if it's unstable, well stabilise it.

**Steven Bruce**

I love the fact that you've got Americans at the bottom of that list as well.

**Ian McDermott**

Yeah, the reason I put Americans there is it's just impossible not to take a pop at them, isn't it? If an American comes into clinic, and this is borne out by experience, if you try and talk to an American about conservative management, they look at you like you're trying to fob them off with third world medicine. They just look at you, what on Earth are you talking about? Because in America as long as you've got money and insurance, then everybody who tears the ACL gets an ACL reconstruction. And that's really not appropriate.

**Steven Bruce**

Does that mean to say that the outcomes are often bad from those reconstructions?

**Ian McDermott**

No, not at all. ACL reconstruction is a really good operation, about 90 to 95% of people are happy with their outcome. It's just that it's a big op. It's a big op, it's painful, risk of infection, nerve or blood vessel damage, blood clots. You've got a year plus, I mean, I prefer my patients do 18 months of rehab after an ACL reconstruction before going back to sport. So it's not a trivial thing to do. And an ACL graft is no ACL. It's never, ever as good as the patient's own original ACL. It's a reconstruction, not a rejuvenation. So, if you need surgery, surgery can be a lifesaver. If you have surgery you don't need, either you're an idiot or your doctor is a crook.

**Steven Bruce**

But if you've got an ACL tear, and you opt for conservative management, rather than reconstruction, how well is it likely to repair itself?

**Ian McDermott**

It doesn't repair. There's a very shocking, interesting, whatever you wanna call it, paper published recently that suggested that a significant proportion of ACL tears grow back. And they had MRI evidence of that. Again, that shows a lack of understanding of physiology and pathology and of knees in general. If an ACL tears, it pings apart, and if it pings apart, there's a gap, there's no way that your collagen fibres are going to grow back through your synovial fluid, meet each other, stick together, grow, re-tension and form a ligament with tension under it. That's absolutely nonsensical. So what that particular study was really looking at is they're looking at MRI pictures of partial tears. And the word partial is difficult, because partial can be anything from 1% to 99%. So it's not a very meaningful statement. But what they were almost certainly looking at is what looked like a total tear on an MRI, but was actually in real life a partial tear with sufficient fibres in continuity for a degree of healing to be possible. So if you have a complete ACL tear, they don't grow back. If you have a partial, well then be careful because partial may be 1% it and maybe 99%. But it's almost an academic question, really, because the most important thing is, does your knee feel stable or wobbly? If you've got a complete ACL tear, with a stable feeling knee with no giving away, unless you're a kid, or an elite athlete, or an American, well, then you're probably going to leave it alone. If you've got a partial ACL tear, with some fibres still remaining in continuity, but you've got a very wobbly, unstable knee that keeps giving way, well then get it reconstructed. Stabilise the knee.

**Steven Bruce**

And let's just say you're an average middle-aged person who's got a full thickness ACL tear, you decide not to do anything to it, are there risks involved in that? Let's say they twist on their leg in the supermarket to reach for the last packet of frozen broccoli, or whatever it is?

**Ian McDermott**

Now, there's very, very clear evidence from umpteen papers that if you have an unstable knee, the longer you leave it, then the more damage you develop in terms of meniscal tears, and articular cartilage damage, and the risk of developing arthritis and the risk of ending up with a knee replacement. So, yeah, tearing your ACL has significant consequences. But that alone, is insufficient. Unless you're talking about kids. If a kid tears their ACL, don't wait for them to grow up, get the ACL reconstructed by paediatric sports knee surgeon. In adults, it all depends on how unstable, how old you are, what's your functional requirements? Are you a sportsman? Are you a couch potato? It's multifactorial. Like most of these things. With all of these decisions, ultimately, it's down to the patient. And some patients, when you're talking to them in clinic, and you start talking about surgery, they're like, oh, no, you can see their body language. They're like, no way, I'm not interested. And some people are saying, no, no, I want it now. And at the end of the day, we're simply there to guide people. But the ultimate decision lies, not exclusively, but largely with the patients.

**Steven Bruce**

Well, we had a discussion on this in a case-based discussion the other day, and we were talking about what do you do when the patient is insistent on a line of treatment, and you don't necessarily believe it's the best course of treatment? And you've said ACL repair is not necessarily going to cause adverse outcomes, but it might not be your preferred route.



**Ian McDermott**

Yeah, obviously, like this is an easy answer. If somebody if a patient asks me to do something that I don't think is right. And when I say, right, I mean, right in their best interests or appropriate, then I won't do it simple as that. What kind of person are you if you knowingly do the wrong medical treatment to somebody just because they want it? That makes you as almost as much of a scumbag as a cosmetic plastic surgeon? Cosmetic plastic surgeons, some of the work they do is incredible, but the ones who operate on people who've blatantly obviously just got psychiatric problems, not physical problems, it's just appalling. So if somebody asked me to do something that's not right, then it's very easy. The answer is no, I'm sorry, I'm not doing it. If you're insistent that you want it, I suggest you go and get a second opinion. And sadly, the sad thing, the sad element of that, is that they probably will go and find somebody who will do it just because they're happy to operate.

**Steven Bruce**

A couple of questions, though, perhaps we can do. Kathy says, what sort of timeframe do you expect knees, that are going to settle down, to settle down in? So you said if a meniscal problem was settling down, how long do you give it?

**Ian McDermott**

Well, the BASK guidelines suggest you should wait three months, but it's not a black and white cutoff. I think the most important thing is, for as long as a knee is improving, then wait and watch. If it's getting better and better and better, well, you won't know where it's gonna plateau until you wait until it's actually plateaued. So despite the BASK guidelines saying three months, I would say, how long is a piece of string? If it's improving, wait and watch.

**Steven Bruce**

Okay, one more question. I don't know who asked this one, but somebody wants to know if there are any indications at all for the benefits of a knee washout?

**Ian McDermott**

Yeah there are. If you've got a septic knee, then you have to wash out the pus. So that's critically important, that's a limb or lifesaving procedure sometimes, or could be. So yeah, an arthroscopic washout for a septic knee. Just a washout on its own, the answer is no. But if you're doing an arthroscopy to remove loose bodies, so you've got a knee that's kind of early arthritis, not severe arthritis, the patient's not bad enough for a knee replacement yet. But let's say they've got one or more loose bodies in the joint and they're giving way and locking, well, then there's an argument for removing those loose bodies, clearing out the debris. But that's relatively rare and you've got to be very careful. It's a real judgement call about whether or not you're going to do that.

**Steven Bruce**

Ian, we're at the end. Sorry to have to cut off before you could finish all those slides. But thank you so much for giving up your time. I know that we've had lots of people saying thank you very much for an interesting show and what they're calling a very frank approach, which I think always goes down very well.

**Ian McDermott**

I don't know why people keep calling me, Frank. My name's Ian!

**Steven Bruce**

But that's it for today. Thanks for joining us and hope to see you again soon. Good afternoon.