



Shelbourne Knee Center
at Methodist Hospital
Specialized Care for Knee Injuries

1815 N Capitol Ave, Ste 600 Indianapolis, IN 1.888.349.5633 1.317.924.8636

K Donald Shelbourne MD
Scott E Urch MD
Physical Therapy

The Long-Term Evaluation of Lateral Meniscus Tears Left in Situ at the Time of Anterior Cruciate Ligament Reconstruction. Shelbourne KD, Heinrich J: Arthroscopy, Vol 20, No 4 (April), 2004: pp 346-351

Purpose: To determine the long-term subjective and objective results of patients with lateral meniscus tears found at the time of anterior cruciate ligament (ACL) reconstruction that were left in situ or abraded and trephined but not repaired or removed.

Type of Study: Retrospective review of prospectively collected data.

Methods: From a database of ACL-reconstructed patients, 332 patients were identified to have lateral meniscus tears that were left in situ or underwent abrasion and trephination. Patients were excluded if they had any lateral or medial partial meniscectomy, previous knee surgery, and greater than grade II chondromalacia in any knee compartment. The tears were classified as posterior horn tears (N=70), stable radial flap tears (N=50), or peripheral or posterior tears (N=212). Patients were evaluated subjectively with a modified Noyes knee questionnaire and objectively using IKDC criteria.

Results: At a mean of 6.6 years (range, 2 to 16.5 years) after surgery, the mean total modified Noyes score for 239 patients was 93.8 ± 7.6 points. At a mean of 5.1 ± 3.8 years after surgery, the objective IKDC evaluation showed that 163 of 170 (96%) patients had an overall rating of normal or nearly normal. Radiograph evaluation showed that 162 patients (95%) had a normal rating, 6 patients had a nearly normal rating and 2 patients had an abnormal rating. Of 332 patients, only 8 (2.4%) required subsequent surgery for the lateral meniscus.

Conclusions: Lateral meniscus tears that are posterior horn tears, stable radial flap tears, or peripheral or posterior-third tears that do not extend further than 1 cm in front of the popliteus tendon can be treated successfully with abrasion and trephination or by being left in situ.