LOG Frequently Asked Questions

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FAQ What can be done for my knee arthritis?

By the orthopedic surgeons of Lancaster Orthopedic Group

Over time our joints are susceptible to degeneration from disease, trauma, and long-term repetitive use. These all eventually lead to pain and discomfort. For many, knee pain stems from bone-on-bone contact in the joint as a result of worn out or inadequate cushioning from the articular cartilage and menisci. Frequently this is the result of the progression of osteoarthritis. Osteoarthritis is the deterioration of articular joint cartilage.

Pain tends to come in a succession of stages for those suffering from knee arthritis, with patients most often seeking treatment because the pain/discomfort has reached a stage where there is deterioration in the quality of everyday life. A physician will initially take x-rays of the knee joint to see how much damage has occurred (often indicated by the lack of space remaining between the bones in the joint). The typical first line of treatment for osteoarthritis of the knee is a conservative, nonsurgical approach. This may include weight loss (for the overweight patient), low impact exercise, physical therapy, corticosteroid injections, analgesic and anti-inflammatory medications (NSAIDS), and viscosupplementation (joint lubricant). Your insurance plan may require that these approaches be taken before they will approve a surgical approach. However, if conservative treatment does not relieve pain and improve function; or if the patient does not tolerate physical therapy, the physician may recommend surgery. The choice of treatment should be a decision between you and your physician. If you are concerned about the decision, you can always seek a second opinion.

While there are non-surgical and surgical interventions short of a total knee replacement which will often provide temporary relief, the long-term resolution to of the osteoarthritic knee will be a total joint replacement. Knee replacement surgery ranges from partial replacement of a portion of the knee joint with an implant to substitute for the damaged weight-bearing surfaces to a Total Knee Arthroplasty (TKA) which replaces the entire knee joint. While knee surgery is a major procedure, advances in medicine, surgery and technology have made it one of the safest procedures performed.

Understanding the decision: Total knee replacement surgery replaces the entire knee joint from femur to the tibia. A partial knee (unicompartmental) replacement involves an implant in just one side of the joint retaining the uninvolved parts. Recovery is generally longer for a total knee replacement, but the long term value lies in the longevity of the implant and the functionality it provides. The unicompartmental approach was developed many years ago for particular segments of the population – older patients that were thinner and had limited damage to one portion of the knee, damage resulting from a traumatic injury rather than arthritis (if your ligaments are intact and if your knee still contains a fair amount of healthy cartilage).

Advantages of a partial knee replacement: Compared to a total knee replacement there is less blood loss, shorter hospitalization, and quicker recovery. Since less bone and cartilage are cut out most patients say that a unicompartmental knee replacement feels more like their real knee compared to a total knee replacement. However, long term, a unicompartmental replacement has a high failure rate. MAKOplasty is a minimally invasive robot-assisted partial knee procedure. Only the diseased portion of the joint is removed, leaving the healthy bone and surrounding tissue untouched. It is important to note that robotic surgeries lead to longer procedure times, meaning the patient's time under anesthesia is increased. Longer procedure times, for any surgery, increase the risk of infection and blood clots. Further, patients should be aware that the robot is a machine being operated by a surgeon. The use of robot assistance does not, by itself, guarantee a good or better surgical outcome. The success of the procedure depends mainly on the training and the experience of the surgeon. Patient selection criteria for MAKOplasty remains the same as that of any partial knee replacement surgery.

Potential downsides to a partial knee replacement: Arthritis may progress in the remaining knee and

(continued from front)

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eventually the partial knee replacement may need to be converted to a total knee replacement. Not all patients experience a shorter recovery. Just like with a total knee replacement, every patient recovers differently. The key to a successful partial knee replacement is proper patient selection. Many surgeons and most literature indicate that only 5-10% of those with osteoarthritis are candidates for this procedure.

Other new techniques include Subchondroplasty, which is a minimally invasive surgery for patients suffering from knee pain associated with chronic bone marrow edema (BME). This technique is still considered experimental by most insurance companies including Medicare. This means that patients must pay out-of-pocket for all associated expenses. Its efficacy has yet to be determined.

At Lancaster Orthopedic Group, we value evidence-based medicine and continue to study new technologies in order to determine if they are safe and provide long-lasting results for our patients. Historically, some new technologies made promises but never delivered, and our physicians are careful to avoid procedures that offer no clinical proof. New procedures are typically discussed and critiqued at national orthopedic meetings and conferences attended frequently by LOG physicians and those forums provide a good medium for reviewing new techniques. LOG has been at the forefront of innovation for 27 years and pioneered minimally-invasive surgery in Lancaster County. Our knee surgeons, combined, do well over 1,000 total knee replacements a year. We continue to focus on decreasing hospital length of stay after total joint replacements and currently are among the lowest in the area. We also use the most current techniques for pain control after surgery. We value the experience that each of our physicians has within his or her subspecialty area of expertise and base all of our decisions on what we believe to be the patient's best interest.

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FAQ: Does LOG offer evening or weekend appointments?

In a continuing effort to provide residents of Lancaster County with the best in subspecialized orthopedic care, Lancaster Orthopedic Group now offers extended hours at 3 office locations.

Saturday morning hours have long been part of the schedule at the Granite Run office. The primary purpose of these office hours is to handle patient issues that arise after office hours on Fridays or in the emergency room during Friday evenings. We do, however, schedule some routine patients during these same hours. Dr. Corey Troxell staffs about half of our Saturday hours.

Evening appointments were made available in early 2011 at the Mount Joy office as well as at the Ephrata office in the ECH Health Pavilion. These "after hours" appointments became so popular among both patients and referring physician offices that we began offering them at our Granite Run office in March of 2012.

Staffing during extended hours includes a physician, nurse, x-ray technologist, and cast technician as well as clerical staff. While we do not accept walk-ins, we do encourage last minute phone calls in the event that there may be an opening in the evening schedule. Offices are open until 9pm during evening hours, and the Granite Run office is open from 9am-noon during Saturday hours.

Our extended hours schedule as of July 1st is as follows:

Monday Evenings: Mt Joy with Corey Troxell, DO

Tuesday Evenings: Granite Run with Wayne Conrad, MD or Joy Long, MD (alternating weeks)

Thursday Evenings: Ephrata Health Pavilion with Corey Troxell, DO

Saturday Mornings: Granite Run (half of the shifts covered by Corey Troxell, DO with the other 15 physicians rotating coverage)