S. Bollen
Recently Retired Consultant Orthopaedic Surgeon
Spire Leeds Hospital, Leeds, UK

Knee arthroscopy: the elephant in the room

Knee arthroscopy has had more than its fair share of bad press in recent years. Even the *BMJ* recommended, in a clinical practice guideline for the degenerative knee and meniscal tears,[1] that arthroscopy is not indicated in nearly all patients with degenerative knee disease. It should be noted, however, that this paper was based on an erroneous interpretation of a number of trials, and was produced by a panel that did not include any British orthopaedic surgeons or fellows of the surgical colleges. Although a robust rebuttal was sent in an open letter to the Editor of the *BMJ*[2] – to which there was no reply – many primary care trusts have now adopted these guidelines, to the detriment of a large number of patients and despite subsequent and, I believe, more reasoned guidelines being produced by the British Association for Surgery of the Knee.

A recent editorial in *The Bone & Joint Journal* titled 'The assault on arthroscopy'[3] rightly addressed many issues in the ongoing debate surrounding arthroscopy, to which I would like to add a further suggestion based on my own experiences.

Over the years, I have had some interesting conversations about arthroscopic knee surgery, including a surgeon with a different surgical specialty at a regional orthopaedic meeting who told me, "I don't do knee arthroscopies for the NHS but I do them privately – just to keep my hand in." On another occasion, I was told that it is commonplace for some surgeons to list six bilateral knee arthroscopic washouts in a morning in the private sector.

To give another example, there were 12 surgeons at a local private hospital in Yorkshire who listed knee arthroscopy as a "special interest" on the hospital's website, yet only four completed a fellowship in knee arthroscopy. One of these non-fellowship surgeons is known to have abandoned a medial meniscal repair, with a tourniquet time of 82 minutes; a specialist may be expected to take between 15 and 20 minutes on average. However, no action was taken by the hospital, and knee arthroscopy is still listed as one of the surgeon's special interests.

Arthroscopy should be quick and effective, minimizing patient morbidity. If a surgeon regularly took three hours to carry out a joint arthroplasty, questions would be asked – and understandably so – but tourniquet times of 45 minutes among non-specialists are regularly recorded for knee arthroscopy without much comment. The articular cartilage should also remain pristine, but in many of the cases that I have had to redo (when referred for a second opinion), parts of the cartilage were trashed by the previous surgeon, a problem that may not be obvious until several years after the original procedure.

If you needed a hip arthroplasty, would you go to a surgeon whose major interest is another subspecialty and does them infrequently, or to someone who had completed a fellowship in joint arthroplasty and does them all the time? The answer is a straightforward one, so why should knee arthroscopy be any different?

It may be unpalatable to state, but many of the problems we have with arthroscopy's image are related to its longstanding reputation as an income generator. The coding may have been a problem, with a single bite taken out of a meniscus or an asymptomatic plica, generating an extra few hundred pounds of income. I have lost count of the number of knees I have rescoped, only to find no sign that they had anything appropriate done in the first place. This is, quite simply, fraud. One can understand the frustrations of the insurance companies.

BUPA insist that a form must be filled in before knee arthroscopy can take place – the only procedure for which this is the case – a precaution that suggests the presence of some dubious decision making. Not surprisingly, adopting this approach has led to hugely reduced arthroscopy rates. At a local private hospital, a surgeon was brought in to do Choose and Book work, but later stopped operating after committing a series of major errors. When a colleague and I were asked to review the patients that had been listed for arthroscopy, we cancelled two-thirds of them, as they had no indication for the procedure.

When I talk to arthroscopic surgery colleagues from around the country, many have similar experiences and opinions. This is not protectionism; we simply care about our specialty, just as other subspecialists do. Until we address this aspect of our profession, we can justifiably expect continuing criticism.

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