



# ESSKA **Meniscus Consensus Project:** Degenerative meniscus lesions



# European Meniscus Consensus

All rights reserved. No part of this publication may be reproduced, distributed, or transmitted in any form or by any means, including photocopying, recording, or other electronic or mechanical methods, without the prior written permission of ESSKA, except in the case of brief quotations with noncommercial use permitted by copyright law.

Please use the following signage while quoting:

*“ESSKA Meniscus Consensus: Copyright ©2016 ESSKA”*

For permission requests, please contact ESSKA Office ([info@esska.org](mailto:info@esska.org))



- **Philippe Beaufils**, *Versailles, France*
- **Roland Becker**, *Brandenburg, Germany*
- **Martin Englund**, *Lund, Sweden*
- **Sebastian Kopf**, *Berlin, Germany*
- **Matthieu Ollivier**, *Marseille, France*
- **René Verdonk**, *Ghent, Belgium*

# Disclosure

## P. Beaufils

Educational consultant for, Smith&Nephew, Zimmer companies

Chief Editor of Orthopaedics and Traumatology: Surgery and Research

## R. Becker

Research grants by Richard Wolf, Arthrex, Mathys

Educational consultant for Mathys, Richard Wolf

Deputy Editor of Knee Surgery Sports Traumatology and Arthroscopy

## M. Englund

None. Research funding is all governmental or from independent foundations



# Disclosure

## S. Kopf

Presentations at Orthopaedic further educations organized by Smith & Nephew and Karl Storz

Research support by Karl Storz company

## M. Ollivier

None

## R. Verdonk

Consultant for Orteq Company



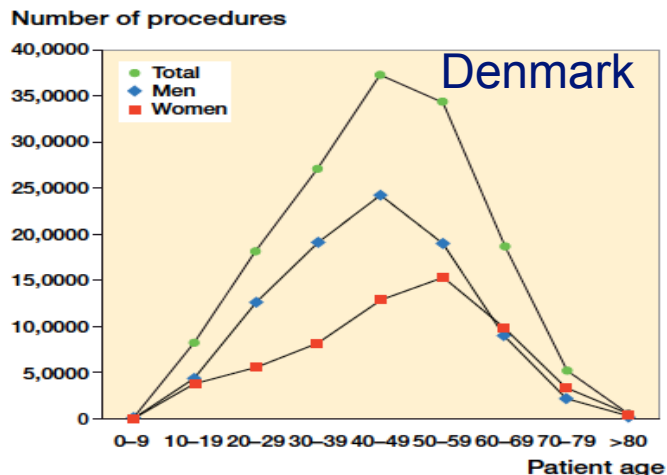
# Why there is a Need for a Consensus about the Treatment of Degenerative Meniscus Lesions?

P. Beaufils – R. Becker

# European Meniscus Consensus

## Why?

Arthroscopic Partial Meniscectomy (APM) is one of the most frequent procedures especially in the field of degenerative meniscus lesions.



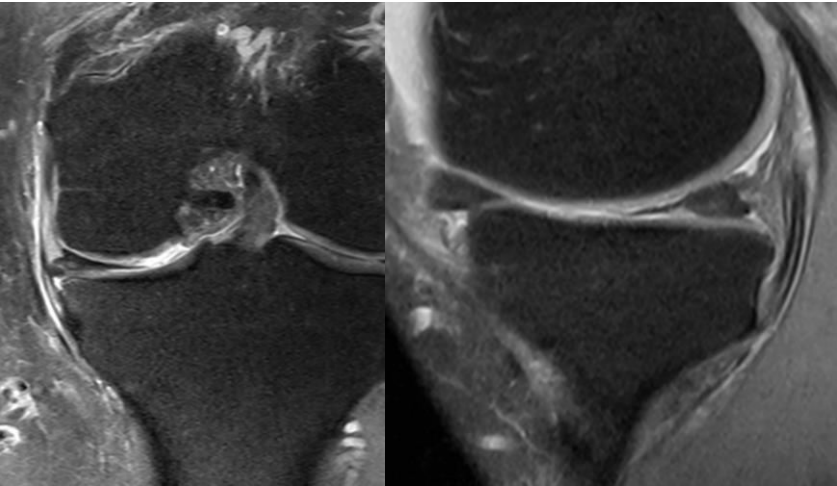
- *Cullen et al. Nat health Stat rep 2009*
- *Thorlund et al. Acta Orthop 2014*
- *ATIH (French Agency for Hospital Information) 2016*



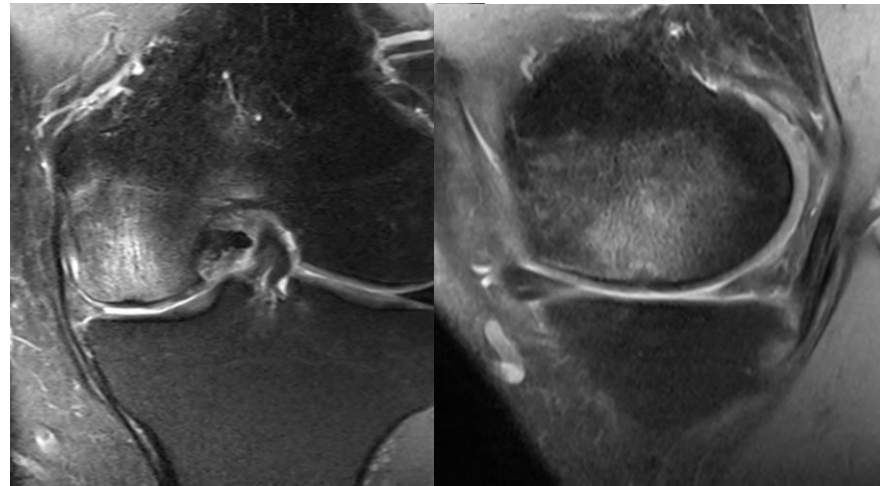
# European Meniscus Consensus

- A lot of success!
- But some failures or complications

Preoperative



5 months postoperative







# European Meniscus Consensus

## Contrast !

Several RCT's seemed to demonstrate no additional benefit of APM compared to non-operative treatment.

- *Moseley et al. N Eng J Med 2002*
- *Kirkley et al. N Eng J Med 2008*
- *Herrlin et al. KSSTA 2013*
- *Katz et al. N Eng J Med 2013*
- *Yim et al. Am J Sports Med 2013*
- *Sihvonen et al. N Eng J Med 2013*
- *Sihvonen et al. Ann Intern Med 2016*



- There is considerable gap between the scientific publications and the daily practice.
- The Purpose of scientific publications is to “scientifically” demonstrate the efficacy, or sometimes the lack of it (!), of a given procedure.
- But RCT’s and meta-analyses, as good as they may be, have their biases and weaknesses and cannot be considered as guidelines per se.

- *Chess et al. BMC Med Res Method 2013*
- *Clavien et al. Br J Surg 2014*





# Gap between daily practice and “science”? Example of Denmark

## Large increase in arthroscopic meniscus surgery in the middle-aged and older population in Denmark from 2000 to 2011

Jonas B Thorlund<sup>1</sup>, Kristoffer B Hare<sup>1, 2</sup>, and L Stefan Lohmander<sup>1, 3, 4</sup>

The **overall annual incidence** of meniscal procedures per 100,000 persons in Denmark **doubled from 164 in 2000 to 312 in 2011** (i.e. 8,750 procedures to 17,368 procedures). A **2-fold** increase was found for patients aged **between 35 and 55**, and a **3-fold increase** was found for those **older than 55**.

# Gap between daily practice and “science”?

## Example of France

Slight decrease of procedures since Guidelines Publication in 2009

Orthopaedics & Traumatology: Surgery & Research (2009) 95, 437–442

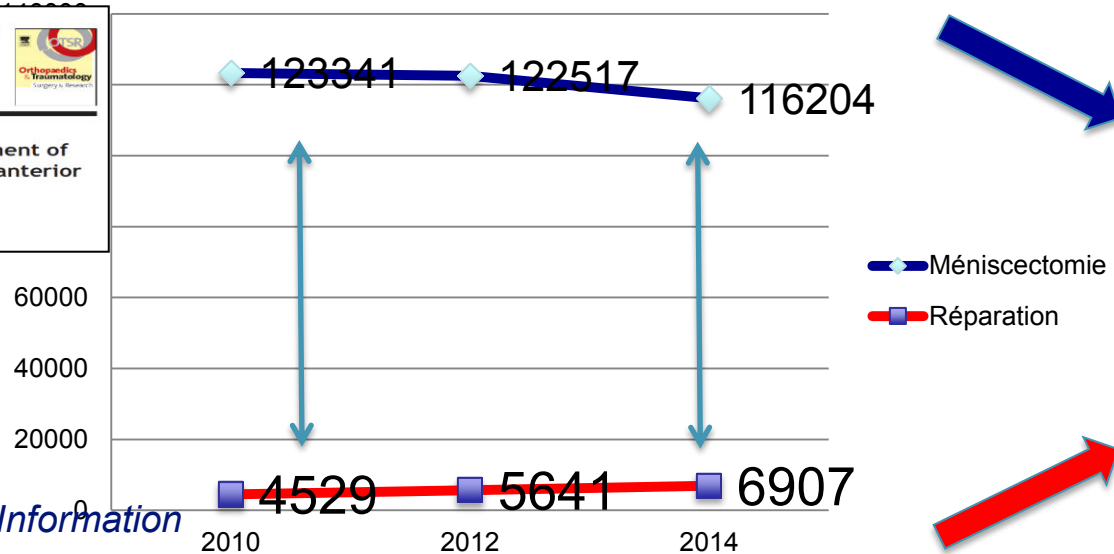
Available online at ScienceDirect  
www.sciencedirect.com

Elsevier Masson France  
EM|consulte  
www.em-consulte.com

REVIEW ARTICLE

**Clinical practice guidelines for the management of meniscal lesions and isolated lesions of the anterior cruciate ligament of the knee in adults**

P. Beaufils<sup>a,1,\*</sup>, C. Hulet<sup>b</sup>, M. Dhénain<sup>c</sup>, R. Nizard<sup>c</sup>, G. Nourissat<sup>d</sup>, N. Pujol<sup>a</sup>



ATIH data 2014

French Agency for Hospital Information



How to deal with this apparent contradiction  
between  
« **science** » vs. « **daily practice** »

How to deal with it? The fight?

# How to deal with it? The fight?



## Pro non-operative treatment

Routine knee arthroscopic surgery for the painful knee in middle-aged and old patients—time to abandon ship

L Stefan Lohmander, Jonas B Thorlund & Ewa M Roos

- *Lohmander et al. Acta Orthop 2016*
- *Thorlund et al. Br J Sports Med 2015*



# How to deal with it? The fight?

## Pro APM

EDITORIALS  
Could the New England Journal of Medicine Be Biased Against Arthroscopic Knee Surgery?

**ARTHROSCOPY**  
THE JOURNAL OF ARTHROSCOPIC AND RELATED SURGERY

PERSONAL VIEW  
Is arthroscopy of the knee completely useless?

META-ANALYSIS - A REVIEWER'S NIGHTMARE

I have personally always thought of meta-analyses as a poor man's research – no original

the paper by Thorlund et al and although anecdotal, in my immediate peer group we have



S. R. Bollen

- El Attrache et al. Arthroscopy 2014
- Lubowitz et al. Arthroscopy 2014
- Rossi et al. Arthroscopy 2014
- Bollen BJJ 2015



Copyright ©2016 ESSKA



# European Meniscus Consensus



These statements are confusing and have not been useful to the clinician in making treatment decisions

 or the Consensus ?

## Focusing on results after meniscus surgery

Philippe Beaufils · Roland Becker · Rene Verdonk ·  
Henrik Aagaard · Jon Karlsson



“The necessity of a consensual process becomes clear, founded on the **independence** of the organizers and with the participation of **all interested parties** ... Work of this kind will permit a probable **reduction in the number of arthroscopic meniscal resections** in our countries in favour of abstention ...





# ESSKA Meniscus Consensus Project: Degenerative meniscus lesions



## What is a consensus ?

### 2 Criteria

1. Independent authorities
  - National public authorities
  - National health care systems
  - Scientific societies

*Beaufils et al. OTSR 2009*  
*Mayr et al. Unfallchir 2010*  
*AANA Committee 2011*  
*Brown J Am Acad 2013*





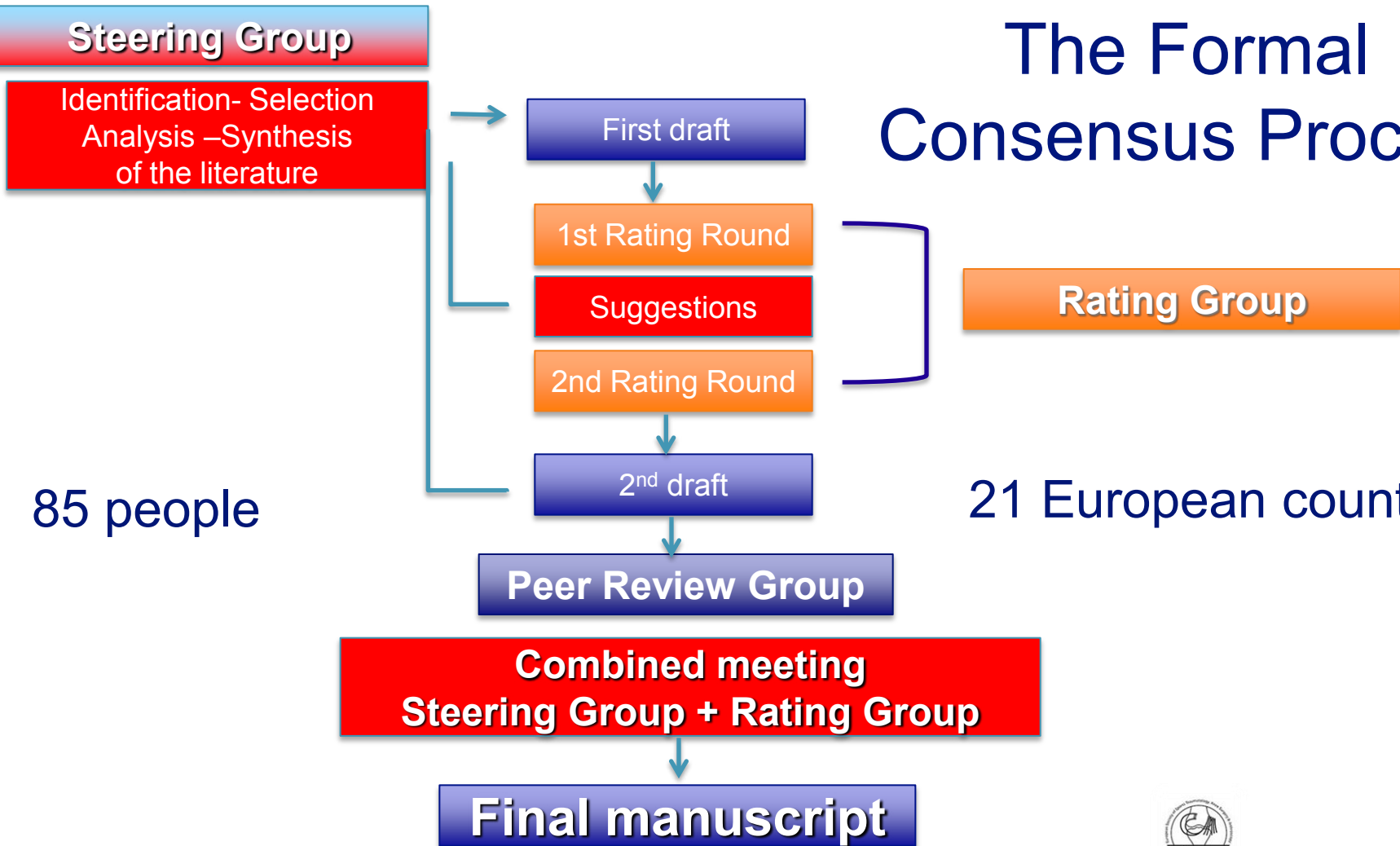
## What is a consensus ?

2. All specialties involved in the field must be represented to expect adoption.

# The Formal Consensus Process

85 people

21 European countries





## Grading of the Answers Based on the Quality of the Available Literature

Grade A: high scientific level

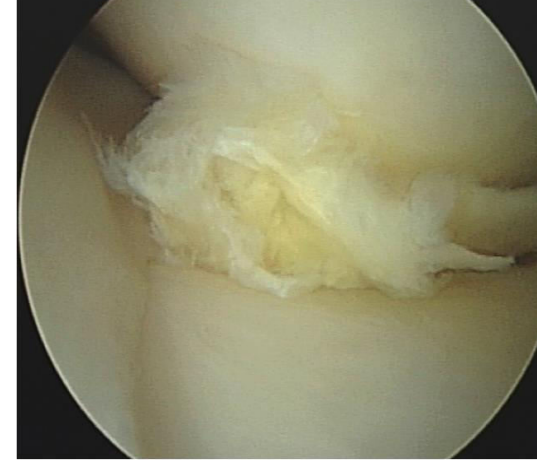
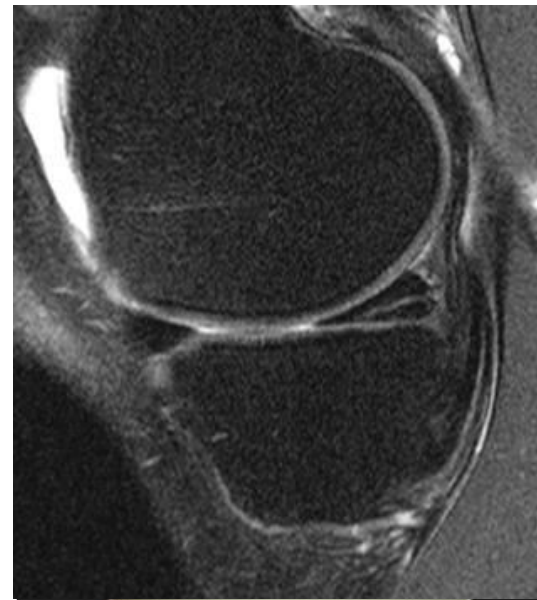
Grade B: scientific presumption

Grade C: low scientific level

Grade D: expert opinion

# Inclusion

- Degenerative meniscus lesions
- No Trauma
- > 35 years





# Exclusion

- Congenital lesions
- Traumatic tears
- Horizontal cleavage in young patients



## Presentation at the 17<sup>th</sup> ESSKA congress Barcelona

- Background: *Martin Englund*
- Imaging: *Matthieu Ollivier & Philippe Beaufils*
- Management: *Sebastian Kopf*
- Strength and Limitations: *Roland Becker, Philippe Beaufils*

Summary and full text are available on



### Meniscus Consensus Project

Chairmen:



Philippe Beaufils Roland Becker

The ESSKA MENISCUS CONSENSUS INITIATIVE was initiated by the ESSKA Board after the congress in Amsterdam in 2014. It has been commissioned to two world-renowned experts in the field, Prof. Philippe Beaufils (France) and Prof. Roland Becker (Germany). The goal of the initiative is to find a European consensus on the treatment of meniscus pathologies. Finding a consensus in such a diverse continent like Europe where medical culture and healthcare systems vary from country to country is not easy. A strict methodology therefore been applied and numerous European experts have been involved in this.

the merit of the two leaders of this group that we are able to come up with this which shall be understood in guidance to ESSKA members. We thank Dr. Jansen Rak, without whom this would not have been possible. A special acknowledgement also goes to Dr. Jansen Rak, without whom this would not have been possible.

### ESSKA Meniscus Consensus Project: Degenerative meniscus lesions

Chairmen: Philippe Beaufils, Roland Becker

[www.esska.org](http://www.esska.org)

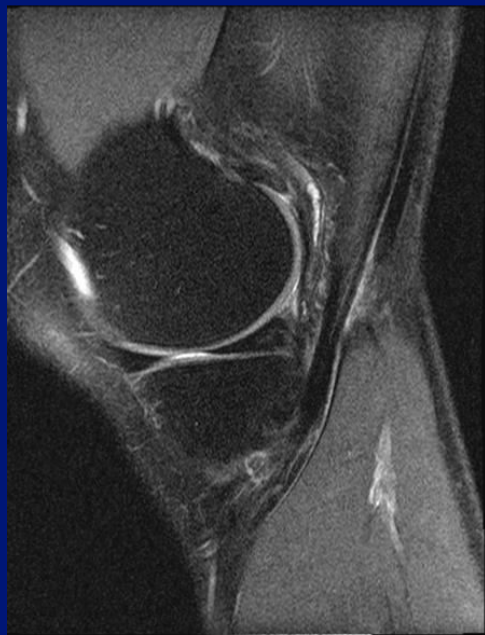


# Background for the consensus of the degenerative meniscus lesion

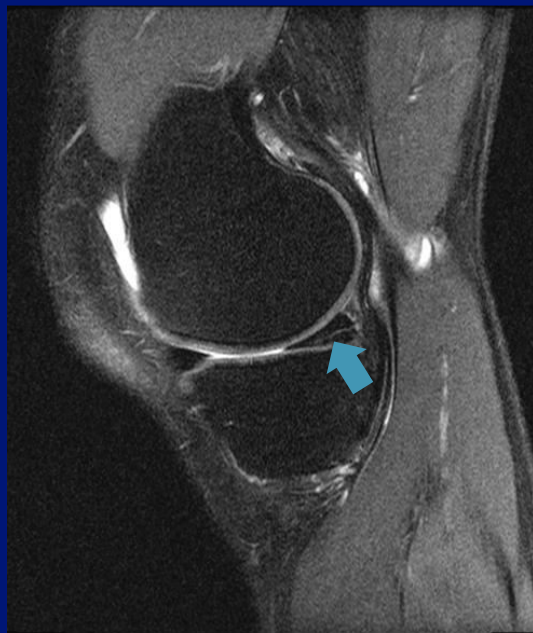
**Martin Englund**

Lund University, Faculty of Medicine, Department of  
Clinical Sciences Lund, Orthopaedics, Lund, SWEDEN

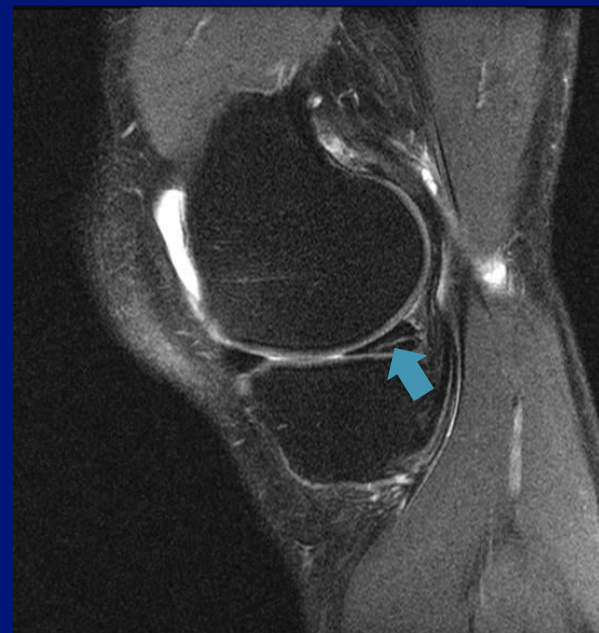
# How do degenerative meniscus lesions develop?



Baseline



2 years



4 years

# Risk factors

- Knee malalignment (the more loaded compartment)
- Bony enlargement of finger nodes (Heberden's/Bouchard's nodes)
- Heavy occupational load (x-sectional)

Englund et al. *Ann Rheum Dis.* 2011

Rytter et al. *J Rheumatology* 2009



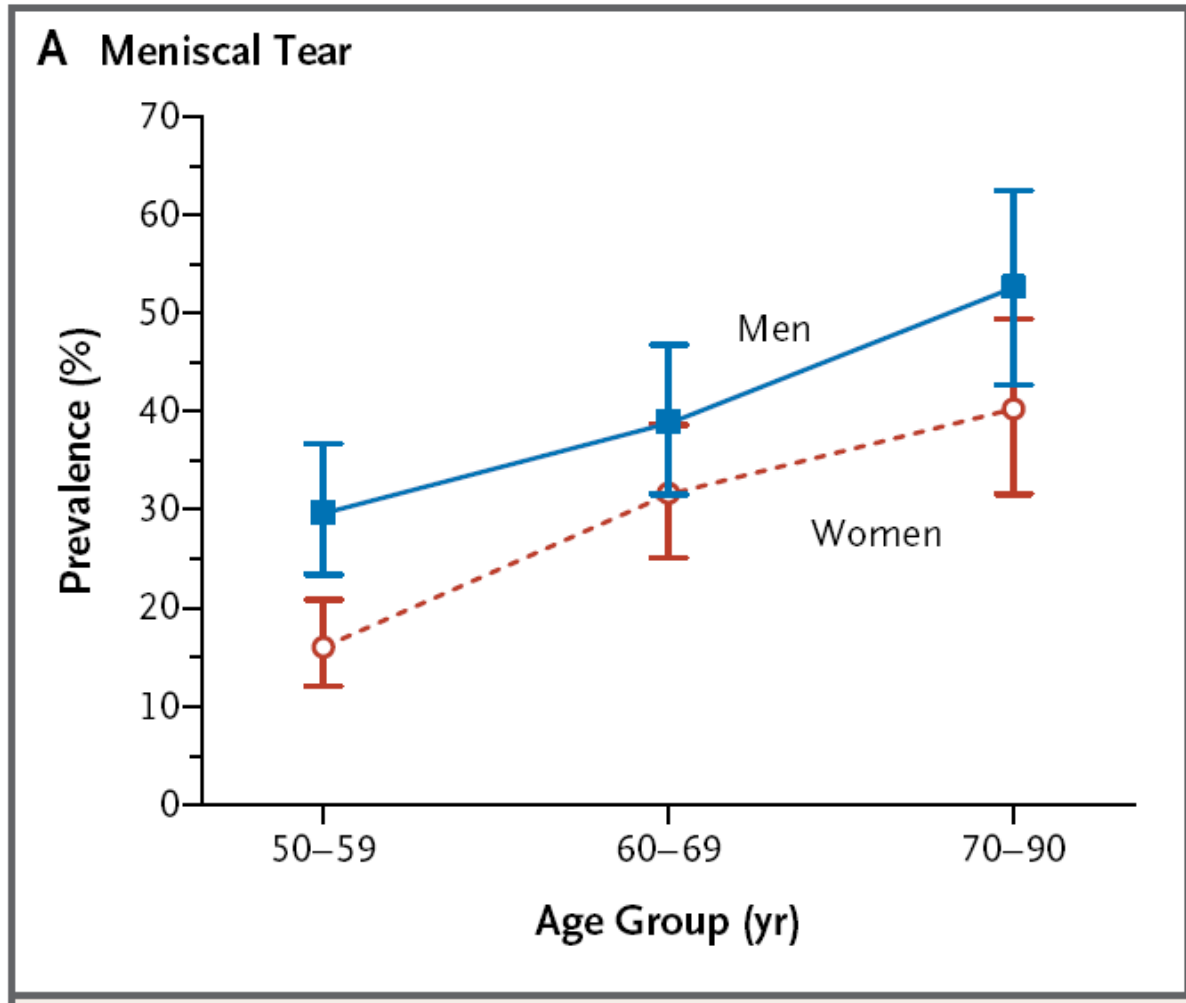
Copyright ©2016 ESSKA

How common are  
meniscus lesion ?



# Prevalence of meniscus tear

n=991 knees  
from general  
population,  
Framingham,  
Massachusetts,  
USA





# Knee symptoms?





# Clinical and autopsy studies

Br. J. Surg. Vol. 62 (1975) 977-981

**Clinical features of the degenerate meniscus  
with the results of meniscectomy**

JONATHAN NOBLE\*

## IN DEFENCE OF THE MENISCUS

A PROSPECTIVE STUDY OF 200 MENISCECTOMY PATIENTS

J. NOBLE, K. ERAT

*From The Princess Margaret Rose Orthopaedic Hospital, Edinburgh*

“The horizontal cleavage lesion probably exists much more commonly than symptoms arising from it. Therefore, other factors must be involved in the production of symptoms.”



# Most meniscus tears are asymptomatic

61% of meniscus tears were found in persons without *any* knee pain, aching or stiffness

## CONCLUSIONS

Incidental meniscal findings on MRI of the knee are common in the general population and increase with increasing age.

Englund et al. *New Engl J Med* 2008

In patients with meniscus tear in a symptomatic knee, 63% had a tear in their asymptomatic knee (mostly degenerative).

Zanetti et al. *AJR* 2003



Just because there is a meniscus tear  
in a patient *with* knee symptoms...  
does *not* necessarily imply it is a

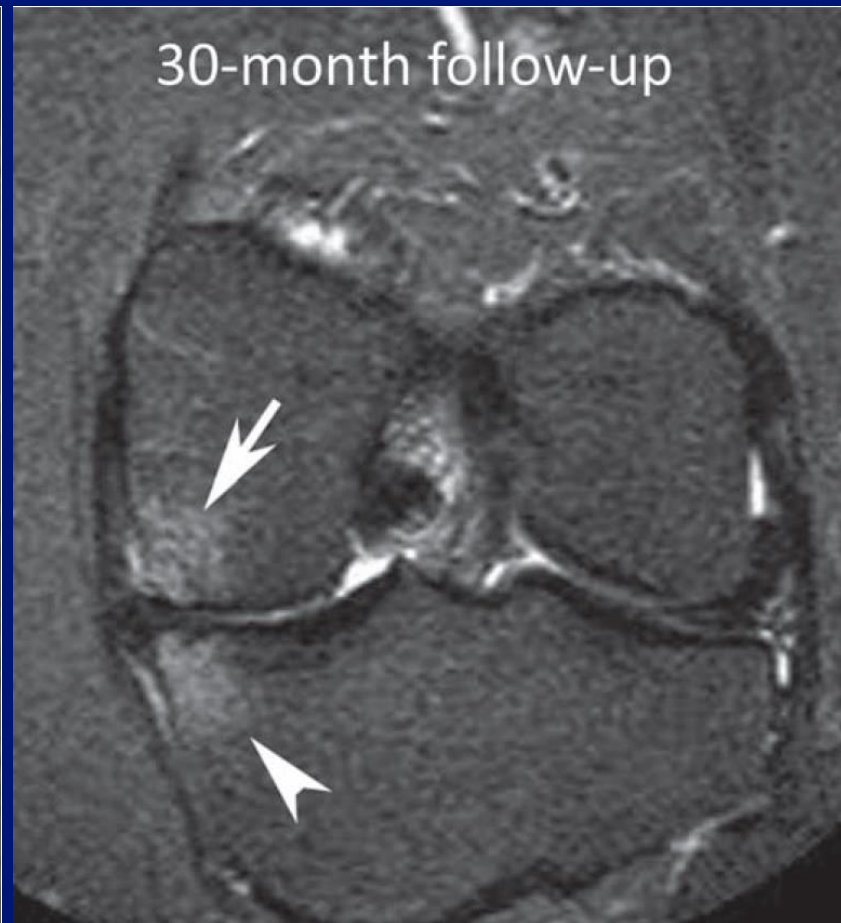
**”symptomatic meniscus tear”!**

# Be careful with the temptation “to pick low-hanging fruit”



# Causal chain of events to knee pain?







# The relationship with osteoarthritis?

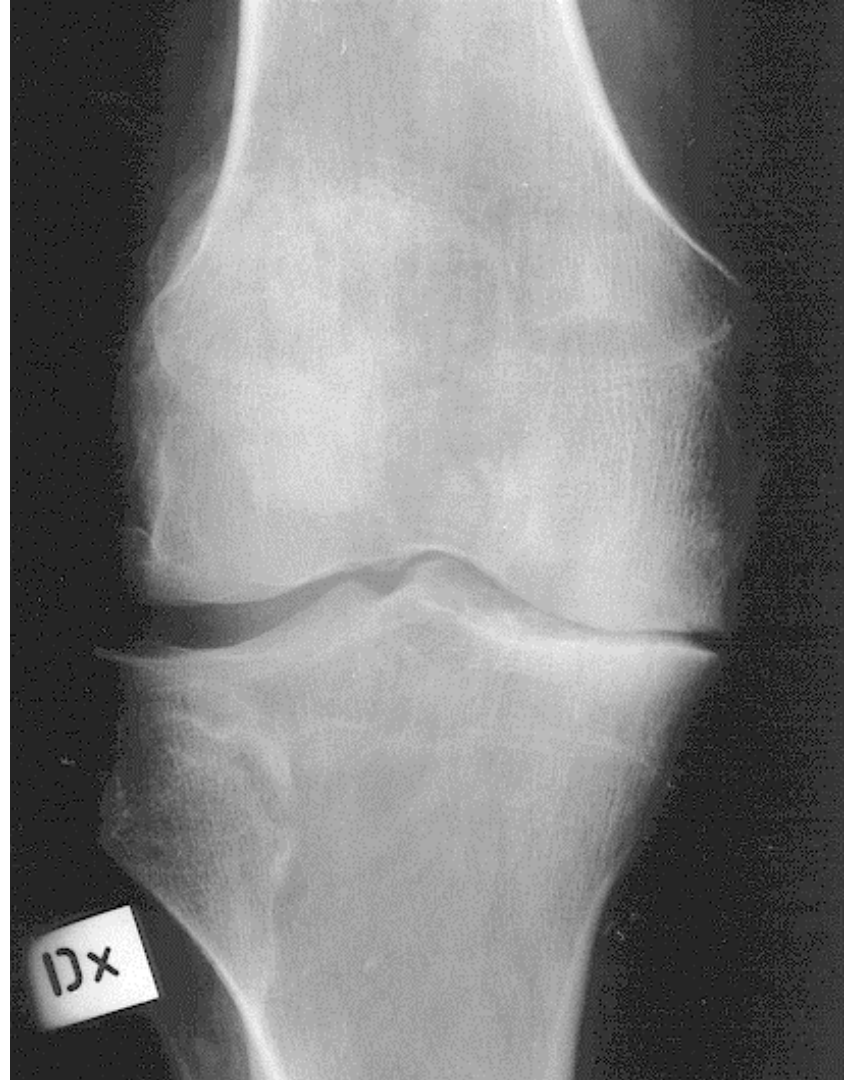
# Risk of symptomatic osteoarthritis after meniscus tear and APM

---

Type of tear	Risk ratio*
Traumatic	2.7
Degenerative	7.0

\*Compared to age, sex, and body mass index-matched population-based reference subjects without known knee injury

Englund et al. *Arthritis Rheum.* 2003



# Osteoarthritis development

Molecular-level  
(early)

Cartilage and meniscus  
(middle)

Osseous  
(late)

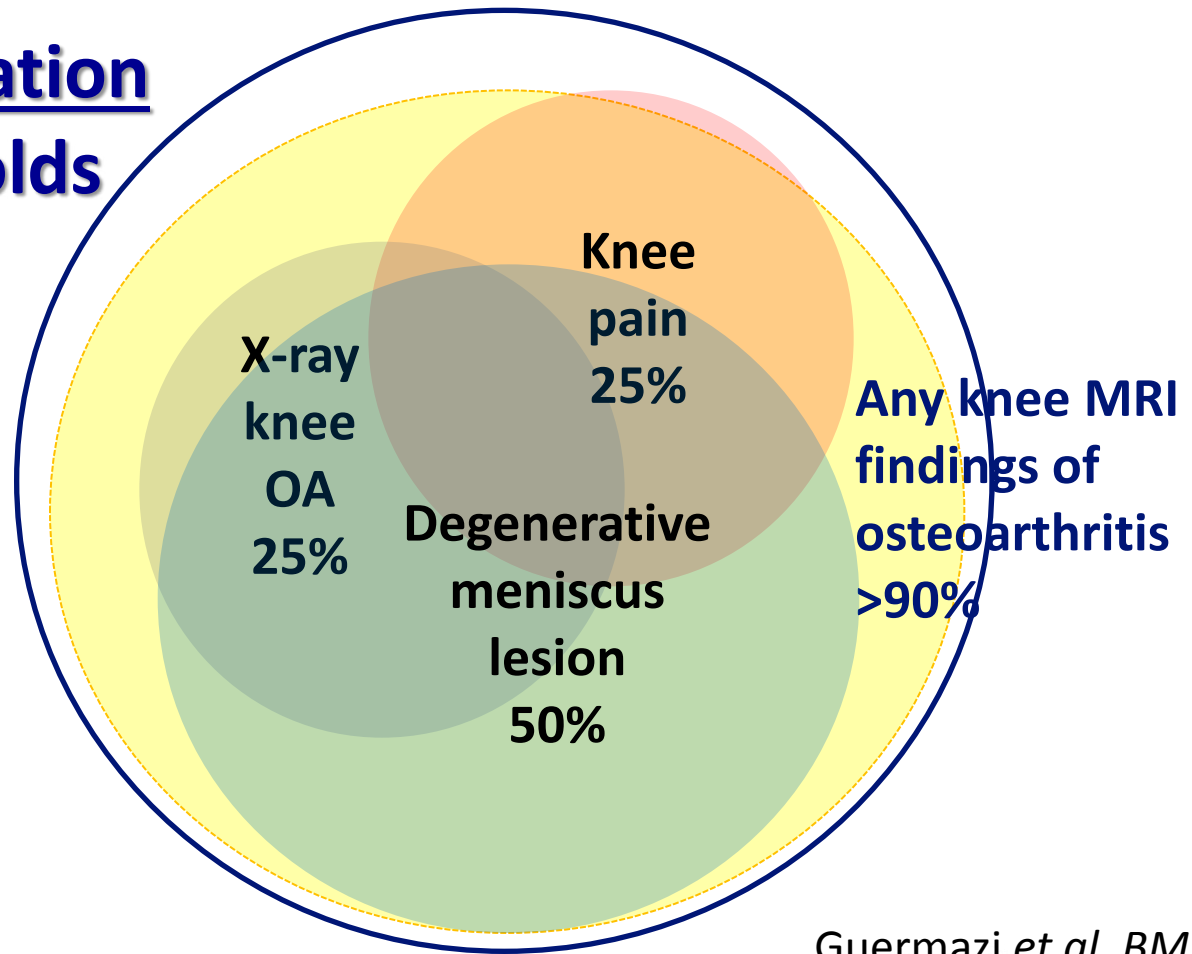
**No**



**Yes**

Symptoms may come early, in the middle, late, or not at all!

# General population 50 to 85-year olds



# Challenge to separate pathologies from ageing



- People do age
- What about our knees?
- **Over diagnosis & over treatment**

# ESSKA Meniscus Consensus Project: Degenerative meniscus lesions

## Key points to background

- ✓ Caused by (or part) of “osteoarthritic-alike” or other slow degenerative processes, and (or) ageing
- ✓ Highly prevalent in general population
- ✓ The lesion *per se* is often not painful (use the term “*symptomatic meniscus tear*” with care)
- ✓ More likely an incidental finding



# Management of Degenerative Meniscus Lesions - Imaging -

**Matthieu Ollivier, Philippe Beaufils**



# European Meniscus Consensus

MRI overuse  $\longleftrightarrow$  Meniscectomy



Need for a standardized clinical and imaging exam





**Which MRI criteria characterize a degenerative meniscus lesion?**

**A degenerative meniscus lesion is usually characterized by linear intrameniscal MRI signal (including a component with horizontal pattern) often communicating with the inferior meniscal surface on at least two image slices. A more complex tear pattern in multiple configurations may also occur. The most common location of a degenerative meniscus lesion is the body and (or) posterior horn of the medial meniscus.**

**Grade B**



# *High Frequency of*

*Meniscus Lesions*

*Knee Pain*

*Associated lesions*



*Do degenerative meniscus lesions cause knee symptoms?*

*There is **very limited evidence** that pain in the degenerative knee is **directly attributable to a degenerative meniscus lesion** even if the lesion is considered to be unstable. Great caution must be taken before arriving at the conclusion that the degenerative meniscus lesion is the direct cause to the patient's knee symptoms. **Grade B***

*What is the role of knee radiographs in the assessment of middle-aged or older patients with a painful knee?*

*Knee radiography should be used as **a first line imaging tool** to support a diagnosis of osteoarthritis or to detect certain rarer pathologies of the knee. Therefore, at least anteroposterior weight-bearing **semi-flexed knee radiography** including a lateral view should be included in the work up of the middle-aged or older patient with knee pain.*

*Grade B*



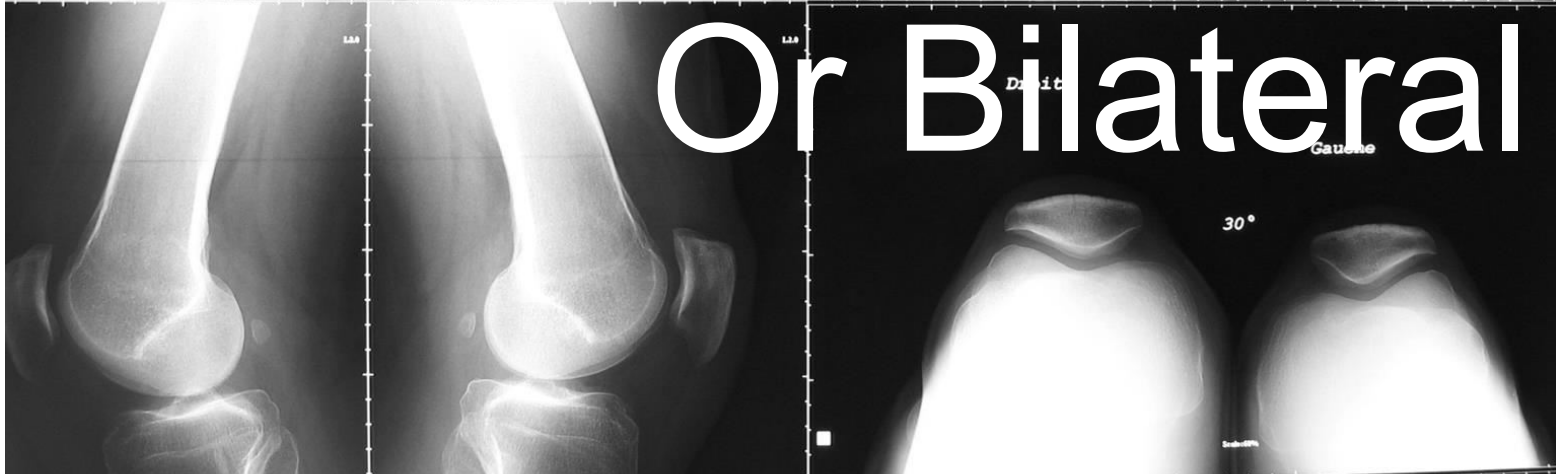
Droit

SCHUIS  
Droit

Droit

# Can be Unilateral





# Schuss view (or Rosenberg view or 45° view)



Weight bearing radiography in extension



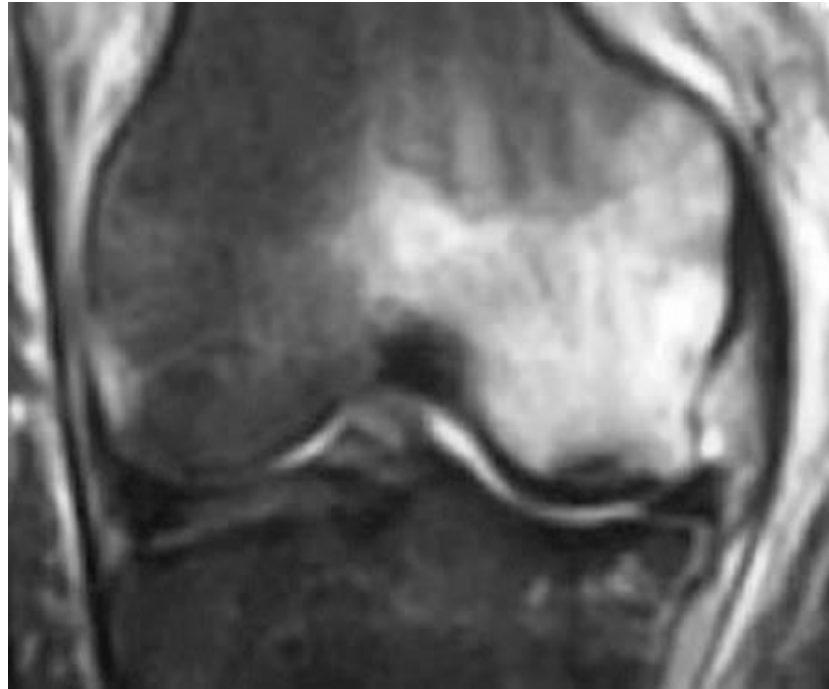
Rosenberg view

***What is the role of knee MRI in the assessment of a middle-aged or older patient with a painful knee?***

***Knee MRI is typically not indicated in the first line work up of the middle-aged or older patients with knee joint symptoms. However, knee MRI may be indicated in selected patients with refractory symptoms or in the presence of 'warning flags' or localized symptoms indicating a rarer disease that needs to be ruled out, e.g., osteonecrosis...***



# For example



Diagnosis of osteonecrosis



# Ischemia + Meniscus Lesion

61 Y old patient

medial knee pain



September 2010

asymptomatic



December 2010



Copyright ©2016 ESSKA

***What is the role of knee MRI in the assessment of a middle-aged or older patient with a painful knee?***

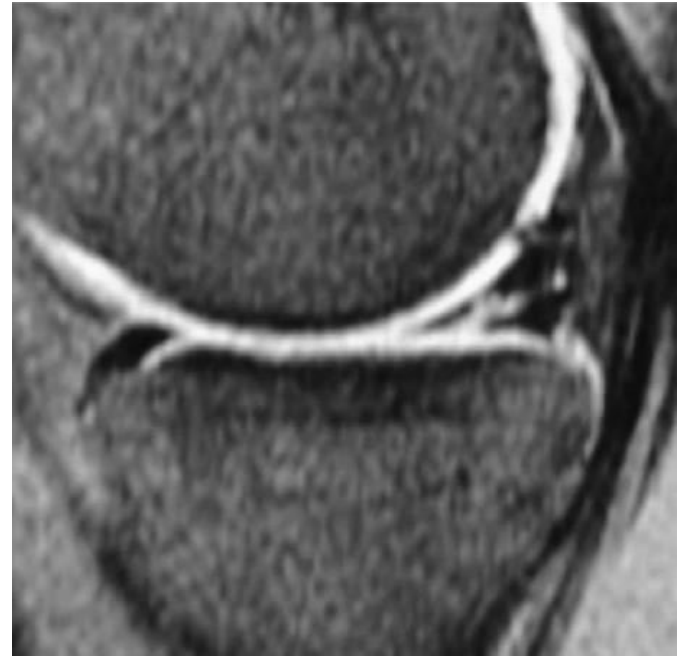
***... Hence, if a surgical indication is considered, based on history, symptoms, clinical exam and knee radiography, knee MRI may be useful to identify structural knee pathologies that may (or may not) be relevant for the symptoms.***



# MRI does not only diagnose meniscus lesions



Grade 2



Grade 3

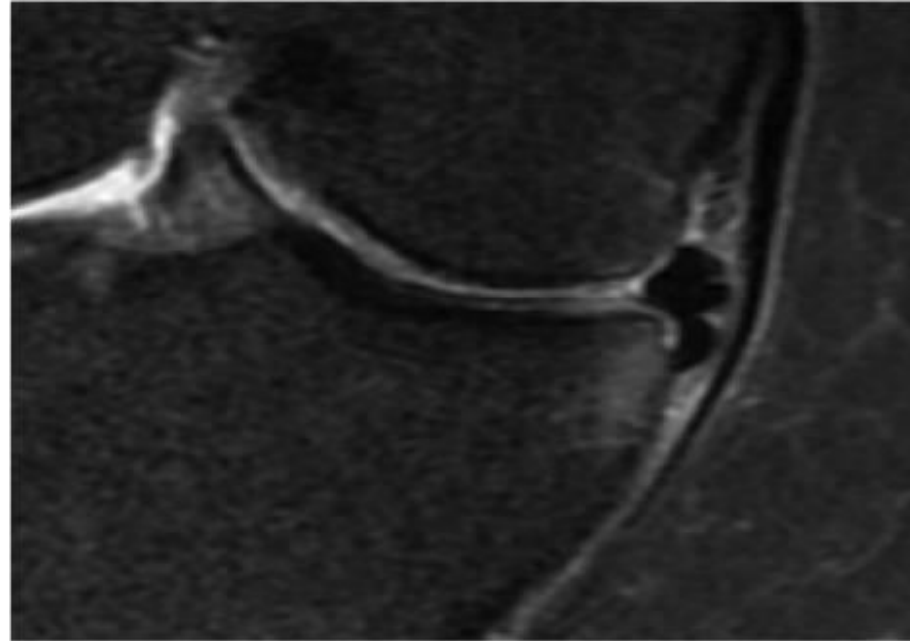
# But also meniscus stability

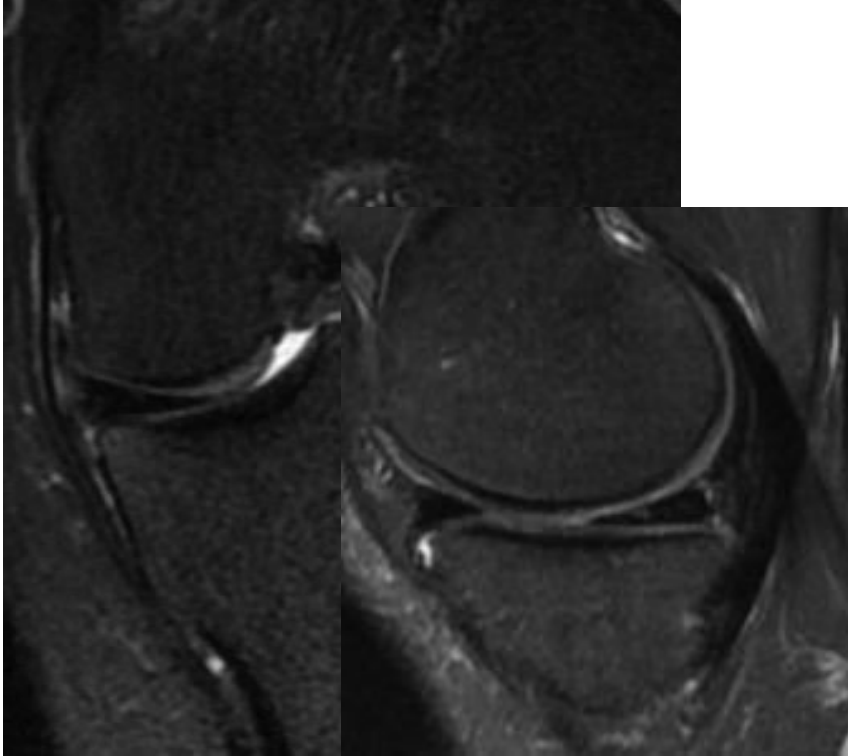
Mechanical symptoms

Displaced flap

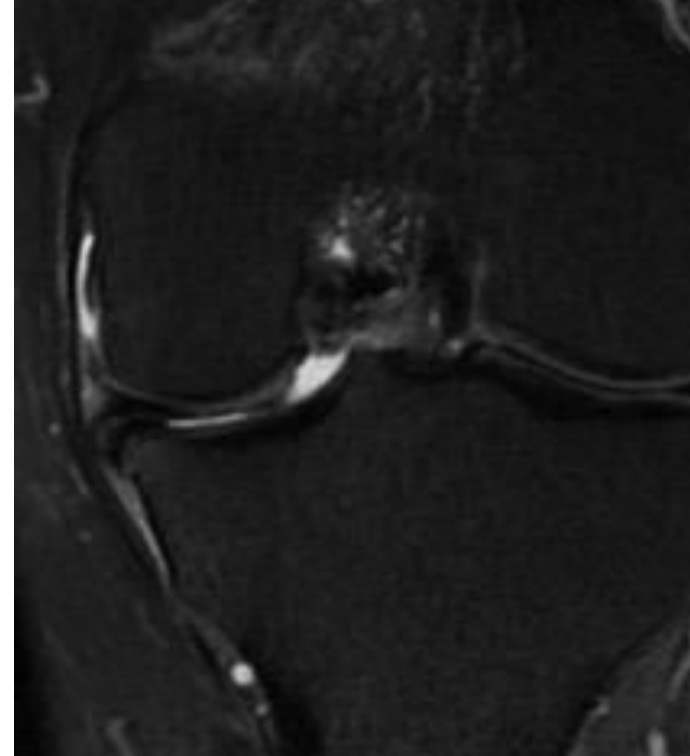


Surgery?





Aug 2015



Dec 2015

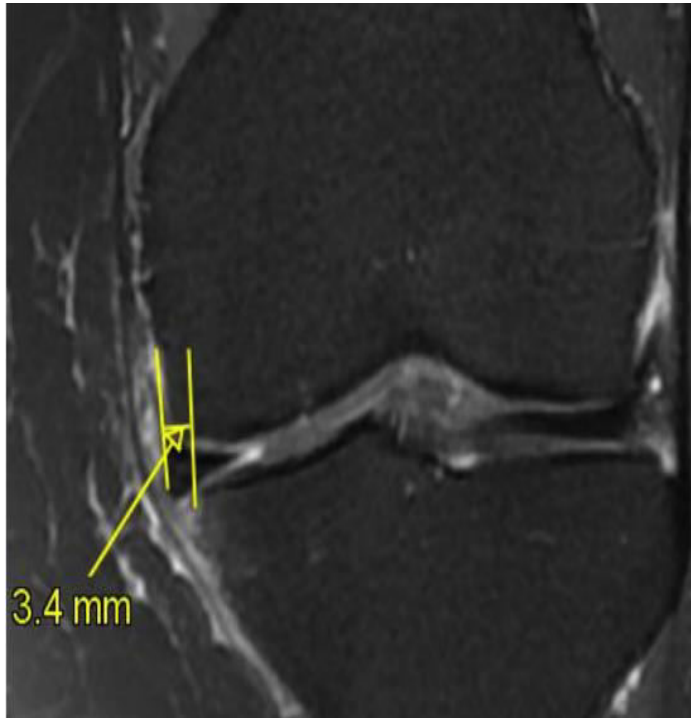
- 
- Stable meniscus lesion
  - Non-operative treatment

- 
- Unstable lesion
  - Surgery?



# Early signs of osteoarthritis



Extrusion



Bone marrow oedema



# To summarize

- Knee pain compatible with degenerative meniscus lesion
- 
- X-rays: first line; MRI for special indications
- 
- MRI when surgery is considered to confirm or exclude meniscus lesion and to evaluate further pathologies



# Management of Degenerative Meniscus Lesions - Treatment –

**Sebastian Kopf**





***When should arthroscopic partial meniscectomy (APM)  
be proposed?***

# European Meniscus Consensus



*When should arthroscopic partial meniscectomy (APM) be proposed?*

1. Surgery **shouldn't be proposed as a FIRST line** of treatment of degenerative meniscus lesions. *Grade A*

# European Meniscus Consensus



2. After 3 months with non-operative treatment and persistent pain / mechanical symptoms, arthroscopic partial meniscectomy (APM) may be proposed.

*Grade B*

# European Meniscus Consensus



*When should arthroscopic partial meniscectomy (APM) be proposed?*

3. Surgery can be proposed **earlier** for patients presenting **considerable mechanical symptoms**. The patient has to be informed of chances and risks of either methods. *Grade D*

However, the steering group wants to state that mechanical symptoms cannot be clearly defined according to the current literature.

# European Meniscus Consensus



*When should arthroscopic partial meniscectomy (APM)  
be proposed?*

4. No arthroscopic surgery should be proposed for a **degenerative meniscus lesion with advanced OA** on weight bearing radiographs .

*Grade A*

Exception should be discussed for young patient with considerable symptoms.



***What does non-operative treatment mean?***

# European Meniscus Consensus



## *What does non-operative treatment mean?*

1. No evidence of which time / type of non-operative treatment can be proposed.
2. In the current literature, RCTs proposed various rehabilitation protocols.

However, non-operative treatment could consist of NSAID (if no contraindication), intra-articular injection, physiotherapy and / or home exercises for 3 to 6 months. *Grade B*



***What is the rate of conversion to surgery in those patients undergoing non operative treatment?***



# European Meniscus Consensus



*What is the rate of conversion to surgery in those patients undergoing non operative treatment?*

Non-operative treatment is **converted to surgery** (cross-over) **in 0 to 35 %** of the patients. *Grade A*

This cross-over rate has to be compared to the rate of arthroscopic treatment failure.

# European Meniscus Consensus



***Is the concept of an unstable meniscus useful for indicating meniscectomy (locking, clicking, MRI flap, etc....)?***

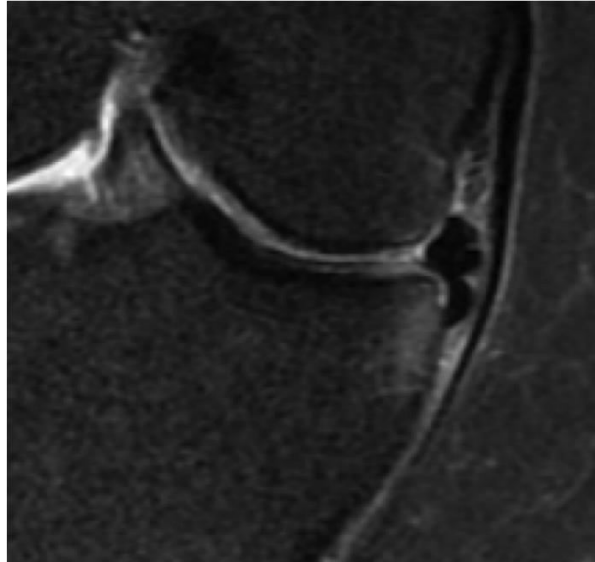
# European Meniscus Consensus



*Is the concept of an unstable of an unstable meniscus useful for indicating meniscectomy (locking, clicking, MRI flap, etc...)?*

A recent study [Sihvonen et al. NEJM 2013] did not find any benefits over sham surgery to relieve knee catching or occasional locking. *Grade A*

Indication for early APM depends on intensity, frequency of mechanical symptoms, and clear physical exam. *Grade D*





***What outcomes can be expected after arthroscopic partial meniscectomy (APM)?***

*What outcomes can be expected after arthroscopic partial meniscectomy (APM)?*

1. Improvement of functional outcomes can be expected after APM . *Grade A*
2. Most of the RCTs found no difference in terms of clinical outcomes after surgery compared to non-operative treatment. *Grade A*

*What outcomes can be expected after arthroscopic partial meniscectomy (APM)?*

3. APM after failed non-operative treatment will result in similar but not superior results compared to successful non-operative treatment . *Grade A*

*What outcomes can be expected after arthroscopic partial meniscectomy (APM)?*

4. Three to 6% of patients will require another surgical procedure in the year following APM. *Grade A*



*What outcomes can be expected after arthroscopic partial meniscectomy (APM)?*

5. Various predictive factors of poor results or treatment failures have been described in the current literature (increased BMI, lateral side, chondral damage, bone marrow edema, meniscal extrusion, total or subtotal meniscectomy. *Grade C*



***What is the rate of surgical complications after APM?***

*What is the rate of surgical complications after APM?*

**The rate of surgical complications is low (0.27 to 2.8%).** *Grade A*  
After APM, the rate of complications is dependent on side: i.e. a lateral meniscectomy is associated with a higher rate of complications than a medial one. *Grade A*



***What is the risk of osteoarthritis after APM?***



*What is the risk of osteoarthritis after APM?*

1. Patients treated with APM for a degenerative lesion **present a higher risk for symptomatic knee osteoarthritis compared to patients with normal knee** (healthy subjects). Risk of OA is higher after APM on the lateral side. *Grade C*



*What is the risk of osteoarthritis after meniscus resection?*

2. Patients with a **total meniscectomy** (removal of the peripheral rim) present a higher risk for symptomatic knee osteoarthritis compared to patients with partial meniscectomy. *Grade C*

# European Meniscus Consensus



***Is there a place for arthroscopic lavage (or lavage-debridement: arthroscopic procedure including degenerative (meniscal/chondral) and/or synovial tissue debridement?) for OA knees?***

*Is there a place for arthroscopic lavage (or lavage-debridement: arthroscopic procedure including degenerative (meniscal/chondral) and/or synovial tissue debridement?) for OA knees?*

**There is no place for arthroscopic lavage** (or lavage debridement) for painful knees with **osteoarthritis** (K/L $\geq$ 2). RCT's have showed that debridement/lavage has little, if any, effect on patients short-terms reported outcomes, satisfaction, or pain compared to non-operative treatment. *Grade A*





## ESSKA Meniscus Consensus Project: Degenerative meniscus lesions



# The algorithm to work with

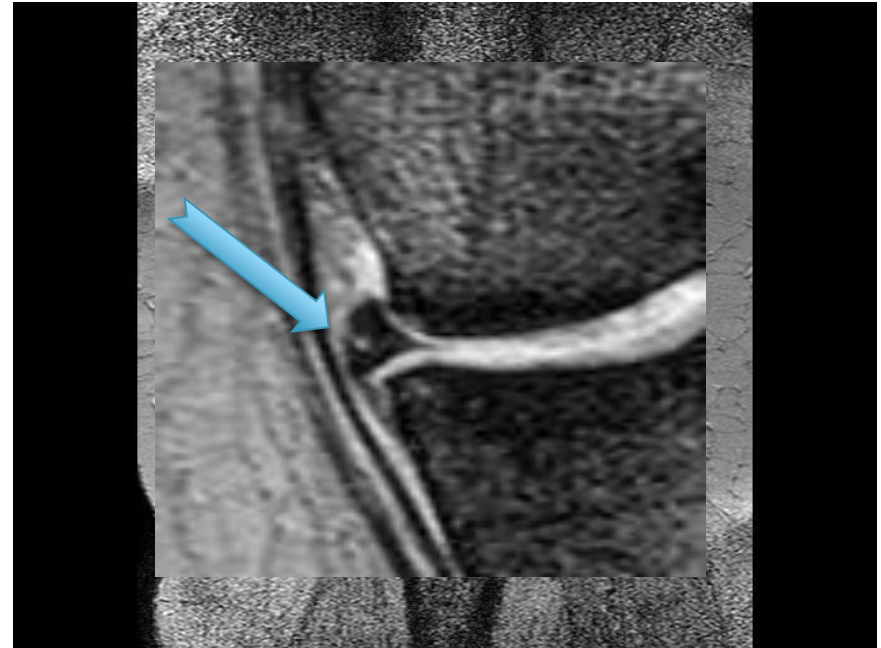
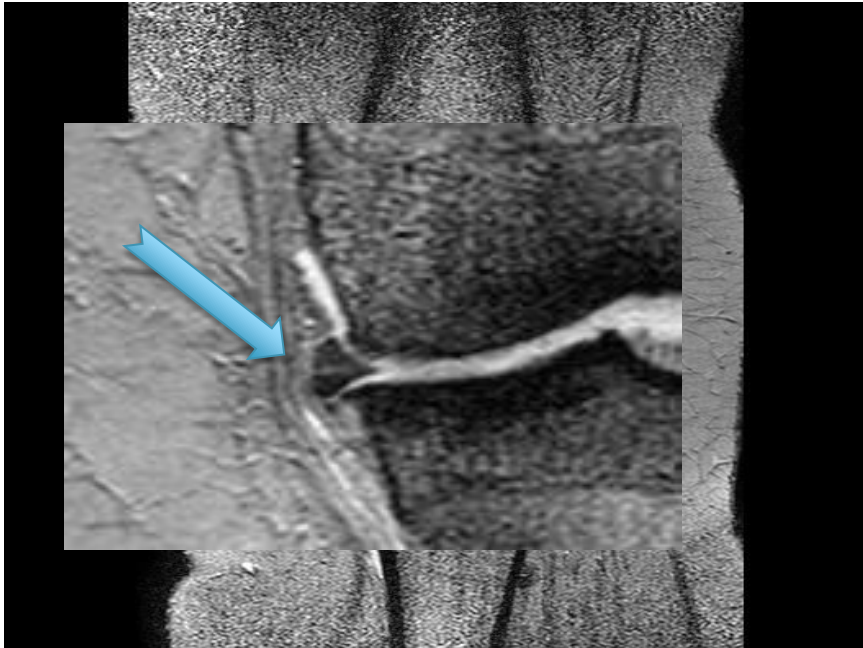
## R. Verdonk

ESSKA **Meniscus Consensus Project:**  
Degenerative meniscus lesions

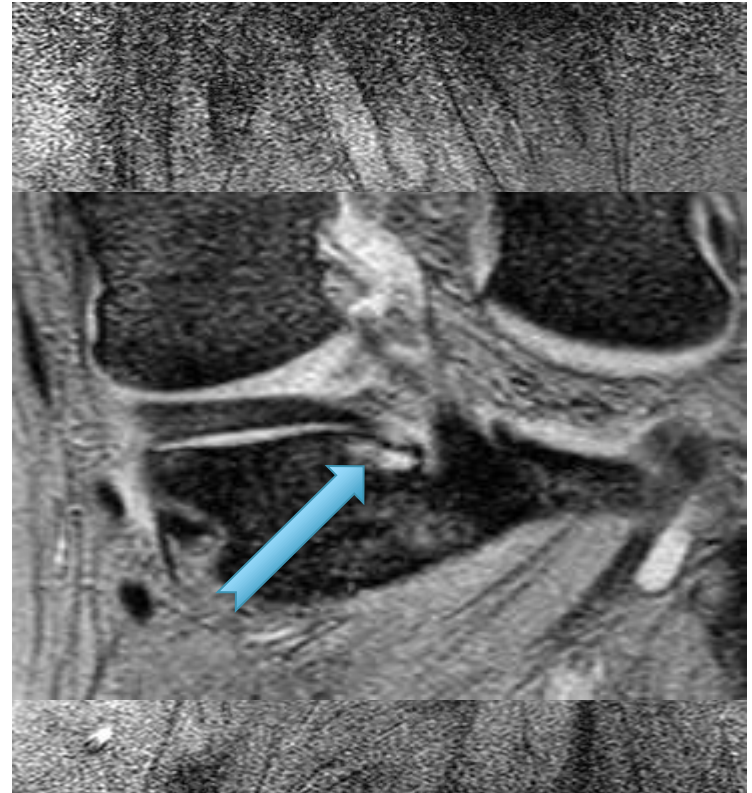
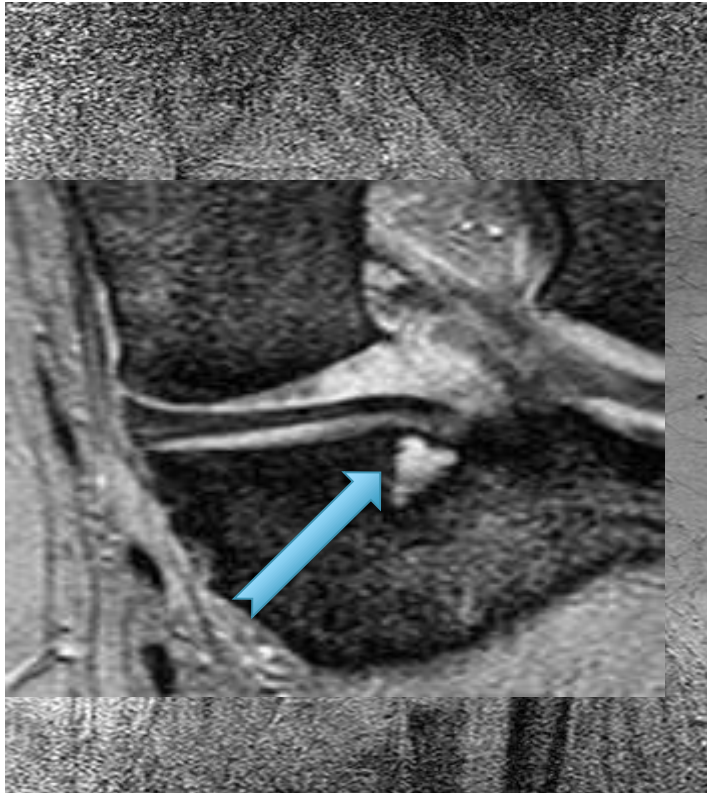
**Let me tell you a story.....**



## ESSKA Meniscus Consensus Project: Degenerative meniscus lesions



**ESSKA Meniscus Consensus Project:**  
Degenerative meniscus lesions



## ESSKA Meniscus Consensus Project: Degenerative meniscus lesions



## ESSKA Meniscus Consensus Project: Degenerative meniscus lesions



**Non-locked painful knee  $\geq 1$  Mo,  
Age  $>35$  yr, clinical history and  
examination compatible with  
degenerative meniscus lesion**

**X-rays**

(Weight bearing AP + lateral + Schuss view)  
**MRI** when special indications

**Non-operative treatment  
+/-injection**

**At least 3 months (onset of symptoms)  
(except considerable mechanical symptoms)**

## ESSKA Meniscus Consensus Project: Degenerative meniscus lesions



Treatment failure

Treatment success

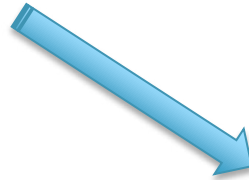
**MRI** if not already done



No OA evidence  
on X-rays / MRI



Arthroscopic Partial Meniscectomy



Evidence of OA on X-rays / MRI



Treatment of early arthritis  
No arthroscopic debridement  
Except considerable mechanical symptoms



# Strengths and Limitations

R. Becker

P. Beaufils

**ESSKA Meniscus Consensus Project:**  
Degenerative meniscus lesions

**Chairmen:** Philippe Beaufils, Roland Becker





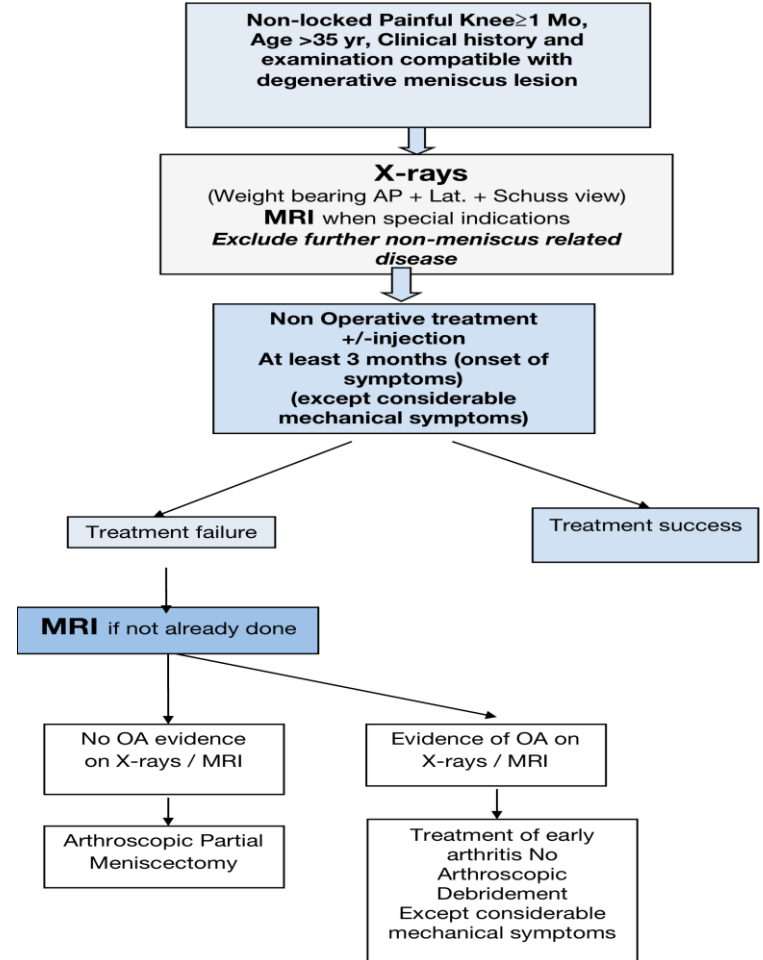


## ESSKA Meniscus Consensus Project: Degenerative meniscus lesions

Chairmen: Philippe Beaufils, Roland Becker

### ESSKA Meniscus Consensus algorithm

#### Degenerative Meniscus Lesion



# Strengths

- First European experience in this field
- Strict independent process
- Large amount of participants:
  - 85 people
  - 21 European countries



## Strengths

Based on:

scientific evidence

clinical expertise



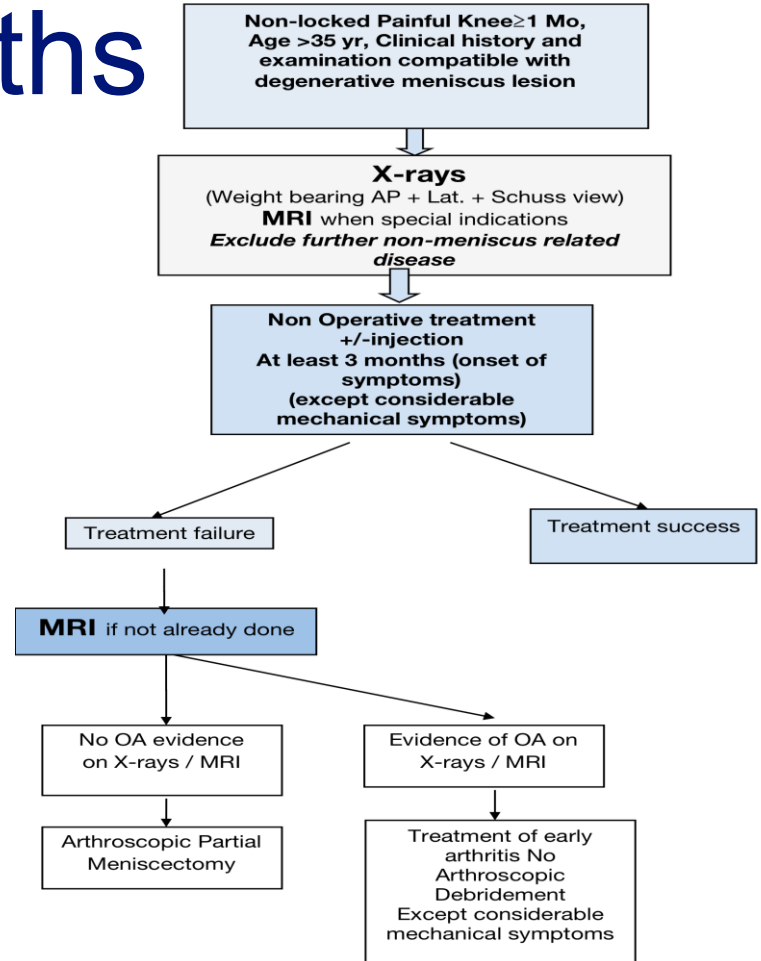
# Strengths

Rather a « framework » than strict guidelines



# Strengths

- APM shouldn't be proposed as a first line treatment = **indication**
- APM could be proposed provided a standardized clinical and imaging exam has been carried out = **preoperative assessment**



# Limitations

1. Quality of the available studies
2. Practical constraints in daily practice
3. Evolution of techniques and indications with time

# 1. Quality of the available studies

- What is a scientific evidence?
- RCT's as good as they may be have their biases and weaknesses :
  - Selection of patients
  - SHAM surgery which doesn't correspond to daily practice
  - « Intention to treat » or « as treated »
  - Conclusion
  - ...



- *Chess et al. BMC Med Res Method 2013*
- *Clavien et al. Br J Surg 2014*



# Two examples

1. Two RCTs with the same patients selection, and study design may have different conclusion
  - Gauffin et al.: in favor of APM
  - Katz et al.: non-operative treatment and AMP have similar outcomes

Osteoarthritis and Cartilage xxx (2014) 1–9

**Knee arthroscopic surgery is beneficial to middle-aged patients with meniscal symptoms: a prospective, randomised, single-blinded study**

H. Gauffin †\*, S. Tagesson ‡, A. Meunier †, H. Magnusson ‡, J. Kvist ‡

† Orthopaedic Department, Linköping University, Linköping, Sweden

‡ Division of Physiotherapy, Department of Medical and Health Sciences, Linköping University, Linköping, Sweden



**The NEW ENGLAND  
JOURNAL of MEDICINE**

**Surgery versus Physical Therapy for a Meniscal Tear  
and Osteoarthritis** MAY 2, 2013

Jeffrey N. Katz, M.D., Robert H. Prother, M.D., Christine E. Chaisson, M.P.H., Leigh de Chaves, P.T., O.C.S.,

# Who is right?



Copyright ©2016 ESSKA



# Two examples

2. The conclusion must not exceed the content of the study
  - « Non-operative treatment has similar outcome than APM »

**is not the same as**

- « Non-operative treatment is the first line treatment. APM should be considered as a second line treatment »



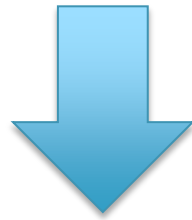
These studies must be read and interpreted  
with great care



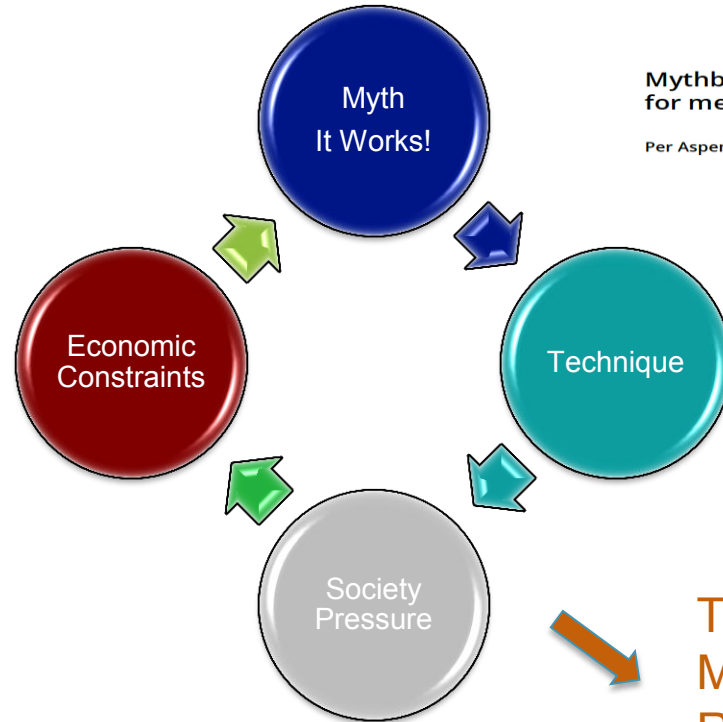
Role of a consensus process including experts involved in daily  
practice of treating patients with meniscus lesions

## 2. Practical constraints

- Is a consensus the only factor which may influence the decision of the surgeon and the patient ?



**NO**



Mythbusting in Orthopedics challenges our desire for meaning

Per Aspenberg Acta Orthop 2015

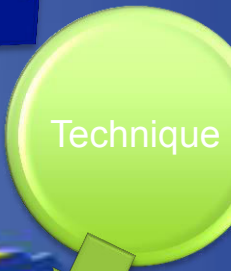
Simple procedure?

Low morbidity ?

The patient says :  
My meniscus is torn  
Role of MRI overuse

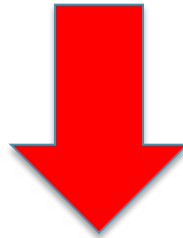


Health care systems are different among European countries. They influence the daily practice and are not always in line with the scientific data.



# Limitations

Are guidelines definitive and strong  
evidence-based publications



**NO**

# Evolution with time !

## example of France

1995

Arthroscopy Guidelines in France

« There are no indications for meniscus repair in stable knees »

2009

Meniscus Guidelines in France

« Meniscus repair is recommended in vertical longitudinal peripheral traumatic tears independent of the status of the ACL »



# Aknowledgements

## Steering Group

S. Kopf (Germany), M. Ollivier (France),  
M. Englund (Sweden), R. Verdonk (Belgium),  
N. Darabos (Croatia), A. Gökeler (The Netherlands),  
M. Hirschmann (Switzerland), C. Hulet (France),  
T. Järvelä (Finland), H. Mayr (Germany),  
P. Ntagiopoulos (Greece), H. Pereira (Portugal),  
N. Rotigliano (Italy)



# Aknowledgements Rating Group

H. Aagaard (Denmark), B. Barenius (Sweden), T. de Coninck (Belgium), D. Dejour (France), M. Denti (Italy), J. Espregueira Mendes (Portugal), C. Fink (Austria), P. Gelber (Spain), A. Georgoulis (Greece), J. Höher (Germany), M. Karahan (Turkey), J. Menetrey (Switzerland), J.C. Monllau (Spain), R. Müller-Rath (Germany), D. Popescu (Spain), N. Pujol (France), P. Randelli (Italy), R. Seil (Luxemburg), B. Sonnery-Cottet (France), A. van Haver (Belgium), T. van Tienen (The Netherlands), P. Verdonk (Belgium), A. Williams (UK), S. Zaffagnini (Italy)

# Acknowledgements

- The 50 members of the peer-review group among 21 European countries
- Mrs. Anna Hansen Rak from the ESSKA office
- Neil Thomas (UK)

Summary and full text are available on



**Meniscus Consensus Project**

Chairmen:



Philippe Beaufils Roland Becker

**ESSKA Meniscus Consensus Project:  
Degenerative meniscus lesions**

Chairmen: Philippe Beaufils, Roland Becker

[www.esska.org](http://www.esska.org)

The ESSKA MENISCUS CONSENSUS INITIATIVE was initiated by the ESSKA Board after the congress in Amsterdam in 2014. It has been commissioned to two world-renowned experts in the field, Prof. Philippe Beaufils (France) and Prof. Roland Becker (Germany). The goal of the initiative is to find a European consensus on the treatment of meniscus pathologies. Finding a consensus in such a diverse continent like Europe where medical culture and healthcare systems vary from country to country is not easy. A strict methodology has therefore been applied and numerous European experts have been involved in this process.

Due to the merit of the two leaders of this group that we are able to come up with this initiative which shall be understood as guidance to ESSKA members. We thank Prof. Philippe Beaufils and Prof. Roland Becker as well as the members of the steering, rating and peer review process. A special acknowledgement also goes to Hans Henrik Hansen Rak, without whom this would not have been possible.



ESSKA



Copyright ©2016 ESSKA