

G R E A T N E W S C O R N E R



Prolotherapy is the Best Treatment for Knee Pain and Instability

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For many years, data has been mounting that arthroscopy just doesn't work any better than conservative care for most knee conditions, including degenerative arthritis. This is based on thorough research published in some of the most prestigious medical journals in the world.¹⁻⁴ This has lead insurance companies to not cover arthroscopic debridement of the knee for knee pain, but they will cover it for mechanical symptoms. This may sound reasonable until one really looks at the definition of mechanical symptoms of the knee: any type of locking, popping or giving way of the knee! Basically, almost every person with a knee has some type of "popping" or crunching (also called crepitation) noise in their knees. This means that a patient who sees an orthopedist who documents mechanical symptoms in the patient's knee and/or if the patient's MRI shows any type of loose body or meniscal tear, then arthroscopic surgery can be done and will be covered by insurance.

One problem with the above scenario is that MRIs cannot reveal the cause of the patient's pain. Among persons with radiographic evidence of osteoarthritis, the prevalence of a meniscal tear was 63% among those with knee pain, catching, or stiffness on most days, and 60% among those without symptoms.⁵ Let's think about this some more. A full 60% of people who have no pain will show a meniscal tear on MRI! The net result is that the number of knee arthroscopies continues to rise because everyone with a knee problem qualifies for it! But there is a better way... and that is Prolotherapy.

If there is one joint in the body that responds tremendously well to Prolotherapy, it is the knee! Whether the condition is degenerative arthritis, pes anserine or patellar tendinopathy, collateral or cruciate ligament sprains—they all respond well to Prolotherapy. For decades, Prolotherapy physicians have treated painful knees, with and without mechanical symptoms, successfully with Prolotherapy. It's really just a matter of how many treatments are needed.

Arthroscopic surgery for mensical issues typically results in meniscectomy (removal). The thinking is simply that the meniscal tear didn't heal on its own, so we need to remove this tissue and the knee will feel better. This type of thinking is a bad idea. I urge you to take a look at the following subheadings excerpted from *Prolo Your Sports Injuries Away!* which may further convince you:

"Study Shows Increased Contact Stress Pressure After Meniscectomy."

"Study Shows Meniscal Surgery Actually Increases Injury."

"Incomplete Healing And Further Deterioration Result After Meniscal Repair Surgery."

"Meniscectomy Causes Arthritis."

"Partial Meniscectomy: More Arthritic Changes Result."⁶

Prolo Your Sports Injuries Away! was written in 2001 and is loaded with references to back up its claims regarding treating mensical injuries. After nearly 10 years, we felt it was time to revisit the mensicus, therefore Caring Medical (my private practice) hired a pre-med college student to co-author a meniscus paper. During her research, she related her findings to me during a meeting, "Meniscectomy surgery results (partial or complete) are terrible! Why would anyone get that surgery?" Well said, Hilary! The data clearly reveals that arthroscopic partial meniscectomy will age a patient's knee by 20 years! In almost every knee arthroscopy report I have seen (hundreds and hundreds), over 90% describe in detail the removal of meniscal tissue (meniscectomy). (See *Figure 1*.) Once the meniscal tissue is gone, there is a tremendous increase in pressure on the articular cartilage and this quickly starts to break down. This is what we call the progression from arthroscopy to arthritis.

Two pre-med college students, Hilary Phillips and Havil Maddela, collaborated with us on Prolotherapy for MRI-documented cases of meniscal degeneration and meniscal tears on patients from Caring Medical. The results of this study reveal that Prolotherapy is the best option for knee pain and instability.

DESCRIPTION OF THE PROCEDURE: The patient was placed in a supine position and general anesthesia was administered. The knee was prepped and draped in usual manner. The tourniquet was raised to 350 mmHg. The arthroscope was inserted into the suprapatellar pouch. The underside of the patella was noted to be free of any pathology. No Loose bodies were noted. The scope was swept from the medial compartment of the knee. A complex tear of the posterior two-thirds of the medial meniscus was evident. Chondromalacia of the medial femoral condyle was quite severe and some areas with bone were exposed. This was over the entire weightbearing surface grade 3 to grade 4. The intercondylar notch exhibited an intact cruciate ligament complex and the lateral meniscus was noted at its free edge of the middle third and slightly posterior third to have an attritional tear. The lateral meniscus was trimmed with a basket forceps taking approximately 10% of the middle third and posterior third. The basket forceps was utilized to trim away the torn meniscus in the medial compartment of the knee and this was further smoothed with a 5.5 mm end cutter and a chondroplasty was performed with similar instrument over the femoral condyle to remove the unstable cartilage. The patient had approximately 20% of the posterior middle thirds balancing it into the anterior third. After this was done to the satisfaction of the surgeon, the knee was irrigated with a Toomey syringe, and closed with 4-0 Vicryl. Depo-Medrol and Marcaine was instilled. A bulky dressing applied. The patient tolerated the procedure well.

Figure 1. Operative report describing meniscectomy during a knee arthroscopy. This patient, like most I've treated, had no idea that their meniscus was removed. They would not have gone through with the arthroscopy, especially if the future arthritis risks were known ahead of time.

Also in this issue, we welcome new columnist, Jack Henry, DC who presents a meniscal tear case. We are looking forward to Dr. Henry's contributions in educating our readership on radiologic findings. *Skill Enhancement* columnist, Rodney Van Pelt, MD demonstrates Prolotherapy for pubis pain. Veterinary columnist, Babette Gladstein, VMD discusses Prolotherapy used in spinal injury cases she has treated.

In the Spotlight first features Peter Blakemore, DO who has written a piece highlighting the Neuromusculoskeletal Medicine residency at Michigan State University. Students can elect to rotate in private Prolotherapy offices, which continues to gain headway into medical residencies and hopefully will soon be offered in the school. Also *In the Spotlight* is an interview I conducted with Joanne Borgstein, MD, who is practicing PRP Prolotherapy at Harvard.

From Germany, Joern Funck, MD reports a *Remarkable Recovery* case and explanation of how to treat the coronary ligament of the knee. In this issue, we also have two articles relating to temporomandibular joint dysfunction and

dentistry. First Roy Hakala, DDS and Kim Ledermann, DDS wrote a great article on Prolotherapy for TMJ dysfunction. Second, our *JOP* team interviewed Jeri Coffey, DDS in her Riverside, Illinois office and consulted her on when to consider a dental cause for a patient presenting with chronic headaches.

Last but not least, in *It's a Wide, Wide World*, Wanona Wellspring, DN has authored an article on using aromatherapy as an adjunctive pain therapy. In addition, Jose Eleazar Calderon de la Fuente, MD from Mexico has written to share the outcome of the first Prolotherapy conference in Mexico City. He did a tremendous amount of work, and the results were nothing short of remarkable in regard to the patients who were treated and the fellow physicians to whom he taught the Hackett-Hemwall technique of Prolotherapy.

As always, thanks to all of our readers for your continued support of Prolotherapy. As the issue shows, Prolotherapy and its practitioners are continuing to improve patients' lives around the world! ■

Until the next injection,
Ross A. Hauser, MD



BIBLIOGRAPHY

1. Moseley JB, et al. A controlled trial of arthroscopic surgery for osteoarthritis of the knee. *New England Journal of Medicine*. 2002;347:137-139.
2. Dervin G, et al. Effect of arthroscopic debridement for osteoarthritis of the knee on health-related quality of life. *Journal of Bone and Joint Surgery American*. 2003;85-A(1):10-19.
3. Kirkley A, et al. A randomized trial of arthroscopic surgery for osteoarthritis of the knee. *New England Journal of Medicine*. 2008;359:1097-1107.
4. Siparksky P, et al. Arthroscopic treatment of osteoarthritis of the knee: are there any evidence-based indications? *Clinical Orthopaedics and Related Research*. 2007;455:107-112.
5. Englund M, et al. Incidental meniscal findings on knee MRI in middle-aged and elderly persons. *New England Journal of Medicine*. 2008;359:1108-1115.
6. Hauser R, et al. *Prolo Your Sports Injuries Away!* Oak Park, IL: Beulah Land Press; 2001:173-176.