The difficult balance between scientific evidence and clinical practice: the 2016 ESSKA meniscus consensus on the surgical management of degenerative meniscus lesions

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Arthroscopic partial meniscectomy is one of the most popular orthopaedic procedures, especially for degenerative meniscus lesions (DML). However, all recently published randomized controlled trials (RCT) [1–6] except one [7] demonstrated no additional benefit of arthroscopic partial meniscectomy compared to non-operative treatment. This stimulated an intense and controversial global debate which was not necessarily useful to clinicians in their daily clinical practice [8–10]. Despite this high-level scientific

evidence, they claimed that patients which were included in these RCT's represent only a minority of those seeking advice for painful knees in association with DML. This is in accordance with the findings of ESSKA's former president Lars Engebretsen and his team in relation with cartilage injuries. Our Norwegian colleagues found that patients qualifying for inclusions in RCT's represented only 4% of the patients they saw in their cartilage clinic [11]. Although there are no exact figures for DML, clinical experience

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supports the hypothesis that the situation is similar in the context of DML. Therefore, there appeared to be a need for a more uniform and clear message, balancing these two controversial opinions.

Ideally, the treatment of DML should be related to both scientific evidence and clinical expertise. In an editorial published 2 years ago in the same journal, Beaufils wrote “this rose the necessity of a consensual process, founded on the independence of the organizers and with the participation of all interested parties to produce the most exhaustive critical analysis of the literature possible [12]. Work of this kind will permit a probable reduction in the number of arthroscopic meniscal resections in our countries in favor of abstention and meniscal repair and an improved nosological definition of the meniscectomy, rendering it pertinent and efficient.” This process, which was called the “ESSKA Meniscus Consensus Project” was initiated by the ESSKA Board after the ESSKA congress in Amsterdam in 2014. The goal of the initiative was to find a European consensus on the treatment of degenerative meniscal 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 84 European physicians, surgeons, and scientists from 22 countries have been involved in this process. The goal was to propose a framework rather than strict guidelines.

The outcome of this process is presented in the current edition of KSSTA [13]. As it could have been anticipated among experienced clinicians, the initiative resulted in a wide consensus among European peers, in the sense that arthroscopic partial meniscectomy should not be proposed as a first line of treatment of DML, which should always be started non-operatively. It is only after a failure of the latter that an arthroscopic partial meniscectomy should be envisaged. In addition to this, it was emphasized that magnetic resonance imaging is not indicated as a first-line diagnostic tool. Standard knee radiographs are still recognized as the first imaging procedure, mainly to rule out underlying osteoarthritis.

However, the initiative did also identify some limitations of our current understanding of DML. Further work needs to be done with respect to the causative factor of knee pain associated to DML. Perimeniscal synovitis is a well-known cause [14, 15], but neither the size, nor the type or the location of the structural lesion of the meniscal tissue, nor the mechanical symptoms have been exactly defined so far. They may be key factors in the surgical decision-making process influencing the current controversial debate.

We hope that these recommendations will deliver a clear message to the orthopaedic community, avoiding any conflicting or political statements, and providing a well-balanced treatment algorithm with a place for both

non-operative and arthroscopic treatment in the orthopaedic armamentarium. As further evidence will be added to the current understanding of the problem, the consensus may be modified in the future.

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