

# Symposium: 2016 Knee Society Proceedings

## Editorial Comment: 2016 Knee Society Proceedings

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It is human nature to seek out new and improved methods for solving the problems we face. Part of the fabric of joint reconstructive surgery is to search for novel and better methods for technical reconstructive challenges, as well as those issues that inhibit or obstruct patient recovery. Of course, manufacturers of implants and devices also are motivated to innovate and modify existing technologies in order to help patients while concomitantly driving sales and improving profits.

Still, time has taught us that newer is not always better. There are many examples in the long history of orthopaedics demonstrating that slow, gradual incorporation of new technol-

ogy is advisable. It is important to remember the unforeseen consequences of certain metal-on-metal hip resurfacing and replacement designs [6], the early failure of new bone cement formulations [1, 4], and the unpredicted failures of even fairly minor modifications to successful products, including certain “high flex” femoral component designs [3]. Orthopaedics certainly is not alone in having suffered such repercussions of untested new technology—novel pacemakers [2] and cochlear implants [5] are just two examples that come to mind from outside our specialty.

The series of selected articles in these proceedings of The Knee Society can be looked at in the context of balancing the old with the new. One such study indicates that while the use of porous metal devices has become the standard method of restoring lost bone in revision TKA surgery, older



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techniques using allograft bone may continue to have an important role to play. Similarly, other studies demonstrate that use of modern crosslinked polyethylene in the knee may offer no advantages and significant concern is raised by the short-term survivorship assessment of a bicruciate retaining total knee design.

These findings must be balanced by the reality that if we do not continue to improve technology and technique, our field will not evolve or improve, and better outcomes for our patients will not be achieved. In addition, certain clinical scenarios we often face have no alternatives but to maximize use of technology, despite high complication rates, as is seen in the study of long,

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extensive endoprosthetic femoral replacement included in these proceedings.

These selected studies provide new and useful information for knee replacement surgeons. Readers may even find a common theme running through these studies—newer and costlier isn't always better both in terms of short- and long-term outcomes. As these papers highlight, it is critical for surgeons interested in developing new methods and techniques to design and participate in prospective randomized studies. In addition, certain clinical scenarios we often face have no alternatives but to maximize use of technology, despite potentially high complication rates, such as cases where reconstruction requires replacement of large segments of bone or mechanical compensation

for major ligamentous insufficiency. If our profession does not drive the assessment of new technologies and techniques, governments and other regulatory bodies may force stagnation in an effort to avoid adverse outcomes. To maintain our right of professional self-direction, we have a responsibility to educate ourselves and be aware of the experiences of our colleagues. The series of studies in these proceedings provide precisely this type of work.

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