Unicompartmental OA & Ligament Deficiency

Andy Williams
Chelsea & Westminster Hospital, London

ACLD + OA

- Early kinematic deficit is lateral
  - If MM remains intact lateral OA possible
- With MM failure kinematic deficit is medial → posteromedial OA

ACLD + OA

- What to do?

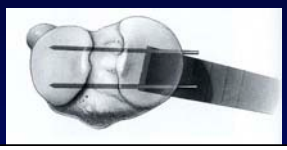
Choice:

- ACLR alone
- Osteotomy
- Arthroplasty [UKR or TKR]

If osteotomy / UKR then: ? Add ACLR

OA & HTO

- OW or CW?
  - For ACL intact- OW
  - For ACLD OA - CW



O.W. H.T.O.

- *Likely ↑ tibial slope*

C.W.H.T.O

↓ slope helps:

- offloads ACL
- helps fixed flexion
- ACLD pattern OA

so
CW HTO ideal

C.W.H.T.O

↓ slope helps:

- offloads ACL
- FFD
- ACLD pattern OA

so
CW HTO ideal

C.W. H.T.O

Choose fixation to allow ACLR

Results:

HTO + ACLR:

Good but no comparison with HTO alone
(Bonnin et al, Lyon; Imhoff et al, Munich)

HTO alone – Good results: Pinczewski- Sydney

UKR and ACLD

ACLD – contra-indication for UKR? Oxford *CORR* '92

- for mobile bearing
- ? For fixed bearing

UKR and ACLD

UKR + ACLR Oxford *JBJS[Br]* 2006

Oxford- 15 cases @ minimum 2.5 years

slightly better than age-matched ACL intact!

Few other publications

Fixed Bearing UKR alone- ?

UKR and ACLD

Surgical 'Top Tips'

- Vertical tibial tunnel

UKR and ACLD

Surgical 'Top Tips'

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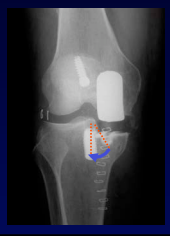


UKR and ACLD

Surgical 'Top Tips'

- Fix graft before starting UKR

Medial OA + Posterolateral laxity

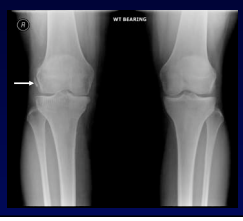
Lateral CW for access to PLC

Medial OA + Posterolateral laxity

Lateral CW for access to PLC

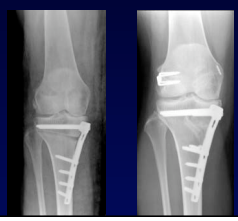
Medial OA + Posterolateral laxity

OW seems to control excess rotation as well as varus



Medial OA + Posterolateral laxity

OW seems to control excess rotation as well as varus

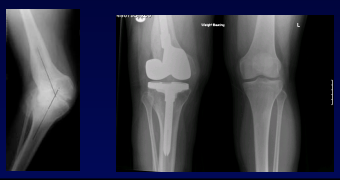


Lateral OA + MCL laxity

Lateral OA + MCL laxity

? UKR + MCLR

→ TKR +/- constraint



TKR / UKR + MCL laxity

? MCL Reconstruction

→ TKR +/- constraint

Answers Please!