

From normal to hyperflexion

Val D'Isère 2012



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Normality

- Active flexion 125°
- Passive flexion 150°



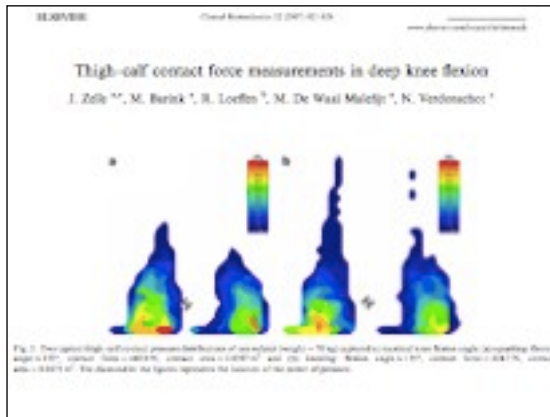
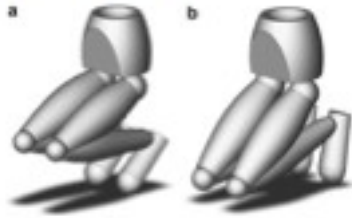
Trochanter major
Lateral malleolus
Lateral epicondyle

Evans & Hoopes



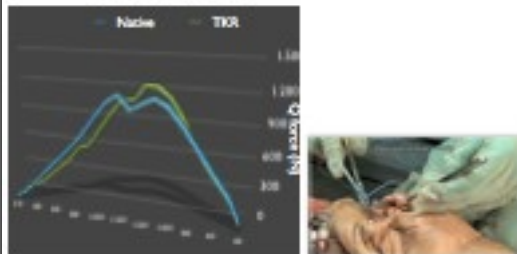
Normality

- Squatting vs Kneeling

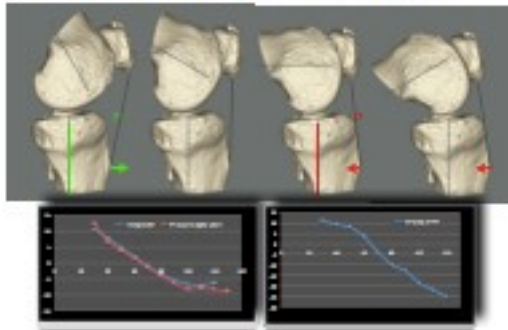


Impact of knee flexion on quad's load

- ankle load 130N



Patellar tendon angle



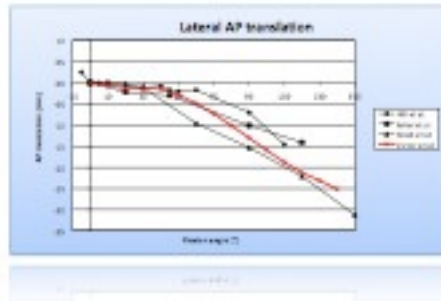
Flexion requirements for ADL

- Stair climbing: 80°
- Sitting: 90°
- Shoelace tying: 105°
- Lifting object from the ground: 70°
- Individual variation, depending on patient height and hip mobility
- The smaller the patient, the more flexion is needed

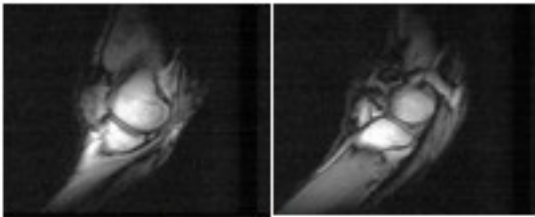
Passive Kinematics



Passive Kinematics

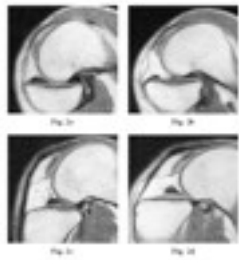


Native knee



Courtesy Andy Williams

Native knee



Can this mechanism be replicated in TKA?



Anatomic contours - tibia



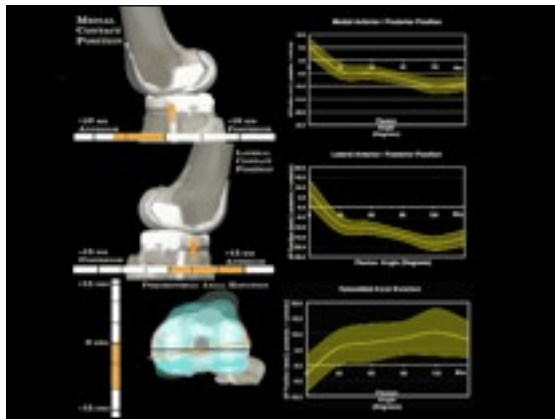
Anatomic contours

- Cupped medial compartment



Anatomic contours

- Sloped lateral compartment



Can this mechanism be replicated in TKA?



Can this mechanism be **safely** replicated in TKA?



Potential cost of high-flexion

- Cam-post dislocation
- ITB traction syndrome
- Femoral component loosening
- Patellar complications
- Anterior knee pain



• KNEE RESEARCH

Femoral component loosening in high-flexion
total knee replacement

AN IN VITRO COMPARISON OF HIGH-FLEXION VERSUS
CONVENTIONAL DESIGN



Closed box geometry



Iliotibial band traction syndrome in guided motion TKA A new clinical entity after TKA

LUDIG LUNCKE, THOMAS LUNCKE, JOHAN BELLIMANN, AND VICTOR



Conclusion

- High flexion characterized by specific kinematics
- TKA can be designed to adapt to high flexion
- The compromises come at a cost

