

SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Ospedaliero - Universitaria di Modena

Policlinico



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Clinica Ortopedica , Policlinico
Università di Modena e Reggio Emilia
Dir.: Prof. Fabio Catani

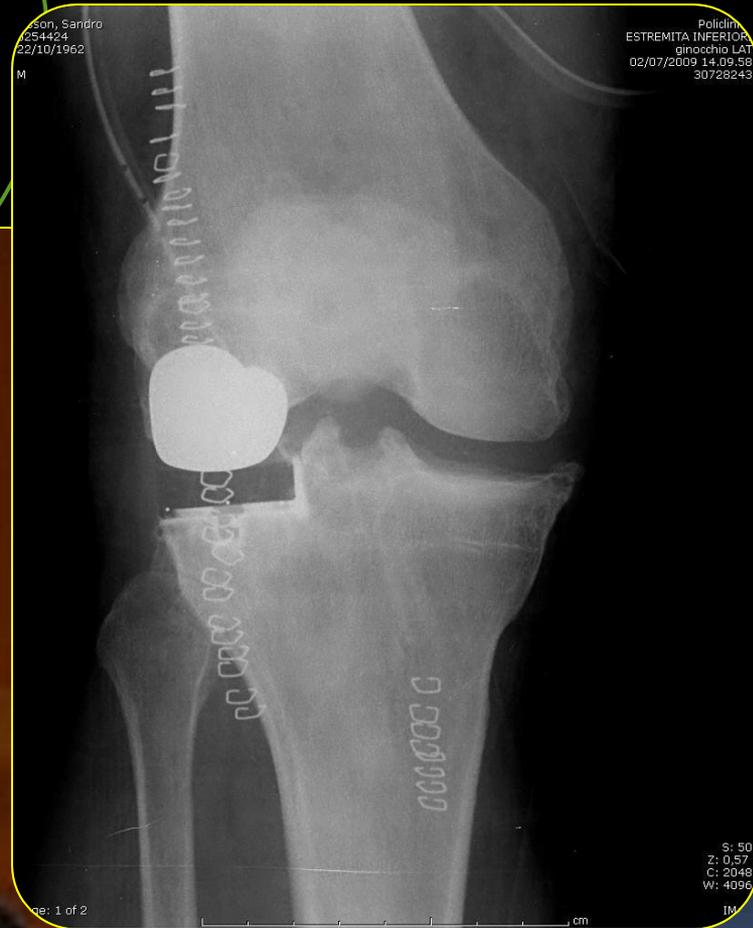
**LE PROTESI
MONOCOMPARTIMENTALI: OGGI**

PMC: cattiva reputazione

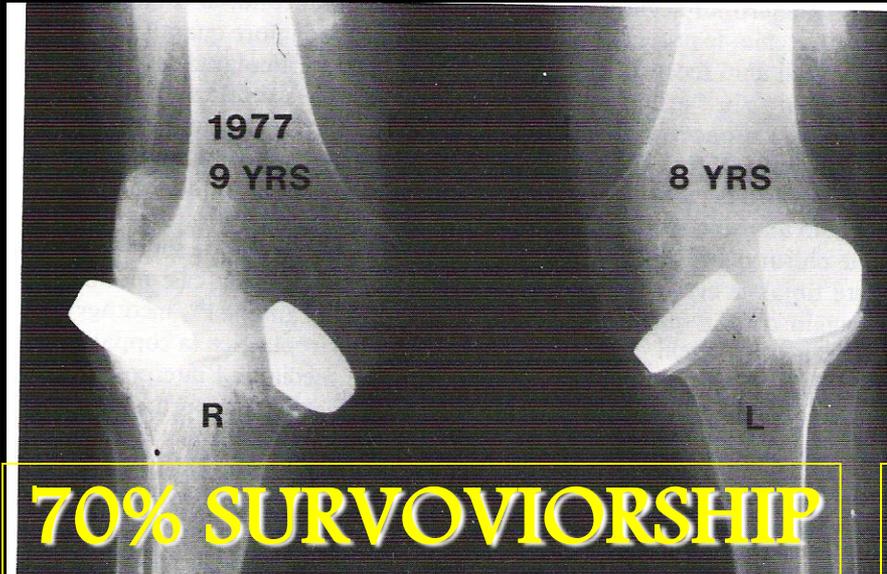
www.ilvillano.it



CHE
C'AZZECCA?



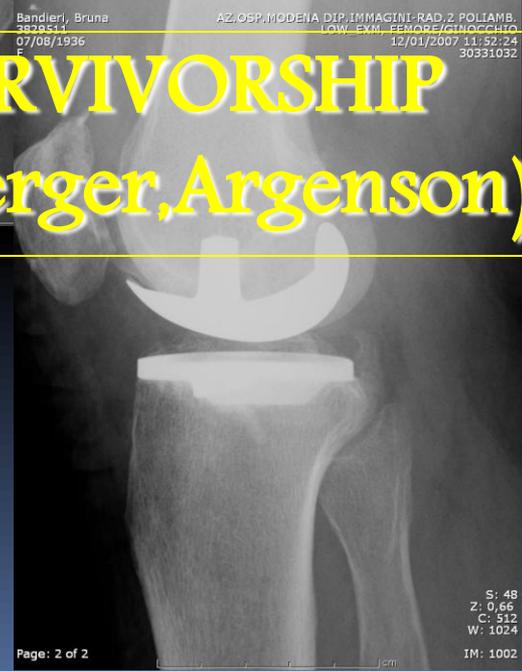
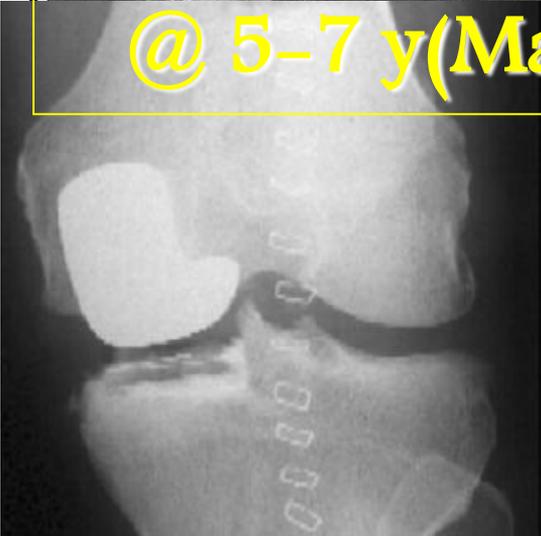
Le cose cambiano



**70% SURVIVORSHIP
@ 5-7 y (Marmor)**



**98% SURVIVORSHIP
@ 10 y (Berger, Argenson)**



Cattivi risultati iniziali

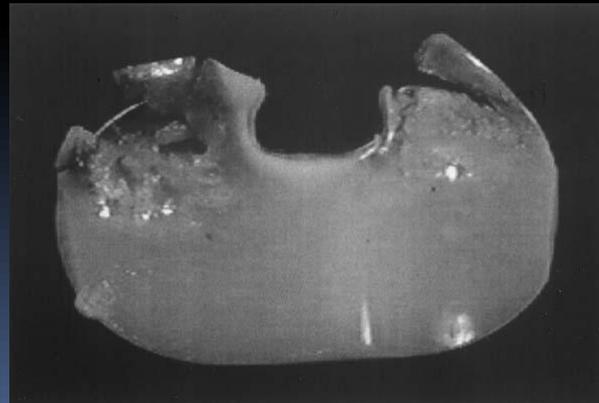
Indicazioni non corrette

Tecnica chirurgica approssimativa

Cattiva cementazione

Polietilene poco

resistente(sterilizzazione, produzione)





PMC *non* è la metà di una PTG

MIS ma anche
piccole protesi

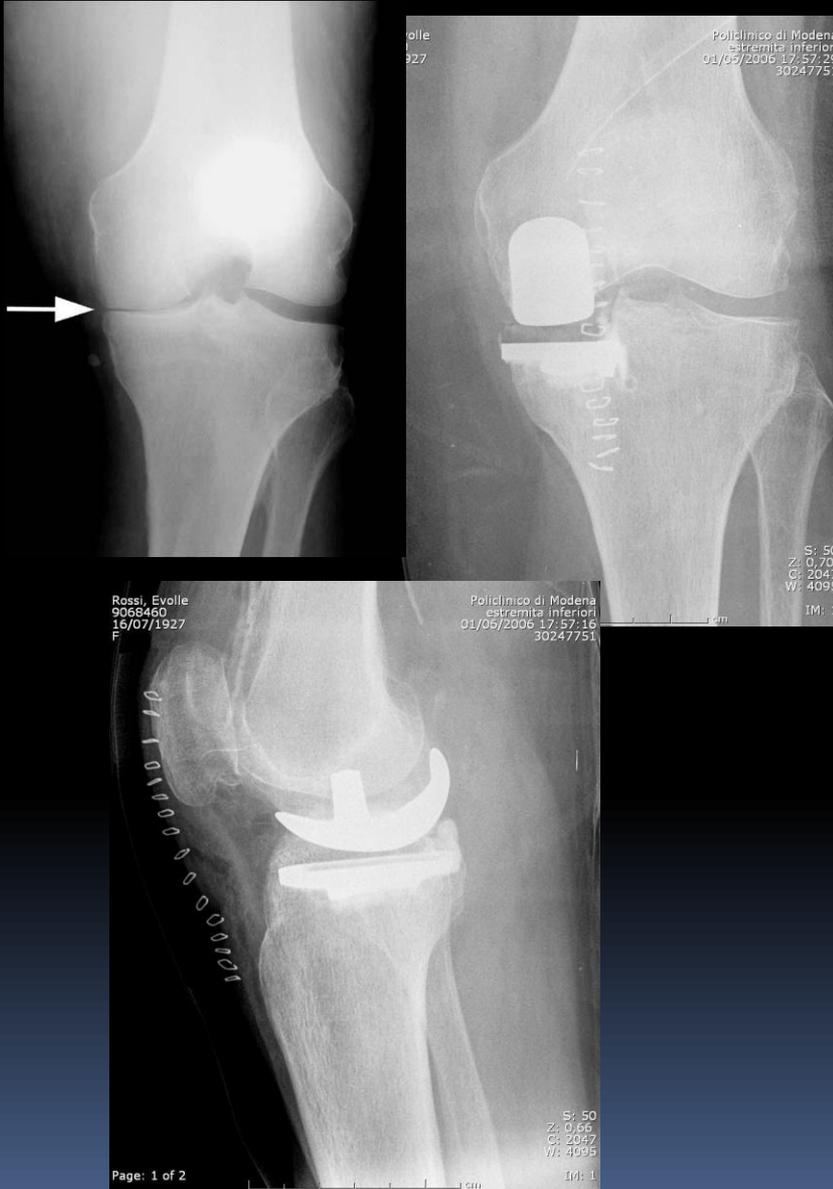


Chirurgia ricostruttiva non distruttiva

Concetto di 1^ e (forse) unica protesi del ginocchio (Chirurgia sequenziale sec. Benazzo)



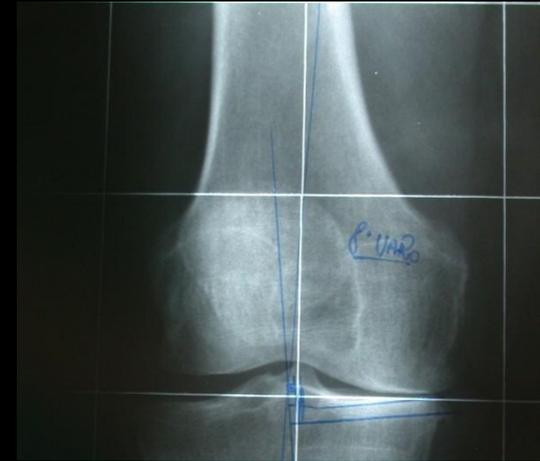
PROTESI MONOCOMPARTIMENTALI



- @ Minor invasività
- @ Minor dolore
- @ Minori complicanze
- @ Minor ricovero
- @ Minori costi
- @ Miglior ROM
- @ *Facile revisione*

INDICAZIONI CORRETTE

- @ Sesso indifferente
- @ Età >50 & 85<
- @ Peso < 120 Kg
- @ BMI tra 32 & 45 (fallimento precoce)
- @ Artrosi (degenerativa) monocompartimentale
- @ Stadio di Ahlback 2-3 (4 ?)
- @ ROM completo (quasi)
- @ Stabilità legamentosa



INDICAZIONI CORRETTE

@ Ginocchio stabile (LCM non retractor)

@ ROM 10° - 110°

@ Varo (correggibile) non > 10°

@ Valgo (correggibile) non > 10°

@ P/F asintomatica

@ Non artropatie infiammatorie

@ *Paziente motivato e informato*



ANTERIOR DEFECT > ACL COMPETENT

Controindicazioni *assolute* alla PMC

Degenerazione bi-tricompartimentale

ROM compromesso

Grave varo-valgo non riducibile

Artropatie infiammatorie in fase attiva

Gravi instabilità post-traumatiche o neurologiche

Controindicazioni *relative* alla PMC

Modesta artrosi F/R (rotula)

Modesto interessamento del compartimento opposto

Età, peso, osteoporosi, malattie infiammatorie poco
attive

LESIONE LCA ?



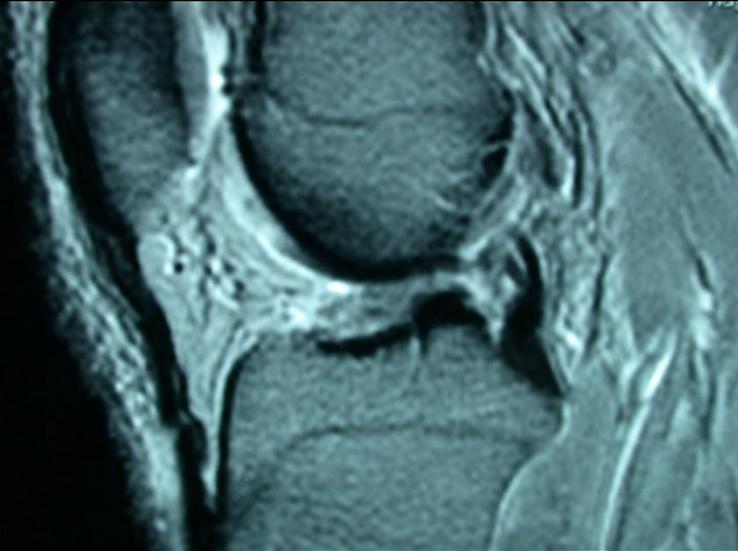
Pandit H., Murray D.V. et alii
(Scuola di Oxford)

“Combined anterior cruciate reconstruction
and Oxford unicompartmental knee
arthroplasty”

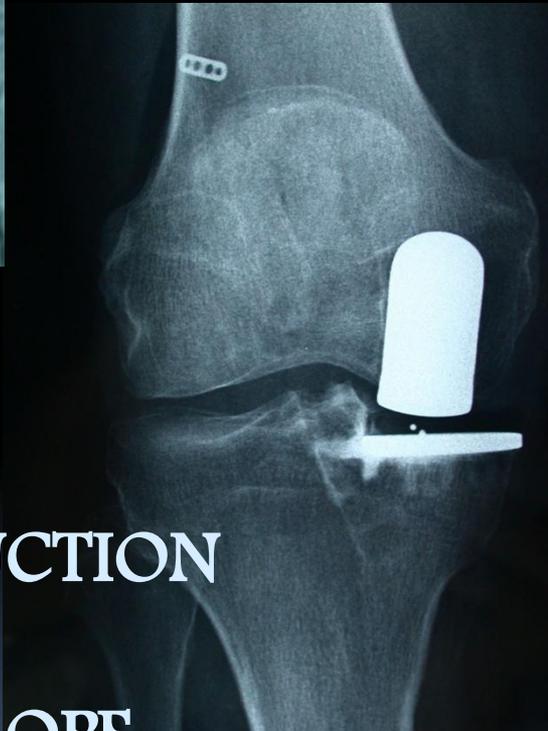
JBJS Br 88–B 887–892 2006



ACL DEFICENCY ?



AVOID MOBILE BEARING !



ACL RECONSTRUCTION
&
LESS TIBIAL SLOPE

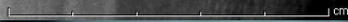
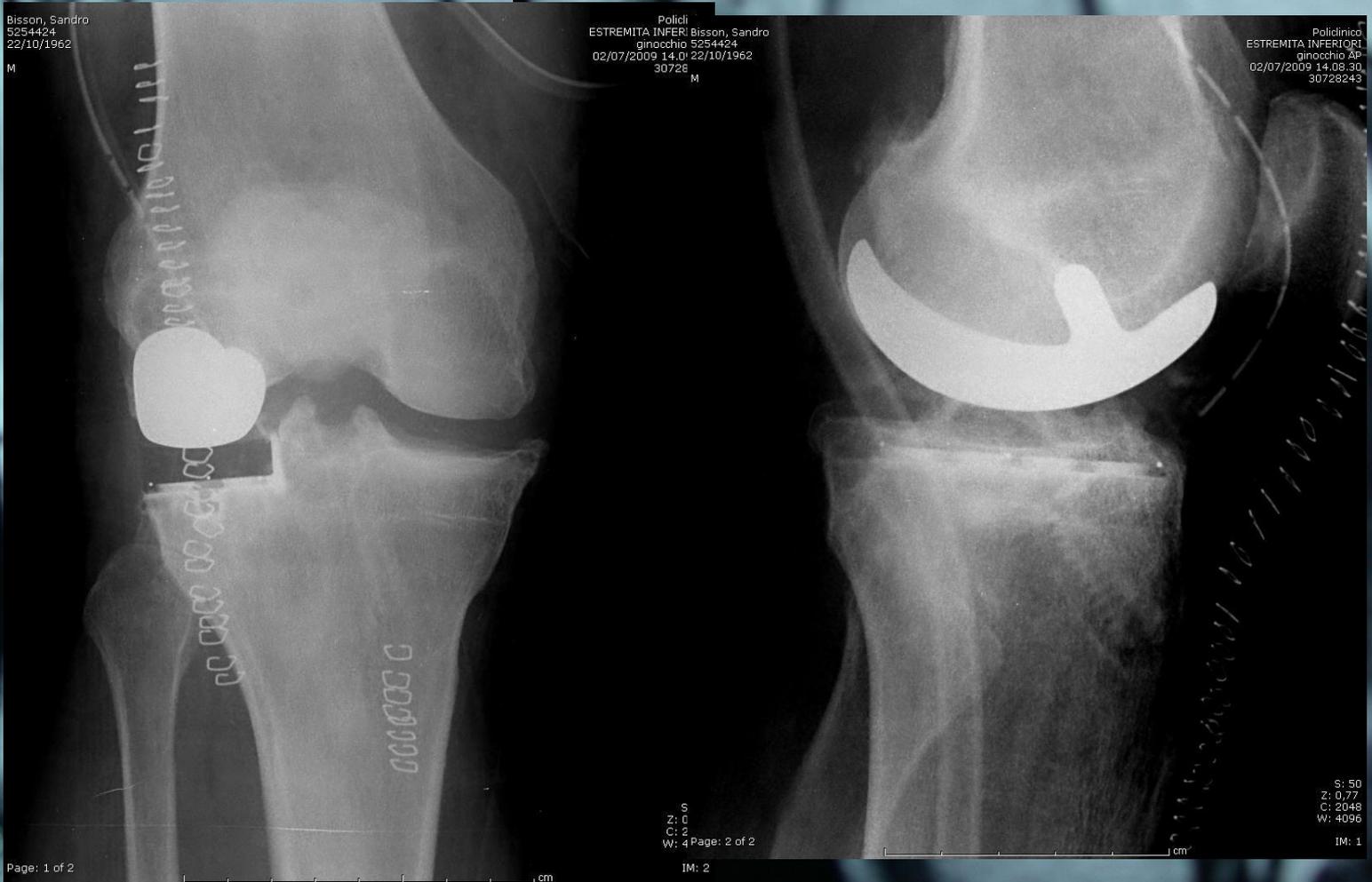
Scb
TSEM
SLP

Bisson, Sandro
5254424
22/10/1962

M

Polieli
ESTREMITA INFERI Bisson, Sandro
ginocchio 5254424
02/07/2009 14.01 22/10/1962
30726
M

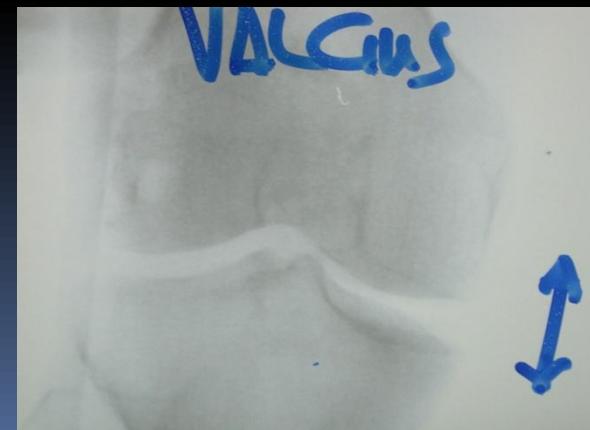
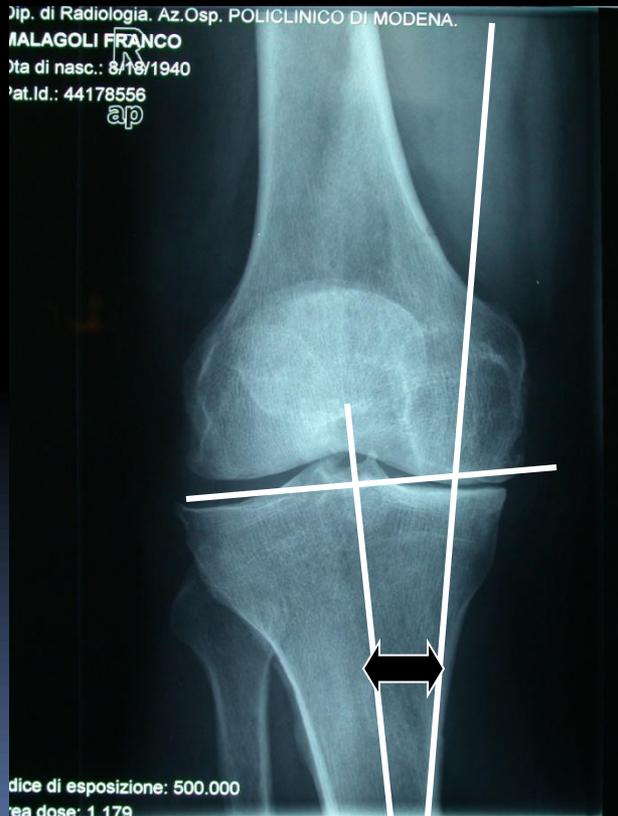
Polidinico
ESTREMITA INFERIORI
ginocchio AP
02/07/2009 14.08.30
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PIANIFICAZIONE CORRETTA

Rx in varo-valgo stress

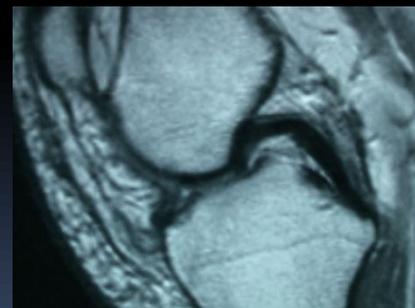
ANGOLO di CARTIER



PIANIFICAZIONE CORRETTA



RMN



Chirurgia corretta

Massimo rispetto della Joint-line

Resezione controllata (minima) della tibia

Bilanciamento corretto degli spazi
in estensione e flessione

Attenzione alla lama di resezione tibiale
(spine tibiale)

Chirurgia (non) corretta

Mal-allineamento

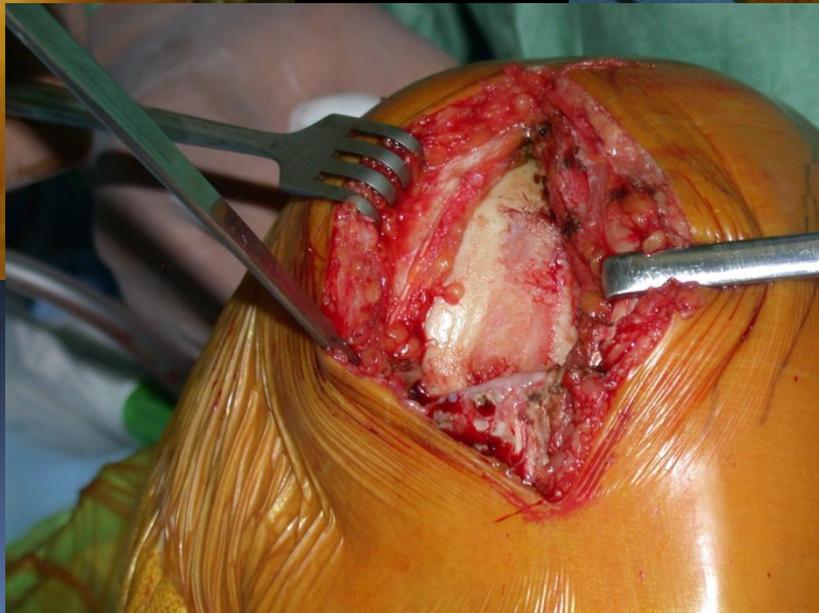
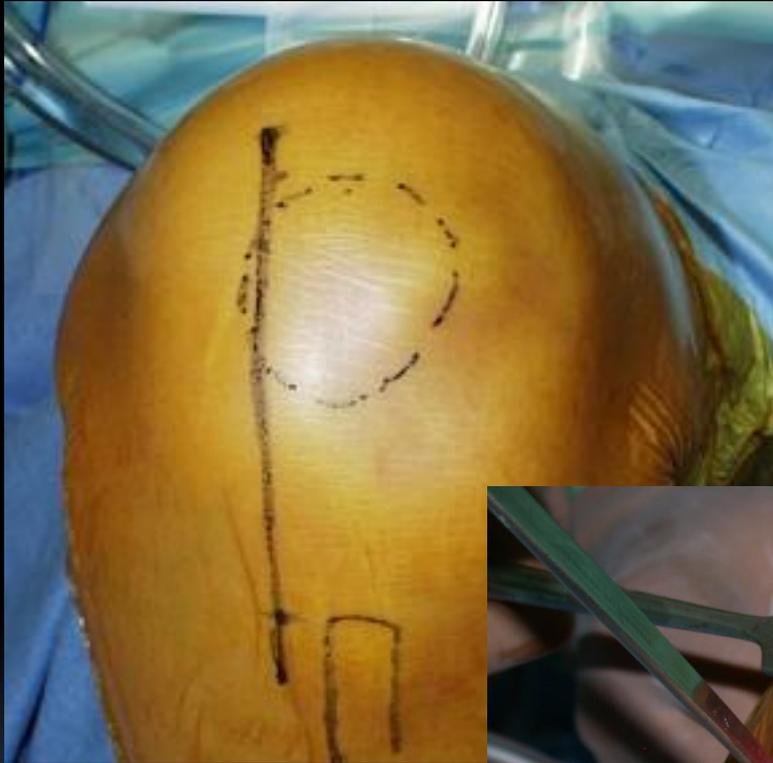


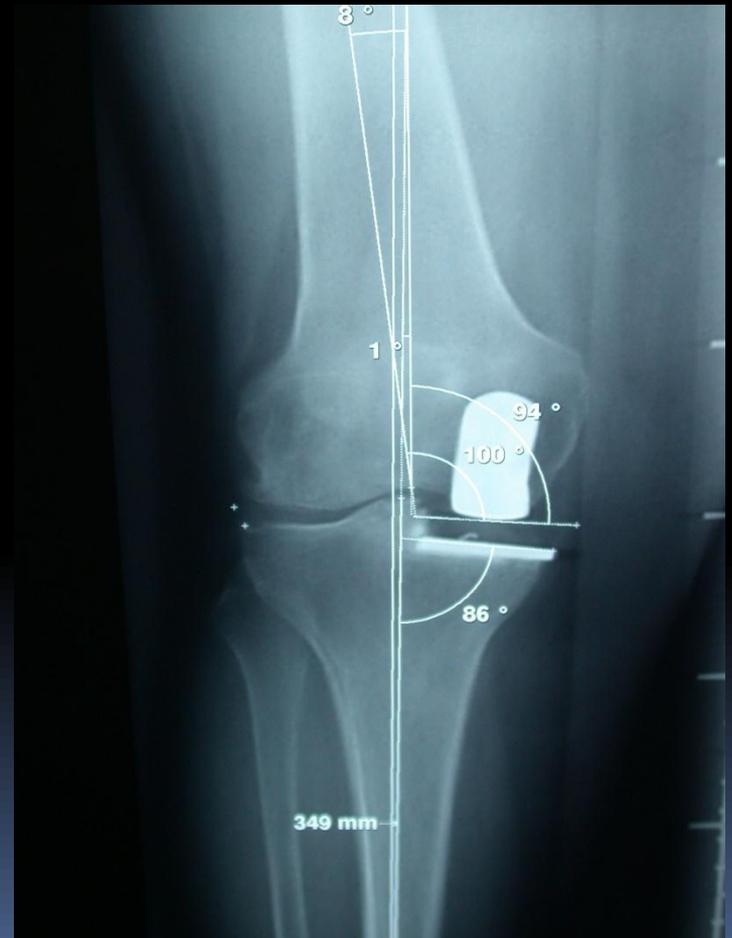
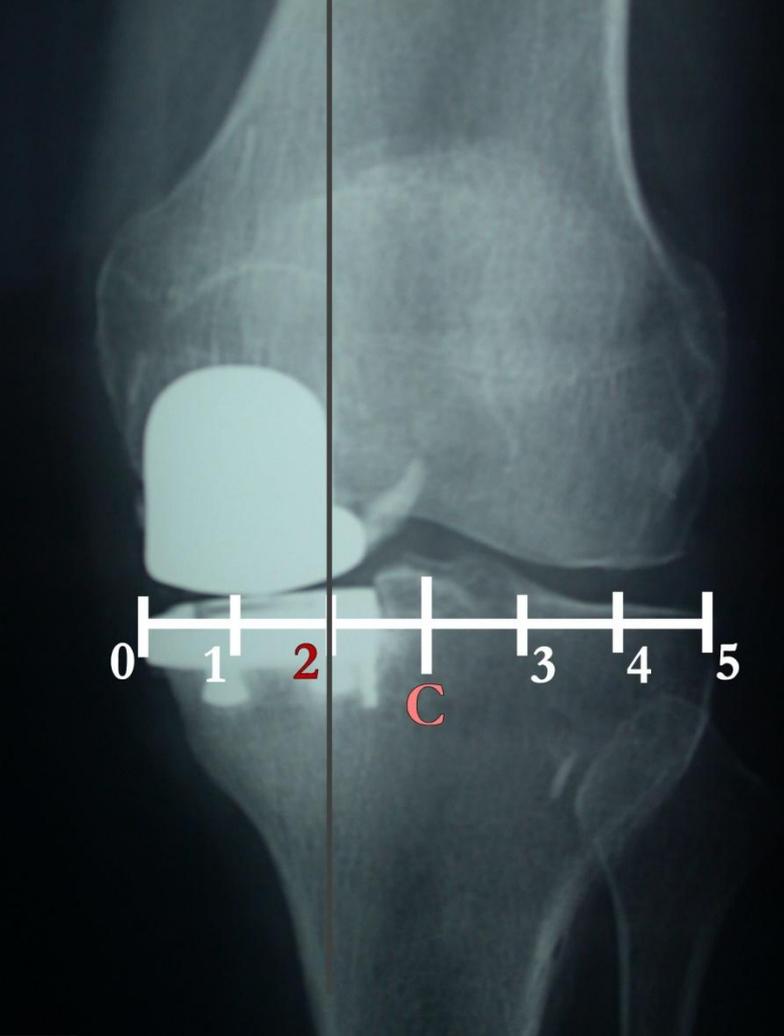
Iper-correzione



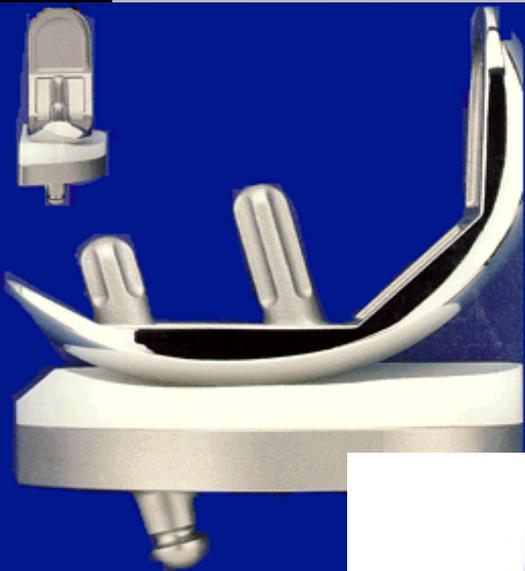
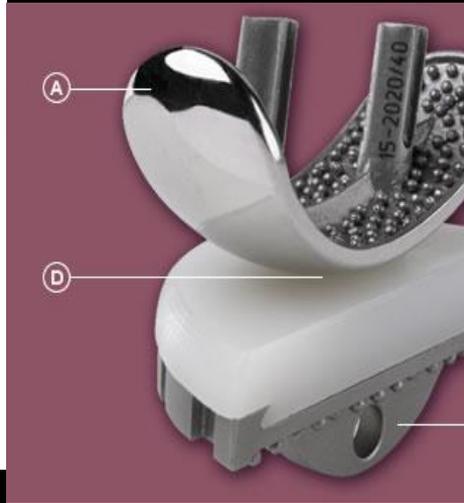
(GOLD) MIS APPROACH

(MEDIAL or LATERAL)



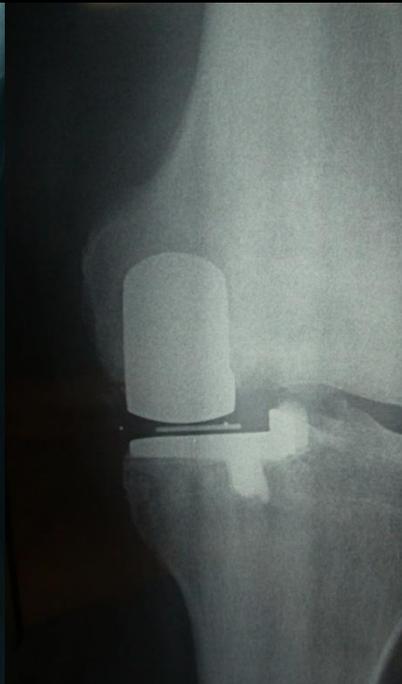
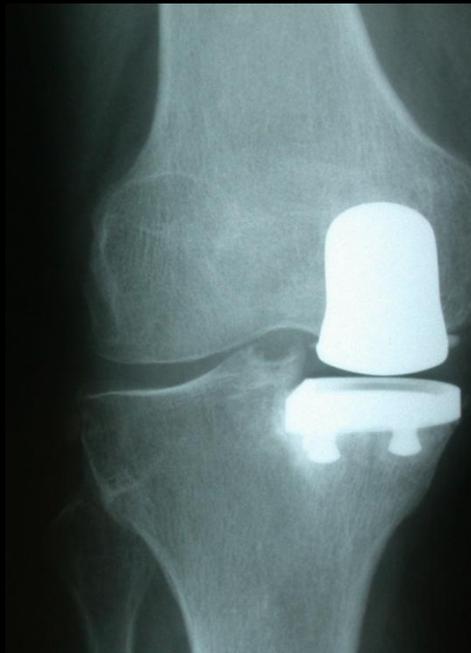


Posizionamento: 85% in zona 2
di Kennedy



Che tipo di protesi?





Che tipo di protesi?



- @ Breve ospedalizzazione(3.4 giorni)
- @ Perdite ematiche : 125 ml (mai trasfuso)
- @ TE : nessuna
- @ 90° flessione :media in 7 giorni
- @ FWB: immediato
- @ SLR: 1° giorno post-op



RIPO RER 2000-2009

PTG vs PMC : 35.494 vs 4.812

89% VS 11%

Incremento delle PMC dal 2000 dal 10% al 13%

RIPO RER 2000-2009

Rischio di fallimento :

PTG 2,2%

PMC 5,8%

PMC fallimenti precoci nei primi 3 anni poi stabilizzazione



Tesi di LAUREA 2011

All-Poly vs MB

Periodo 2003-2007

150 PMC controllate

10 fallimenti (6%)

9 su 10 all poly

(1 modello protesico prevalente)



PTG looks good, feel bad

PMC looks good, feel better

Tissue Sparing Surgery (TSS)

 Springer  Journal of Orthopaedics and Traumatology

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Journal List > J Orthop Traumatol > v.9(3); Sep 2008

J Orthop Traumatol. 2008 September; 9(3): 171–177. PMID: PMC26569
Published online 2008 July 8. doi: 10.1007/s10195-008-0015-5.

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Tissue sparing surgery in knee reconstruction: unicompartmental (UKA), patellofemoral (PFA), UKA + PFA, bi-unicompartmental (Bi-UKA) arthroplasties

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N. Confalonieri, Phone: +39-02-57993299, Fax: +39-2-57993299, Email: norbconf@tin.it .

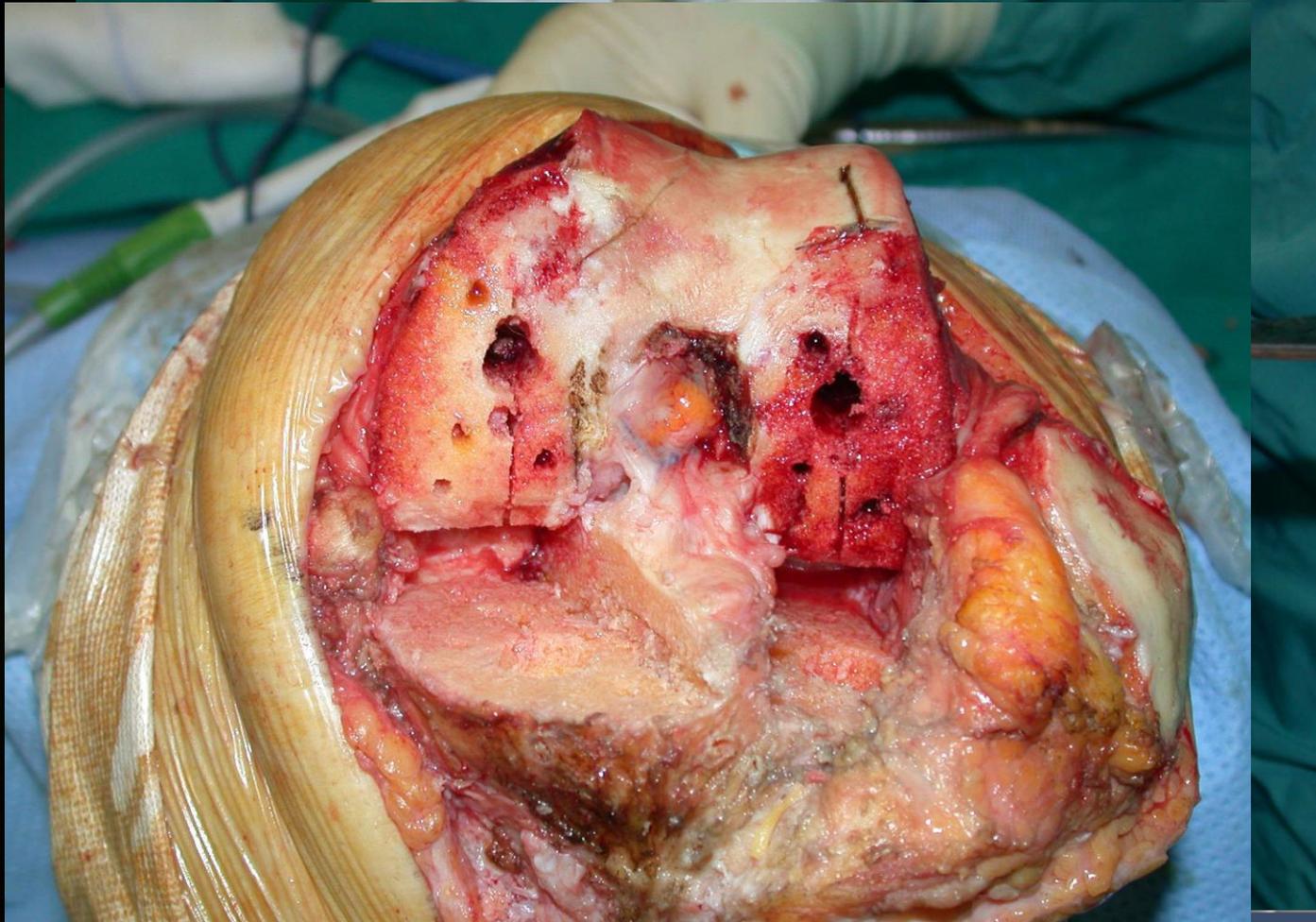
[✉]Corresponding author.

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Abstract

Recently mini-invasive joint replacement has become one of the hottest topics in the orthopaed

Patologia Bi-compartimentale



RM: arthroscopia - RM00825
29
11/09/2008 14:33:51
60109454

SUPTECO

Z: 1
Cl: 2048
W: 4050
Compracci: 2728
IM: 1

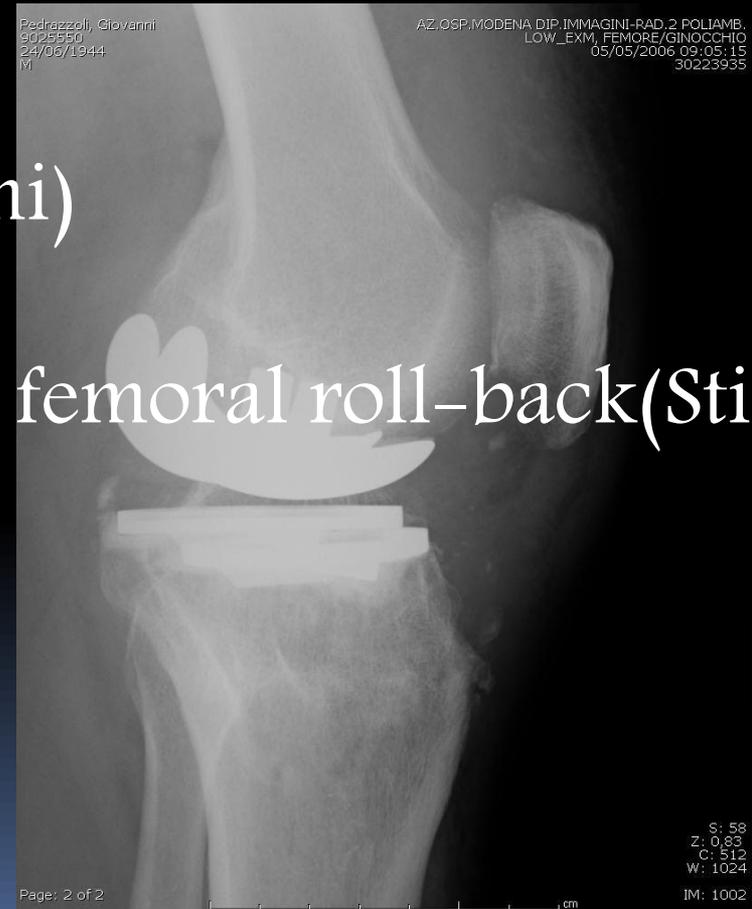
PROTESI BI-MONOCOMPARTIMENTALI



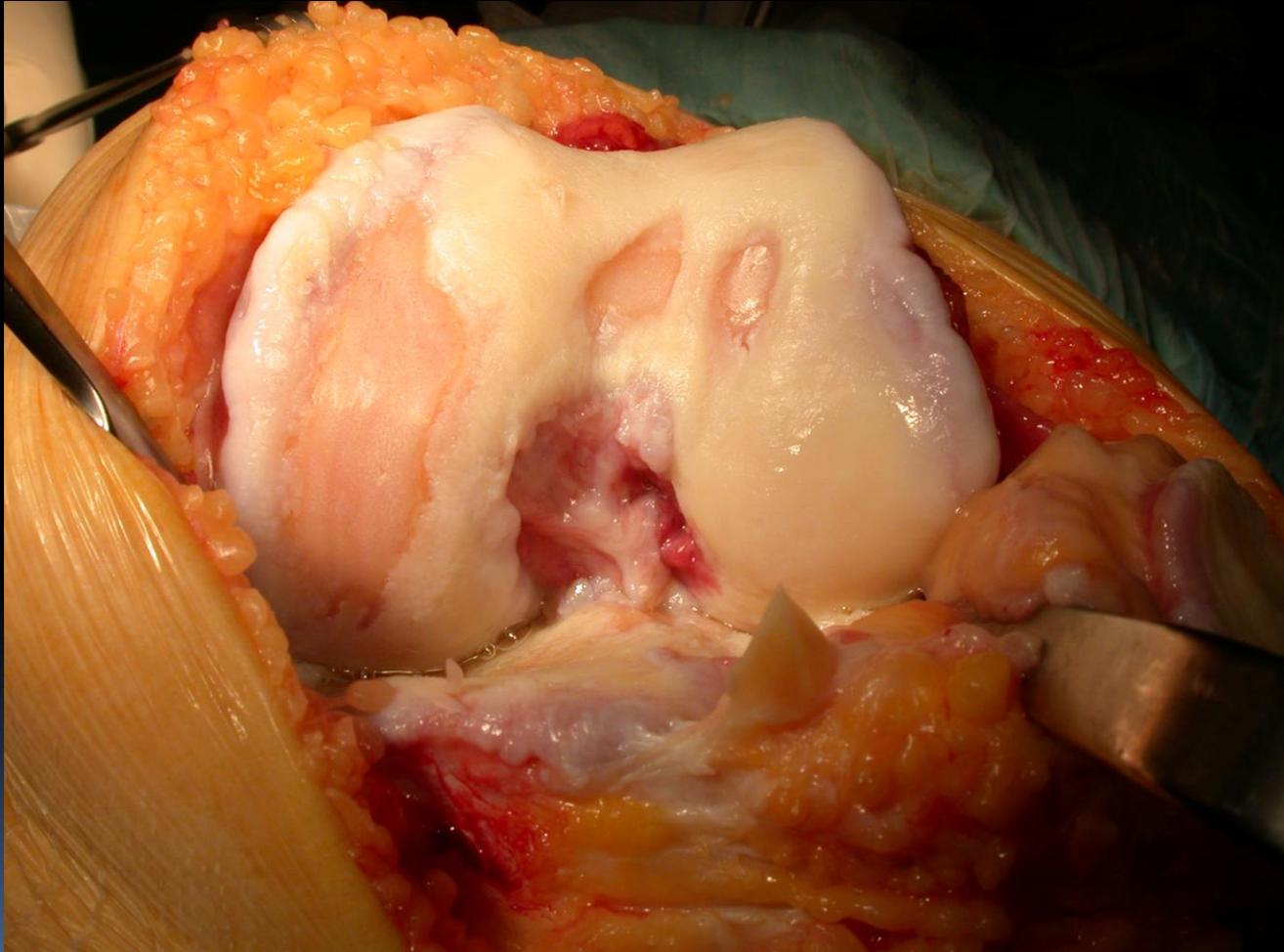
Normal Gait (Andriacchi)

Normal Flexion

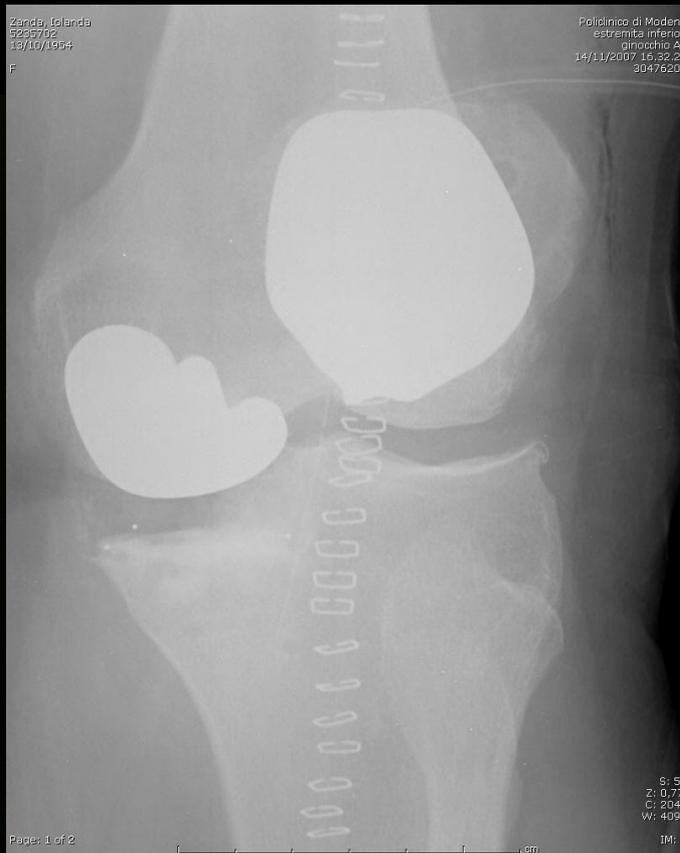
Physiological posterior femoral roll-back (Stiehl)



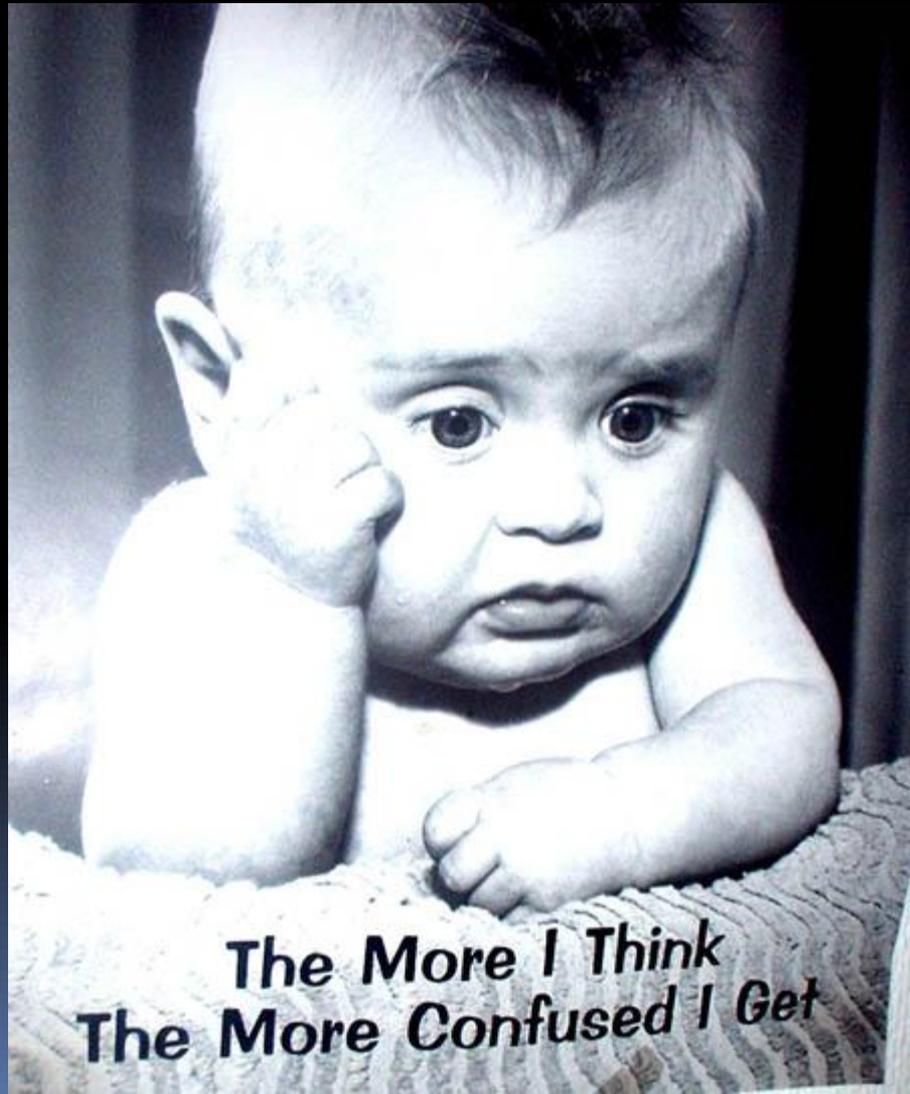
PATOLOGIA F/T e F/R



PROTESI MONOCOMPARTIMENTALE + FEMORO-ROTULEA



SCENARIO CLINICO



**The More I Think
The More Confused I Get**

Persona attiva (lavoro o sport)

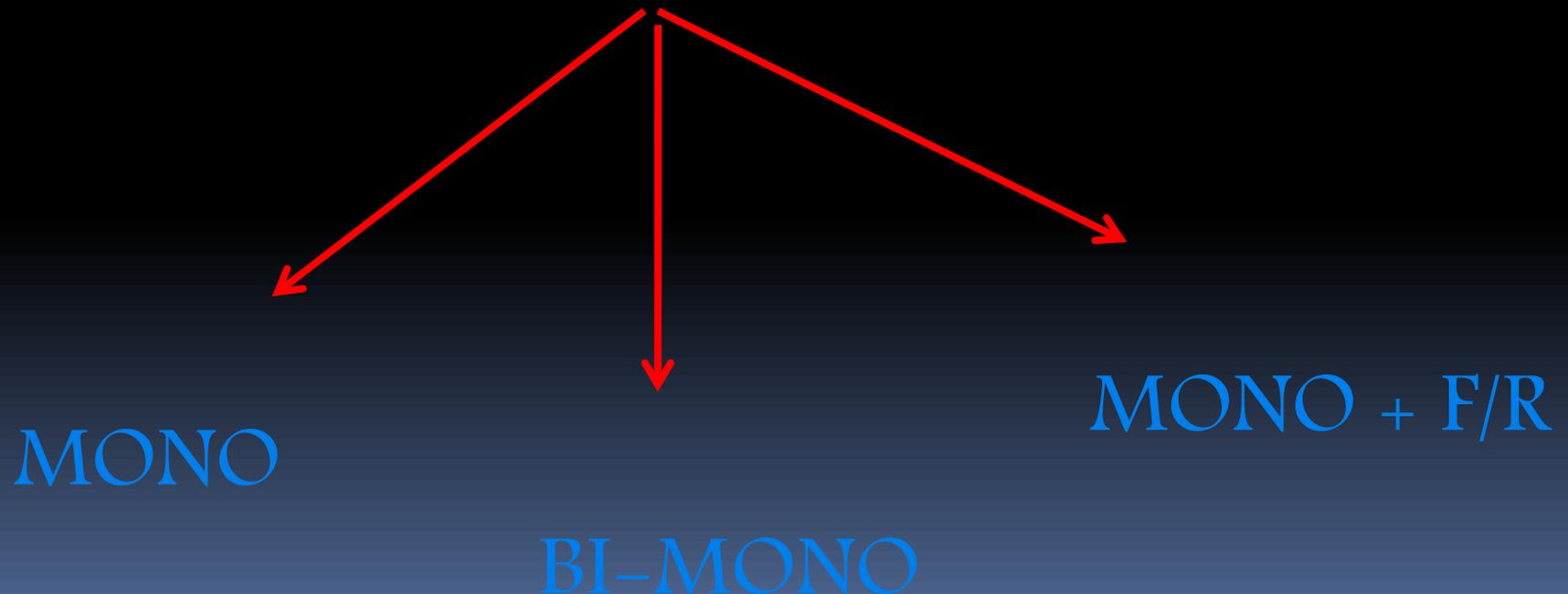
Patologia Mono o Bi-compartmentale (F/T o F/R)

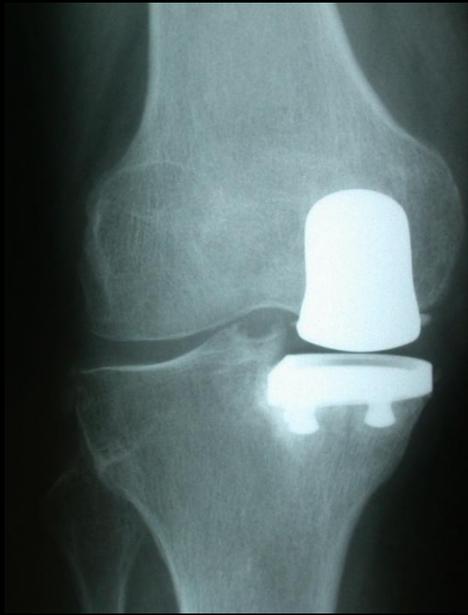
Legamenti competenti

Patologia di origine meccanica o degenerativa

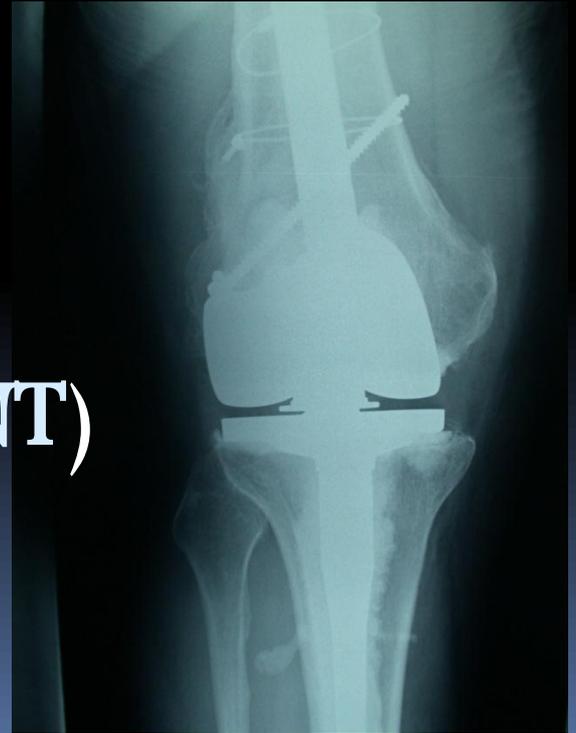
Buon bone stock

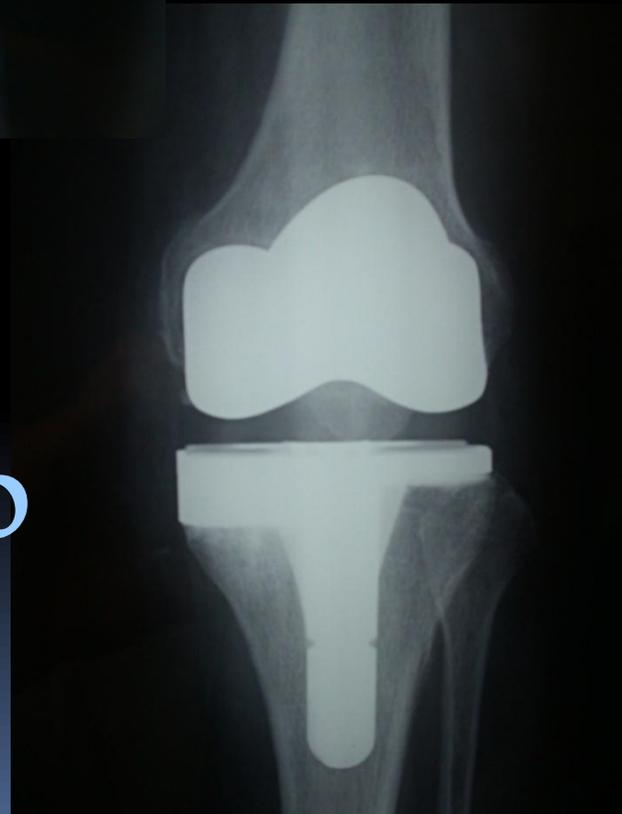
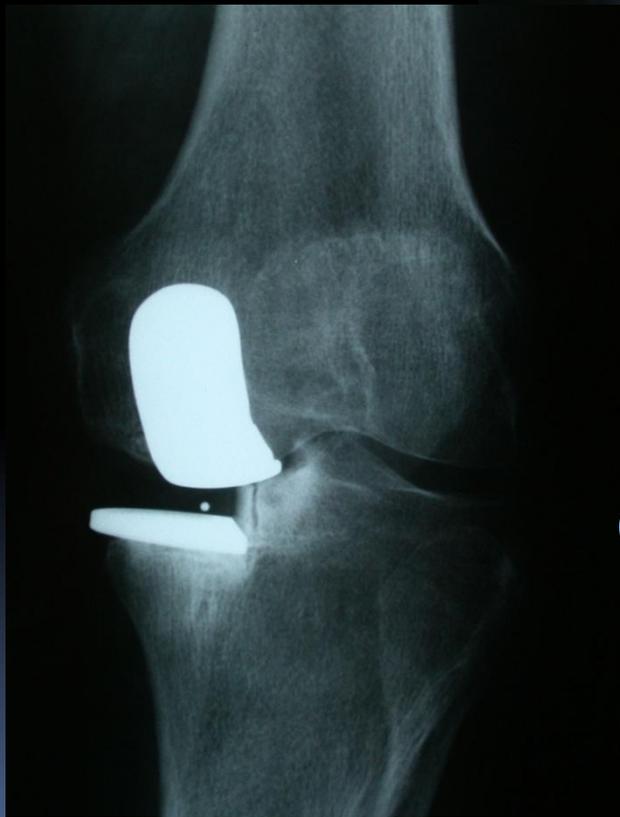
ROM completo





ONE
FRACTURE
(^DCAR ACCIDENT)





1
cedimento

Mobilizzazione tibiale asettica

Mercuri, Natalina
5237442
04/01/1951
60 YEAR
F



Pc
ESTREMITA INF Mercuri, Natalina
gimoc 5237442
27/06/2011 11:04:01/1951
31 60 YEAR
F

Page: 2 of 2



Policlinico
ESTREMITA INFERIORI
gimocchio LAT
27/06/2011 14:18:59
31043651

S: 50
Z: 0,60
C: 2048
W: 4096

IM: 2

Page: 1 of 2

WHY DON'T YOU FORGIVE
YOURSELF FOR SLEEPING

