The knee is also manipulated at this time to break up any scar tissue that may have formed which will help to restore knee motion.

Who is a Candidate?

Almost anyone with severe arthritis – bone on bone is not a problem – who wishes to avoid invasive knee replacement surgery.

There are a few exclusions, including too much angular deformity of your knee or excessive stiffness. I can tell you after examining your knee and evaluating your X-rays if JDA is an alternative for you.

Can other joints besides the knee be treated?

Yes, at present the procedure is also offered for the ankle, the thumb and the Great Toe.

Rehabilitation

You bear weight, bend your knee, and begin activities as tolerated immediately after pin removal.

The knee should gradually improve over the ensuing weeks and months.

Success Rate

In a major study 80% of patients were still satisfied with their knee five years after surgery.

Only 17% of patients elected knee replacement, and all of them were still significantly improved vs baseline when they had the knee replacement.

Ten year success rate data is being calculated.

Illinois Sportsmedicine and Orthopaedic Center

Joint Distraction Arthroplasty (JDA)

1714 Milwaukee Ave.
Glenview, IL 60025
Phone: 847-699-6810
Fax: 847-699-6545
Website: www.ISMOC.net

Joint Distraction Arthroplasty (JDA)

Safe, Highly Successful, Minimally Invasive Surgical Procedure For:

- Relieving knee arthritis pain and restoring function

- Avoiding Invasive knee replacement surgery

-Regenerating new cartilage

History - Background

JDA for the knee was developed primarily in the Netherlands. It has been used with high success there for decades. I have spent time with the primary developer of the technique, Dr Peter Van Roermund in the Netherlands. It works by a similar principle to another procedure called "High Tibial Osteotomy" which I have performed for thirty years. The American Academy of Orthopaedic Surgeons asked me to write their Instructional Course Lecture on this technique and to teach a course for Orthopaedic Surgeons at their annual meeting due to my work in this area.

Surgical Technique

JDA is performed under general or spinal anesthetic in a hospital or surgicenter on an outpatient basis.

First the knee is examined with an Arthroscope. Torn cartilage is re-moved and usually vascular access holes are made in the exposed bone with tiny wires where cartilage used to be. This allows stem cells from the bone to gain access to the knee.

Stainless steel pins are then inserted into the femur (thigh bone) and tibia (leg bone) through small punctures – no incision is used.

Next telescoping rods are attached to the pins lengthwise across the knee.

Then the rods are elongated slightly to create space in the knee where the cartilage used to be to allow new cartilage to grow. The joint space is also equalized during this step. This concludes the procedure.

Post-Operative Care

You will be able to bear weight on the knee the day of surgery. However since the rods prevent bending of the knee, crutches must be used to avoid severe limping.

The day after surgery you will be seen in the office and a little more space will be created in the knee. This is completely painless.

Superficial skin tract infections are common. You will need to take antibiotics for a period of time, if this develops.

Pin Removal

Six weeks after pin implantation you will return to the operating room and the pins will be painlessly removed under anesthetic.