Patellofemoral osteoarthritis coexistent with tibiofemoral osteoarthritis in a meniscectomy population

M Englund, L S Lohmander

OBJECTIVES: To evaluate the frequency of patellofemoral osteoarthritis and its relevance to symptoms and function in a meniscectomy population. 

METHODS: 317 patients with no cruciate ligament injury were evaluated (mean (SD) age, 54 (11) years). They had undergone meniscal resection 15 to 22 years earlier (follow up rate 70%). Standing tibiofemoral and skyline patellofemoral radiographs were graded according to the OARSI atlas. The Knee Injury and Osteoarthritis Outcome Score (KOOS) was used to quantify symptoms and function. Controls were 68 unoperated subjects identified from national population records.

RESULTS: Patellofemoral osteoarthritis (isolated or coexisting with tibiofemoral osteoarthritis) was present in 66 of 317 index knees (21%) and 21 of 263 unoperated contralateral knees (8%, p < 0.001). In 57/66 (86%) of these index knees, tibiofemoral osteoarthritis was present (mixed osteoarthritis). In a model adjusted for age, sex, and body mass index, the odds ratio for patellofemoral osteoarthritis (alone or in combination with tibiofemoral osteoarthritis) was 2.6 (95% confidence interval, 1.1 to 6.6) after medial meniscectomy and 5.3 (1.9 to 15.0) after lateral meniscectomy, using controls as the reference. Individuals with a mixed knee osteoarthritis pattern had more symptoms, lower function in sports and recreation, and worse knee related quality of life than subjects with isolated tibiofemoral osteoarthritis.

CONCLUSIONS: Mixed patellofemoral and tibiofemoral osteoarthritis is common in a meniscectomy population. Patellofemoral osteoarthritis is a contributing cause of knee symptoms and reduced knee related quality of life and is relevant to the management of knee complaints of this group of patients.
underwent surgery in 1973. Age at examination, sex ratio, and general geographic living area were also similar to other patients in the study cohort (table 1).

### The Knee Injury and Osteoarthritis Outcome Score

To evaluate knee specific, patient relevant outcome we used the Swedish version of KOOS, www.koos.nu. KOOS was developed for short and long term follow up studies of knee injury and knee osteoarthritis, and comprises five subscales: pain, other symptoms, activities of daily living, function in sports and recreation (Sport/Rec), and knee related quality of life. A score from 0 to 100 is calculated for each subscale, with 100 representing the best result. The patients examined in 1994 completed the KOOS questionnaires in 1996 by mail. Their radiographic knee status was still considered to be relevant to their self report two years later. The other subjects completed their questionnaires on their own in conjunction with the clinical and radiographic assessment. Self reported outcome was not obtained from 11 patients who had radiographs taken.

We created a definition of a symptomatic knee based on the patient’s self report from the KOOS questionnaire and consensus among the authors. This operational definition aimed at identifying individuals symptomatic enough to possibly seek medical care.

Information on occupational workload and leisure physical activity level was collected for both patients and control subjects. Estimates were made retrospectively by the subject and divided into five year periods from the time of surgery until the time of assessment. Occupational load was graded as clerical work/unemployed/retired, light labour, moderate labour, or heavy labour. Leisure physical activity level was divided into five year periods from the time of surgery until the time of assessment. Occupation and leisure physical activity level was described as low, moderate, high (regular sporting activity/labour, or heavy labour). Leisure physical activity level was divided into five year periods from the time of surgery until the time of assessment.

### Radiographic examination

A skyline view of the patellofemoral joint was obtained with a vertical beam with the subject standing with the knee in 50° of flexion (fig 1). Standing anteroposterior and lateral images of the knees in 15° of flexion were obtained from patients and control subjects using a fluoroscopically positioned x ray beam. A Siemens Basic Radiological System (Siemens, Erlangen, Germany) was used for patients who were followed up in 1994 and 1995, and for the control subjects. For patients who were assessed in 2000, we used a Phasix 60 generator (CGR, Liège, Belgium). Two patients did not undergo radiographic examination of the contralateral knee.

The skyline patellofemoral images and frontal knee radiographs were assessed for joint space narrowing (JSN) and osteophytes according to the atlas from Osteoarthritis Research Society International (OARSI). The presence of these features was graded on a four point scale (range 0 to 3, with 0 = no evidence of bony changes or JSN). We did not score sclerosis, attrition, malalignment, or patellar subluxation. The lateral knee radiographs provided additional information in cases when there was doubt about, for example, the location of an osteophyte or the presence of absence of JSN. Ten patients (3%) were operated on in the index knee with a high tibial osteotomy for osteoarthritis. Two of these subjects and three additional patients underwent high tibial osteotomy of the contralateral knee. When the patient had undergone subsequent tibial osteotomy or arthroplasty for osteoarthritis, JSN was regarded as grade 3 in the affected tibiofemoral compartment. In these cases, the contralateral and the patellofemoral compartment (in case of total arthroplasty) were assessed on preoperative images.

One trained observer (ME) read all knee radiographs within a period of two weeks with films from patients and controls mixed and blind to clinical details. The patellofemoral images from the patients who underwent surgery in 1973 and 1978 have been read by other observers in a previous study. Interrater reliability (κ statistic) for these readings and present grading was κ = 0.65 for the presence of patellofemoral osteoarthritis.

We considered radiographic osteoarthritis to be present in the patellofemoral joint or a tibiofemoral compartment if any of the following criteria were fulfilled: JSN of grade 2 or more, the sum of the two marginal osteophyte grades from the same compartment ≥2, or grade 1 JSN in combination with a grade 1 osteophyte in the same compartment. This cut off approximates grade 2 knee osteoarthritis, based on the Kellgren and Lawrence (K/L) scale.

### Table 1

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Patients (n = 317)</th>
<th>Controls (n = 68)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic data at follow up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>251 (79%)</td>
<td>50 (74%)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>54 (11)</td>
<td>56 (12)</td>
</tr>
<tr>
<td>Follow up time (years)</td>
<td>18 (2)</td>
<td>–</td>
</tr>
<tr>
<td>Body mass index (kg/m²)</td>
<td>26 (4)</td>
<td>26 (4)</td>
</tr>
<tr>
<td>Median occupational workload</td>
<td>Light labour</td>
<td>Clerical work</td>
</tr>
<tr>
<td>Median spare time physical activity</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographic data at index surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>36 (12)</td>
<td>–</td>
</tr>
<tr>
<td>Arthroscopic technique</td>
<td>48 (15%)</td>
<td>–</td>
</tr>
<tr>
<td>Medial meniscectomy</td>
<td>250 (79%)</td>
<td>–</td>
</tr>
<tr>
<td>Total meniscectomy</td>
<td>155 (49%)</td>
<td>–</td>
</tr>
<tr>
<td>Degenerative meniscal tear</td>
<td>121 (38%)</td>
<td>–</td>
</tr>
</tbody>
</table>

Values are n (%) or mean (SD).

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*Figure 1* Knee positioning to obtain skyline patella radiographs.
Statistical analysis
Probability (p) values for binary data in 2×2 tables were calculated with Fisher’s exact test and continuous data by the Mann–Whitney test or t test as appropriate. The effects of the evaluated risk factors, using the presence or absence of patellofemoral osteoarthritis as the dependent variable, were analysed by means of logistic regression. The multivariate odds ratio (OR) estimates with 95% confidence intervals (CI) were based on the models with all variables entered. We considered a p value of 0.05 or less to be significant, and all tests were two tailed (SPSS for Windows, release 12.0.1; SPSS Inc, Chicago, Illinois, USA, 2003).

RESULTS
Radiographic osteoarthritis
Mixed knee osteoarthritis—that is, combined patellofemoral and tibiofemoral osteoarthritis—was present in 57 of 317 index patients’ (operated) knees (18%). Nine subjects (3%) had isolated patellofemoral osteoarthritis, and 98 (31%) had radiographic osteoarthritis confined to the tibiofemoral joint in their index knee. Of the unoperated contralateral knees, 13 of 263 (5%) had mixed osteoarthritis, eight subjects (3%) had isolated patellofemoral osteoarthritis, and 31 of 263 patients (12%) had isolated tibiofemoral osteoarthritis. Patellofemoral osteoarthritis (either in mixed or isolated pattern) was present in 27 (9%) and unilateral in 43 (14%). In the control subjects, six of 68 right knees and four of 68 left knees had patellofemoral osteoarthritis (isolated or mixed osteoarthritis pattern).

Subjects with mixed osteoarthritis pattern had more severe tibiofemoral changes than subjects with isolated tibiofemoral osteoarthritis: the sum of all osteophyte and JSN grades from the tibiofemoral joint was 5.0 v 3.1 (p, 0.001).

Table 2

<table>
<thead>
<tr>
<th>Prevalence of patellofemoral osteoarthritis (n (%))</th>
<th>Crude OR</th>
<th>Adjusted OR</th>
<th>95% CI*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control subjects†</td>
<td>6/68 (9)</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Medial meniscectomy</td>
<td>48/250 (19)</td>
<td>2.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Lateral meniscectomy</td>
<td>18/67 (27)</td>
<td>3.8</td>
<td>5.3</td>
</tr>
</tbody>
</table>

*Adjusted for age, sex, and body mass index.
†Reference category.
CI, confidence interval; OR, odds ratio.

Table 3

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Prevalence of patellofemoral osteoarthritis (n (%))</th>
<th>Crude OR</th>
<th>Adjusted OR</th>
<th>95% CI*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at follow up (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;50†</td>
<td>19/121 (16)</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>50 to 59</td>
<td>19/98 (19)</td>
<td>1.3</td>
<td>1.5</td>
<td>0.7 to 3.1</td>
</tr>
<tr>
<td>&gt;60</td>
<td>28/98 (29)</td>
<td>2.1</td>
<td>2.2</td>
<td>1.1 to 4.3</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men†</td>
<td>50/251 (20)</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>16/66 (24)</td>
<td>1.3</td>
<td>1.1</td>
<td>0.6 to 2.4</td>
</tr>
<tr>
<td>Body mass index (kg/m²)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25.0</td>
<td>23/126 (18)</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>25.0–29.9</td>
<td>29/153 (19)</td>
<td>1.0</td>
<td>1.0</td>
<td>0.5 to 2.0</td>
</tr>
<tr>
<td>&gt;30.0</td>
<td>14/38 (37)</td>
<td>2.6</td>
<td>2.8</td>
<td>1.2 to 6.4</td>
</tr>
<tr>
<td>Localisation (compartment)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medial†</td>
<td>48/250 (19)</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Lateral</td>
<td>18/67 (27)</td>
<td>1.5</td>
<td>2.2</td>
<td>1.1 to 4.5</td>
</tr>
<tr>
<td>Type of resection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial†</td>
<td>13/63 (21)</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>22/99 (22)</td>
<td>1.1</td>
<td>1.6</td>
<td>0.7 to 3.8</td>
</tr>
<tr>
<td>Total</td>
<td>31/155 (20)</td>
<td>1.0</td>
<td>1.2</td>
<td>0.5 to 2.5</td>
</tr>
<tr>
<td>Type of meniscal tear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Longitudinal†</td>
<td>23/139 (17)</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Degenerative</td>
<td>31/120 (26)</td>
<td>1.8</td>
<td>1.8</td>
<td>0.9 to 3.5</td>
</tr>
<tr>
<td>Radial</td>
<td>5/24 (22)</td>
<td>1.3</td>
<td>1.0</td>
<td>0.3 to 3.3</td>
</tr>
<tr>
<td>No visible tear or not classified</td>
<td>7/34 (21)</td>
<td>1.3</td>
<td>1.5</td>
<td>0.5 to 4.0</td>
</tr>
</tbody>
</table>

*Adjusted simultaneously for all other risk factors listed.
†Reference category.
CI, confidence interval; OR, odds ratio.
and lateral osteophyte grade ⩾ 2). Of the 29 patellofemoral joints with combined JSN and osteophytes, the JSN was predominately medial in 12 subjects, lateral in 12, and five patients had symmetrical narrowing. Nine of the 12 subjects with medial patellofemoral JSN had medial compartment tibiofemoral osteoarthritis (with JSN); the other had no tibiofemoral JSN. Of those with lateral patellofemoral JSN, six had medial, one had lateral, and five had no tibiofemoral JSN.

**Risk factors**

There was an increased likelihood of developing patellofemoral osteoarthritis (in either mixed or isolated osteoarthritis pattern) after medial or lateral meniscectomy compared with the control subjects (table 2).

The multivariate effects of each investigated risk factor to the development of patellofemoral osteoarthritis in the patients’ operated knee were analysed by logistic regression. The presence of tibiofemoral osteoarthritis was by far the strongest factor associated with patellofemoral osteoarthritis (OR = 10.6 (95% CI, 4.8 to 23.5)). When including tibiofemoral radiographic status in the model, all other risk factors were non-significant.

Excluding radiographic tibiofemoral status as an explanatory variable, the factors significantly associated with patellofemoral osteoarthritis were age 60 years or older, obesity, and lateral meniscectomy more than medial (table 3).

We separately evaluated the effect of the retrospectively estimated knee load in the patients who had such data available (n = 163). Analysis was made in a single model adjusted for gender, sex, body mass index (BMI), and the operated compartment. Subjects with leisure physical activity level estimated as “very high” or “high” had a higher prevalence of patellofemoral osteoarthritis than subjects with “low” or “moderate” level of activity (the highest report of the five year interval estimates counted): 25% v 15% (OR = 4.3 (95% CI, 1.5 to 11.9). Essentially the same result was obtained when using the median activity level of the estimates (data not shown). Occupational workload did not affect the frequency of patellofemoral osteoarthritis (p > 0.9).

Intraoperative patellofemoral cartilage status was noted in 70% of the surgical reports. Patellofemoral cartilage changes (superficial fibrillation and so on) were noted in 31% of those with patellofemoral osteoarthritis at follow up (16 of 51) compared with 19% of those without (33 of 170) (p = 0.001). There was no effect on the frequency of patellofemoral osteoarthritis resulting from the type of surgery—that is, open v arthroscopic meniscectomy (p = 0.21).

**Patient relevant outcome**

The most common outcome 15 to 22 years after an isolated meniscal injury and resection was having a healthy knee—that is, being asymptomatic as assessed by the KOOS, with no radiographic knee osteoarthritis (29%), followed by being symptomatic with no definite radiographic osteoarthritis (21%), having symptomatic tibiofemoral osteoarthritis (15%), having asymptomatic tibiofemoral osteoarthritis (14%), and having symptomatic mixed knee osteoarthritis (12%).

Patients with mixed osteoarthritis scored the worst on the KOOS questionnaire. The differences in mean scores of KOOS between subjects with isolated tibiofemoral osteoarthritis and mixed knee osteoarthritis were significant for the subscales “other symptoms”, “Sport/Rec”, and “quality of life”, but not for “pain” (p = 0.18) and “activities of daily living” (p = 0.3) (fig 2).

**DISCUSSION**

To our knowledge, we are the first to report an increased frequency of patellofemoral osteoarthritis concomitant with tibiofemoral osteoarthritis after a meniscal tear treated by surgical resection. There is a paucity of epidemiological studies evaluating risk factors for patellofemoral osteoarthritis. Meniscectomy has been identified as an important risk factor for tibiofemoral osteoarthritis, but little is known of the frequency of osteoarthritis in the patellofemoral joint in relation to this intervention. Thus, with low losses in a 15 to 22 year follow up, we studied a well defined cohort of 317 subjects who had undergone meniscal resection. A standardised skyline radiographic projection of the patellofemoral joint was used as it allows more precise location of change, greater sensitivity in identification of symptomatic subjects, and better reproducibility.

Tibiofemoral osteoarthritis with coexisting patellofemoral involvement was a common finding. There are several possible explanations, which probably involve both systemic and local factors. First, we have previously reported on the association between radiographic hand osteoarthritis and radiographic tibiofemoral osteoarthritis after meniscectomy, suggesting an interaction between local joint factors and a genetic predisposition to osteoarthritis. Such a genetic trait for osteoarthritis may also predispose to meniscus tears, as well as patellofemoral osteoarthritis. Patellofemoral cartilage changes were noted at the time of index surgery in many of the osteoarthritis cases. This suggests that preradiographic or incipient osteoarthritis may already have been present at that time. For many of these mostly middle aged subjects, the meniscal tear may merely have been the “signal feature” of an already developing osteoarthritis.

Second, osteoarthritis disease activity primarily in the tibiofemoral joint may be associated with activation of cytokine and protease cascades that act locally on all joint tissues and compartments, or even systemically. In our cohort, medial facet patellofemoral osteoarthritis (which is unusual) seems to be relatively frequent (most meniscectomies were medial, with frequent medial tibiofemoral osteoarthritis). Altered loading patterns may act locally on the patellofemoral joint owing to malalignment caused by unicompartamental tibiofemoral osteoarthritis. Furthermore,
the osteoarthritides may increase knee joint laxity or be associated with quadriceps weakness increasing the risk for patellofemoral disease. Neurogenic pathways may also affect joint metabolism.23

Although small subject numbers warrant caution in interpretation, lateral meniscectomy in particular appears to be associated with osteophytosis of the patellofemoral joint. In a previous report on this population,11 lateral meniscectomy was more often associated with radiographic osteoarthritis of the tibiofemoral joint compared with medial meniscus resection, in line with other studies.24 25 It was suggested that this depended on increased cartilage stress because of loss of the mechanically more important lateral meniscus.26 27 The high prevalence of osteoarthritic changes in the patellofemoral joint after lateral meniscectomy could thus be secondary to the increased frequency of osteoarthritides in the tibiofemoral compartment.

A limitation associated with the present study is that no long leg films to measure knee alignment were obtained. Other limitations are inherent with any historical cohort study. However, the loss to follow up was low. By excluding subjects with cruciate ligament injury, the cohort is enriched in those with degenerative meniscal injuries—that is, lesions that may occur in the absence of overt knee trauma. The radiologist’s written statement from the preoperative knee radiographs (normally frontal and lateral projections only) was used to exclude subjects with radiographic osteoarthritides at the time of index surgery. In 31 patients (10%) the preoperative radiographic statement or films were not available. Thus the odd subject with radiographic patellofemoral or tibiofemoral osteoarthritides at baseline may have been included in the cohort, although the relatively young age at surgery makes this unlikely.

Our results corroborate observations that risk factors for patellofemoral osteoarthritides and tibiofemoral osteoarthritides are typically the same.28 29 30 Using retrospective estimates of body weight, made from the subjects operated on in 1973 and 1978 (data not shown), we did not find any evidence that individuals first developed osteoarthritides and then become sedentary and obese, although the strength of our conclusion is limited by the cross sectional nature of the BMI data. Patellofemoral osteoarthritides has been linked to elite physical knee loading as a risk factor.31 32 Nevertheless, within the limitations associated with restricted subject numbers and retrospective estimates, our study suggests an association between continued high knee load after the meniscectomy and the increased risk of patellofemoral osteoarthritides.

The importance of patellofemoral osteoarthritides to symptoms and functional limitations has been emphasised,1 but the focus in epidemiological studies of knee osteoarthritides remains on investigating tibiofemoral osteoarthritides. We find that subjects with a mixed radiographic osteoarthritides pattern have the worst outcome. It is unlikely that the small increase in severity of radiographic changes in the tibiofemoral joint in subjects with concomitant patellofemoral osteoarthritides is a major contributor,33 34 suggesting that patellofemoral involvement may be more important.

Conclusions

Mixed patellofemoral and tibiofemoral osteoarthritides is common after meniscectomy, not only isolated tibiofemoral osteoarthritides. Patellofemoral osteoarthritides is a contributing cause of knee symptoms and reduced knee related quality of life in a meniscectomy population, and is relevant to the management of knee complaints in this group of patients.

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