

# Arthroscopic Pathology or Normal Variant

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**T**hroughout the history of arthroscopy we have been able to further define pathological lesions, as well as discover lesions that were never apparent to us during open surgery. The ease of being able to place the arthroscope into different anatomical areas, that were heretofore unapproachable open, has been of great value to the orthopedic surgeon. Magnification has brought to light pathological conditions that, again, were not that apparent to us during open procedures. However, with all of these incredible advantages and breakthroughs, the temptation to overemphasize the pathological nature of the physical findings still remains a concern.



Knee arthroscopy was the first area the orthopedic surgeon ventured into. From those early procedures, we rediscovered the presence of the plica. There is no question that there is such a thing as a pathological plica, but they are not that common. Early in the history of arthroscopy, some physicians in the process of applying for membership in the various societies would present their series of 100 cases, and 30% of them would be plica excisions. It is obvious that these were patients with some sort of painful knee condition, but certainly the plica could not be blamed in most circumstances for that condition.

The presence of a minimally torn and degenerative meniscus in the presence of moderate osteoarthritis can be a source of pain but, oftentimes, with aggressive radical resection, the patient's condition actually worsened. We have become far more conservative in our approach to partial meniscectomy and the osteoarthritic knee for that very reason.

With the advent of being able to identify the superior labral anterior-posterior (SLAP) lesion in the shoulder as a source of pain and dysfunction, we have spent most of our time developing techniques to repair the SLAP lesion rather than spending more time trying to identify which lesions are pathological and which ones are not. In our department's Board review data, there are 3 times as many SLAP lesions being repaired by the younger orthopedic surgeon, who is in his board collection period, than are done by the experienced arthroscopist

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who has been in practice more than 10 years. This calls to mind the need for identifying a pathological condition vs what might be considered a normal variant, or nonpathological, condition.

There certainly are other anatomic areas that we are quite familiar with that are associated, somewhat questionably, as the progenitor of pain for a given condition. For instance, we know that triangular fibrocartilage complex (TFCC) tears in elderly patients are quite common but, again, may not represent a true pathological condition. Ankle impingement surgery can be quite beneficial but, oftentimes, there are anterior osteophytes that are totally asymptomatic that are resected and do not bring about the relief we expected.

Hip arthroscopy is becoming popular. Yet, labral lesions, as well as other conditions, such as femoroacetabular impingement (FAI), in some cases merely may reflect early onset of osteoarthritis. The role of repair and excision of these conditions needs to be studied in more depth.

Our enthusiasm for technology must be tempered with time spent discriminating between what is truly pathological and what is a normal variant. It is far too long between the podium presentations on new ideas and surgical approaches to the actual valid outcome studies. Certainly, results from level 1 studies can come quite late in the world of orthopedics. Although level 1 studies are not the only valid way to assess the efficacy of a procedure, we do need to look at a more scientific approach earlier in our analysis of orthopedic conditions and procedures.

We must be vigilant—before the government and insurance companies grasp one published article and decide to set policy. Once that happens, the ability to reverse their decision is extremely limited.

## AUTHOR'S DISCLOSURE STATEMENT

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