

QUESTIONS AND ANSWERS WITH DR. KENNETH SANDS, M.D.

Dr. Sands was the first surgeon in Georgia to perform a modern metal-on-metal total hip resurfacing and the first surgeon in Northwest Georgia to perform the Oxford Knee.

Knee Replacement, is there an alternative?

Yes. In April of 2004, the FDA approved the first mobile bearing partial replacement in the United States. The Oxford Partial Knee Replacement has been in existence overseas since 1987. Traditional fixed bearing partial knees have been available in the United States for decades; however, their success has overall failed to match the success of total knee replacements at 15 years, except for a few exceptions. The long-term data from centers overseas have shown that the Oxford has a 93% success rate at 15 years which mimics published results for total knee implants at 15 years.

Is there a benefit to the Oxford knee?

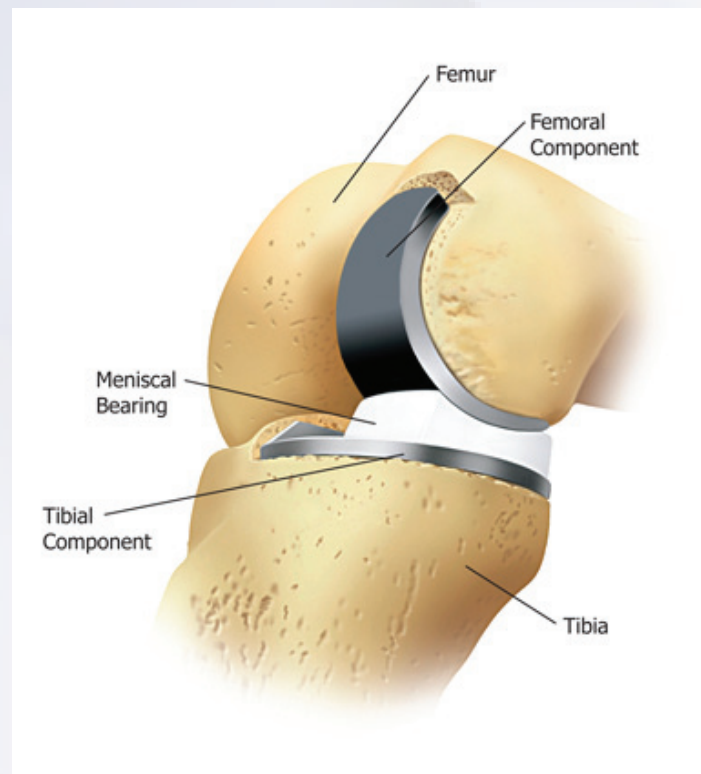
Absolutely yes in the correct patient. The Oxford Knee is designed to preserve healthy knee structures. My interest in the Oxford system stemmed from my desire to implant a more natural feeling implant with proven longevity. Although technology has increased significantly in the total knee market, total knee implants still perform in an abnormal manner compared to the natural knee. This paradoxical knee motion seen in total knee replacements stems from a loss of certain ligaments. The Oxford Knee is designed for patients with arthritis on the inside portion of their knee. By maintaining the natural ligaments, the Oxford Knee allows the patient's knee to function in a more normal manner. The mobile bearing plastic acts like the patient's natural cushion, which helps off load the stress across the joint and increases the potential life of your knee implant.

Who is the correct patient?

The correct patient has degenerative joint disease mainly of the inside compartment of the knee with intact ligaments. Special stress x-rays are performed in the office to determine the extent of arthritis in the knee. The area around the knee cap is generally ignored. Ignoring the knee cap compartment is a large departure from traditional teachings about partial knee replacements. In previous studies, researchers have shown that failure of traditional partial knee replacements be-

tween year 10 and 15 are related to wear of the plastic fixed liner and changes in the knee cap joint secondary to impingement of the thigh component with the knee cap. Impingement has not been a factor with the Oxford Knee mainly because of certain differences with implantation that prevent such a complication.

Age is not a factor in selecting the appropriate patient, neither is weight. Traditionally both age and weight have been factors in selecting patients for traditional fixed bearing partial replacements, however, studies on the Oxford have shown no correlation with increased failure. Rheumatoid arthritis and fixed contractures still hold true as poor candidates for fixed or mobile bearing partial knee replacements.



Are there complications?

This operation is not for every patient or even for every surgeon. The FDA tightly controls surgeon access to the procedure. The literature has been very clear with regards to decreased complications when performed by surgeons that do at least 10-23 Oxford Partial Knee Replacements per year. Although the operation is less invasive, it is more technically demanding than a total knee or a fixed bearing unicompartamental knee.

Dislocation of the plastic liner is a unique complication of the Oxford Mobile Bearing Knee. There is a 1.6% incidence of liner dislocation. Degeneration of other parts of your knee is another potential complication. The incidence of developing arthritis in the outside portion of your knee with the Oxford is 3.2%, which is less than the incidence reported with fixed bearing partial replacements.



My Experience

I have been greatly pleased with our results. I have been performing Oxford Partial Knee Replacements for approximately 4 years. I have noticed that their rehab has been significantly faster, and there has been a decrease in blood loss and perceived pain. Unfortunately, this operation is not for everyone. In general it should account for 20 – 30% of patients requiring a total knee replacement. In the end only time will tell if the American experience can match the European and Australian experience, however, I am very enthusiastic and pleased to offer patients in the tri-state area another option for treatment of knee osteoarthritis.

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