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Authors’ reply to Joshi

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We thank Joshi for his interest in our research article.1 2 We agree that the finding of a degenerative meniscal tear on magnetic resonance imaging (MRI) is no cause for treatment, surgical or non-surgical, and that the common use of MRI in middle aged and elderly patients with chronic knee pain is costly and unwarranted. The increasing accessibility to MRI is indeed a likely contributor to the current high rate of arthroscopic knee surgery in middle aged and elderly people because a tear once shown demands to be treated even without a proven cause of symptoms.

Asymptomatic meniscal tears verified by MRI are common in the population,3 and the poor correlation between symptoms and MRI findings is also well established in orthopaedic populations.1 4 Pain, mechanical symptoms, impaired function, and the resulting reduction in quality of life drive patients to seek treatment, and this is where the expectation of relief lies. Our study showed equal improvement between treatment groups in these aspects, except for symptoms, which were significantly more improved in the exercise therapy group.2 Neither clinical assessment nor patient symptoms could differentiate a group improving more with surgery. We therefore disagree with Joshi that “good clinical assessment correlated with patient symptoms is sufficient for a surgeon to decide which patient needs arthroscopic surgery.”2

Joshi also states that “with exercise alone the meniscal tear remains or worsens over time” and “no patient aged 35 to 60 would want to continue sporting activities knowing that he or she has a meniscal tear.” These statements are opinion. Exercise therapy was associated with immediate and sustained relief in mechanical and other symptoms. In the exercise therapy group the percentage of participants who reported “at least moderate problems with their knee catching or hanging up” decreased from 24% at baseline to 6% at 2 years. Similar improvements were seen in those reporting “at least moderate grinding, clicking, and other noise” (decreased from 59% to 29%) and “at least moderate pain when bending knee” (decreased from 58% to 16%). In addition, those reporting “at least moderate problems with swelling and stiffness” decreased (49% to 14% and 49% to 10%) after exercise therapy.

Participants in our study were younger, slimmer, and more physically active than those in previous studies. They were also eager to return to physical activity. The HUNT activity index, measuring frequency, duration and intensity of their physical activities, improved by 1.4 points in the exercise group compared with 0.9 in the knee arthroscopy group.

Surgeons, GPs, physiotherapists, and others can comfortably inform patients of these facts when engaging their patients in shared decision making about their treatment. As suggested by Finnikin,4 in a letter to the accompanying editorial,7 “Shared decision making for management of knee pain should begin in the GP surgery and continue through the patient’s treatment. Given the research findings, it would be difficult to see why patients who are adequately supported in the decision making process would be choosing surgery over physiotherapy.”

Competing interests: None declared.

References
1. Joshi A. Exercise therapy is supplementary to arthroscopic surgery when surgery is indicated. BMJ 2016;354:i4822.


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