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Do you have a question related to this column or a general orthopedic question you would like to have answered in a future issue? Send an e-mail to AskPiedmont-Ortho@sosbonedocs.com.

Q. I am having stabbing pain on the outside of my knee, and it is locking up occasionally when I walk. My family doctor thinks I may have a torn meniscus. What are my treatment options?

A. Tears of the meniscal cartilage in the knee are a common occurrence. There are two menisci in the knee, medial and lateral, which act as cushions between the tibia (shinbone) and femur (thigh bone). Absence of these cushions can lead to early arthritis.

The meniscus can be torn by a twisting injury, general wear and tear, or a combination of both. Symptoms are usually similar to what you describe: sharp, localized pain on the inside or outside of the knee where it bends, swelling, catching, or locking up of the knee. X-rays will not show a torn meniscus but will indicate if arthritis is present in the knee. MRI scanning is typically done to diagnose a meniscal tear.

Treatment options for a meniscal tear depend on your age, your activity level and the nature of the tear. They include observation, supervised physical therapy, anti-inflammatories and cortisone injections. Surgical options include arthroscopy and tear debridement (removal) or arthroscopy with meniscal repair.

In general, middle-aged and older adults with symptomatic, degenerative (wear and tear) meniscal tears that have not gotten better with non-operative treatment are candidates for arthroscopy (a minimally invasive surgical procedure) and removal of the torn portion of the meniscus. We leave as much as possible of the healthy rim to cushion the joint.

For younger patients with meniscal tears, especially those associated with trauma and ligament injuries, arthroscopy with repair is the preferred option because of the known association between less knee cushion and arthritis in later life.

Recovery from arthroscopy with meniscal removal or repair usually takes 4-6 weeks. Risks include infection (<1%), knee stiffness, and incomplete pain relief, especially if arthritis is present. The success rate for meniscal repair is about 75% when performed in conjunction with ACL reconstruction, but 50% or less when done in isolation.

Q. My daughter is a high school soccer player who just tore her anterior cruciate ligament and meniscus in a game. What can we expect with her treatment?

A. The anterior cruciate ligament (ACL) is one of the main stabilizing structures inside the knee. When it is torn, the knee can feel wobbly and give way. The meniscus, as stated above, is the main cushioning structure between the two bones of the knee. Tearing both the ACL and the meniscus is a serious injury. In an athlete who wants to return to cutting and pivoting sports, the ACL is commonly reconstructed, or replaced with other tissue, usually the patient's hamstring tendon or part of the patellar tendon. The procedure is done arthroscopically without "opening up" the knee. As noted above, meniscal repair and ACL reconstruction performed at the same time have a reasonably high success rate.

Rehabilitation after surgery is critical. The first goal is to achieve full extension, a straight leg, usually within 2-3 weeks. Bending to at least 90 degrees by 2 weeks is another early goal. Strengthening exercises are added as knee motion progresses. Straight-ahead running starts around 4 months, with return to play generally in 6 to 9 months. Current opinion is that it may take up to a year after surgery for your knee to return to normal. Rehabilitation takes a lot of effort, but when you are done, you'll have a good leg to stand – and play – on.