position as patient advocates to ensure access to safe and effective treatments. Surgeons need to be aware of evidence-based methodologies such as MCII (meaningful clinical important improvement). They need to know that even when treatment effects do not reach an MCII cutoff value, there could still be a significant proportion of patients who cross that threshold and for whom clinically significant improvement can be achieved.

Informed expert opinion on the CPG process itself is absolutely necessary to make sure these analyses are a reasonable assessment of the available medical evidence to ensure patients are cared for with both evidence and access in mind. A flawed process will lead to decreased access to safe and effective treatments. Indeed, as a result of the AAOS CPG process, there are insurers who have decided not to cover viscosupplementation for patients with osteoarthritis. How can a process not be flawed that includes Level I studies that show a statistically significant benefit for some patients, especially when that treatment is for a disease (knee OA) that is not preventable, and for which there is no cure. In our opinion, it does not serve AAOS members and our profession to recommend against a treatment that AAOS members provide their own patients, many of whom demand such treatment because viscosupplementation decreases their knee OA pain and limitations of function with a risk-to-benefit profile they prefer to alternative treatments, including no treatment at all. We could not state it better than that.

All human endeavor is potentially flawed and open to both criticism and improvement; the CPG process is not immune to this reality. We think the Academy is to be applauded for initiating and supporting such an effort. Now would be a good time to improve it to make sure it adheres to the AAOS mission, which is to “champion the interests of all patients, serve our members and the profession, and advance the highest quality musculoskeletal health.”

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New England Journal of Medicine Article Evaluating the Usefulness of Meniscectomy Is Flawed

To the Editor:
ElAttrache et al.1 have raised concerns regarding the New England Journal of Medicine (NEJM) article by Sihvonen et al.2 and we want to further underline their impression. The NEJM article describes the efficacy of arthroscopic partial meniscectomy in patients with a degenerative tear of the medial meniscus without knee osteoarthritis in a randomized double-blind, sham-controlled trial and found no significant benefit of partial medial meniscectomy over sham surgery.

However, to assess the benefits of an intervention aimed at restoring meniscal function and relieving knee pain, a detailed analysis of the meniscal tear is important but was not included in the stratification process. Differentiation of the meniscus tears with respect to the tear depth, tear location, the radial location, the tear pattern (longitudinal, horizontal, radial, vertical flap, horizontal flap, or complex), and the quality of the tissue might lead to another outcome than described.3 Sihvonen et al.2 show that 2 patients underwent meniscal repair, which indicates that the tear pattern had an impact on the way of treatment.

It is possible that some patients with complex degenerative meniscus tears, vertical flaps, or horizontal flaps without osteoarthritis would benefit from surgery but were not appropriately addressed in this study.

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Tibial Insertion Is Not a Circle But an Ellipse

To the Editor:

We read the article “The Shape and the Thickness of the Anterior Cruciate Ligament Along Its Length in Relation to the Posterior Cruciate Ligament: A Cadaveric Study” by Triantafyllidi et al.1 with great interest. We would like to commend the authors on their work.

Knowledge of the geometric characteristics, including length, cross-sectional area (CSA), and surface attachment, of the anterior cruciate ligament (ACL) is important for determining the mechanical properties and obtaining optimal ACL reconstruction. Previous cadaveric studies measured areas at the midpoint of the ACL, and the average minimum CSA after removing the synovial membrane was found to be 35.3 mm² (range, 30 to 43 mm²). In a study on older cadavers, Harner et al.2 also measured CSA using a laser micrometer system, and they found that the CSA of the ACL midsubstance was approximately 3.5 times smaller relative to the ACL tibial and femoral insertions, which ranged from 114 mm² to 229 mm². Although 77.8% of specimens had elliptical insertions and 22.2% had triangularly shaped tibial insertions,3 the tibial graft position in single- and double-bundle ACL reconstruction is usually presented as a circle, which does not give an accurate picture of the position of the graft sites on their insertions. In a real situation, it is the irregular surfaces that can be considered, for easier presentation, as an ellipse. The size and position of the ellipse surface of the drilled tibial tunnel affect the drill bit diameter, sagittal or drill guide angle (angle at which the tunnel intersects the tibial plateau), and transverse angle (tibial drill guide adjustment by rotating the guide around the tibial shaft).4

The authors measured and compared the thickness of a native ACL, and they measured the most commonly used grafts on the midsubstance and tibial attachment. The thickness in the midsubstance of the native ACL and grafts used is from 4 to 6 mm, whereas on the tibial insertion, the thickness is twice as thick (12 mm) relative to the native ACL. If the grafts and the native ACL have a similar CSA in the midsubstance, it is geometrically impossible that the native ACL be twice as thick as the grafts at the place of tibial insertion. We believe that the CSA of the tibial insertion is not a circle but an ellipse, and therefore there is an error in Figure 8 in the article of Triantafyllidi et al.1

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Authors’ Reply

Thank you for giving us the opportunity to highlight once again the complex anatomy of the ACL. The most