

Using Allogeneous Structural Bone Graft for Uncontained Tibial Bone Defects ≥ 10 mm in Depth in Primary Total Knee Arthroplasty

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Abstract

Background

In primary total knee arthroplasty (TKA), tibial bone defects ≥ 10 mm in depth often become uncontained defects, a condition most surgeons find challenging to treat. Although the allogeneous bone graft is a useful method, complications such as infection and nonunion are likely to occur. There are several reports on the use of allogeneous bone graft in revision TKA; however, few studies have investigated its use in primary TKA. We performed primary TKA using the allogeneous bone graft as a structural bone graft to treat uncontained defects ≥ 10 mm in depth. This study aimed to assess the clinical and radiographical results after primary TKA with allogeneous structural bone graft (ASBG).

Methods

Seventeen patients (mean age, 69.2 years) with a follow-up period of at least 7 years, were retrospectively reviewed. All cases had been treated for medial bone defects using the ipsilateral medial tibial allogeneous bone. Clinical evaluation included the assessment of the knee and function scores and knee angle, and the hip-knee-ankle (HKA) angle, bone union, and radiolucent line (RL) were assessed radiologically.

Results

The mean depth of the medial tibial defects after tibia cutting was 16.8 mm. Nonunion occurred in one case, and RL occurred in another. We observed a significant difference when the preoperative knee score and HKA angle of patients was compared with that at 1 year postoperatively and the final evaluation. No major complications were observed.

Conclusion

The ASBG technique produced favorable surgical outcomes and may be an acceptable procedure for managing uncontained tibial bone defects ≥ 10 mm in depth in primary TKA.

Background

Primary total knee arthroplasty (TKA) produces good long-term results. However, we sometimes encounter cases with medial tibial uncontained bone defects, which require some ingenuity. Generally, uncontained bone defects < 5 mm in depth are filled with bone cement, while defects of 5–10 mm in depth are treated with bone graft, and defects ≥ 10 mm in depth are treated using metal augmentation [1]. When the bone defect is ≥ 10 mm in-depth, the management can be challenging. The use of metal augmentation for uncontained defects ≥ 10 mm in depth creates further bone loss and can make future revision surgery difficult. Although there have been a few reports of primary TKA with autologous bone

graft for uncontained tibial bone defects ≥ 10 mm in depth [2, 3], it is difficult to obtain a bone block ≥ 10 mm thick from the resected femoral or tibial bone. An allogeneous bone graft is useful because it is freely shaped, is usually available in sufficient quantity, and is usable as a structural bone graft. However, most of the reports using allogeneous bone graft have been for revision TKA or primary and revision TKA, not for primary TKA alone. Therefore, in the present study, we aimed to assess clinical and radiographical results following primary TKA with allogeneous structural bone graft (ASBG).

Methods

We performed primary TKA using medial tibial allogeneous bone as a structural bone graft for uncontained defects ≥ 10 mm in depth. Further, we assessed the clinical and radiographical results after primary TKA with ASBG for uncontained tibial bone defects ≥ 10 mm in depth.

For this study, we retrospectively enrolled 35 patients who underwent TKA with allogeneous bone graft at a single institution between January 2008 and December 2014. The study included patients with a record of primary TKA for ≥ 10 mm deep uncontained medial bone defects following proximal tibial cutting, the use of the allogeneous bone of ipsilateral medial condyle of tibia, and a clinical and radiological follow-up period of at least 7 years. Patients with valgus knees and patients who underwent revision TKA were excluded. Of the 35 patients, 21 underwent primary TKA using ASBG. Of these, the allogeneous bone of the femoral head was used in three patients, and one patient relocated and could not be followed up for more than 7 years, resulting in a final number of 17 patients (17 knees) who met all the inclusion criteria. Fifteen women and two men constituted the study sample, and the mean age at surgery was 69.2 years (range, 50–83 years). The diagnoses were osteoarthritis ($n = 11$) and rheumatoid arthritis ($n = 6$). The mean follow-up duration was 96.4 months (range, 84–150 months).

Surgical procedures

The tibial bone was cut to a depth of 8 to 10 mm from the articular surface of the lateral tibial condyle. No more than 10 mm of the tibia was removed because additional removal would have resulted in an unacceptably small tibial surface and a lower joint line. The sclerotic surface of the medial tibial bone defect was refreshed to expose a flat cancellous bony surface. In the absence of anteroposterior cortical rims, the host bone was cut obliquely beneath the defect, resulting in a slope surface, to preserve as much bone as possible (Fig. 1a, b). Conversely, in the presence of anteroposterior cortical rims, the host bone was cut to form a basket shape (Fig. 2a-c). The bone defect was measured using a sterilized ruler (depth, anteroposterior width, and mediolateral width). For ASBG, we used the proximal medial tibial allogeneous bone on the same side. The allogeneous bone was carefully fashioned to fit the bone defect and reconstruct the missing rim. A precision fit of the bone graft to the defect was essential to prevent cement from entering the interface. Kirschner wires (1.5 mm) were used to provisionally stabilize the allogeneous bone to the host bone (Fig. 1c, Fig. 2d) and were removed after cementing the tibial implant (Fig. 1d). In most of the cases (except case 6), tibial extension stems were added. The length of the extension stem was greater than the depth of the bone defect.

Postoperative rehabilitation was similar to that prescribed for patients without bone grafting. The day after surgery, patients started quadriceps femoris strengthening exercises, with no restriction placed on weight-bearing. The drainage catheter was removed on the second postoperative day, and the patients commenced with passive and active joint exercise.

Clinical assessments

The knee and function scores of the Knee Society clinical rating system [4] and the knee angle were evaluated preoperatively, 1 year postoperatively, and at the final follow-up, and complications were identified from the medical records.

Radiological assessments

The hip-knee-ankle (HKA) angle was measured preoperatively, 1 year postoperatively, and at the final follow-up using weight-bearing anteroposterior radiographs. Bone union and radiolucent line (RL) were assessed immediately after surgery, 3 and 6 months after surgery, and at the final follow-up using non-weight bearing anteroposterior and lateral radiographs (Fig. 3). RL > 2 mm was defined as positive. Two orthopedic surgeons who were members of the Japanese Orthopedic Association evaluated the radiographs.

Statistical analysis

The normality of clinical and radiological parameters was confirmed using the Shapiro–Wilk test. The postoperative course of these parameters was examined using repeated-measures one-way analysis of variance and multiple comparison test (Bonferroni method). Statistical analyses were performed using IBM SPSS Statistics for Windows, ver. 27 (IBM Corp., Armonk, Tokyo, Japan). A p -value of ≤ 0.01 implied statistical significance.

Results

Patient demographic data and radiological outcomes are summarized in Table 1.

The mean size of the medial tibial defects after tibia cutting was 16.8 mm (range, 12–30 mm) in-depth, 34.4 mm (range, 24–40 mm) in anteroposterior width, and 25.4 mm (range, 17–35 mm) in medio-lateral width. Of the 17 cases, nonunion was observed in one patient (case 3, 5.9%), who showed resorption of the transplanted bone, and the presence of RL was observed in one patient (case 13, 5.9%). Bone union was confirmed in an average of 4.9 months. The results of the repeated measures one-way analysis of variance showed a significant improvement in the knee score and HKA 1 year postoperatively and at the final evaluation compared with the preoperative assessment (Table 2). Preoperative function score, knee flexion, and extension did not differ significantly from the assessment 1 year postoperatively and at the final follow-up, although they showed a tendency to improve. No major complications, such as transmission of infection, dislocation of graft bone, or loosening of the prosthesis, were observed.

Table 1
Baseline characteristics of patients included in this study

Case	Age (years)	Sex	Diagnosis	Defect measurements after tibia cutting (mm)			Bone union	Union time (months)	RL
				AP width	ML width	Depth			
1	65	M	RA	40	20	12	+	3	-
2	57	F	OA	24	17	17	+	3	-
3	50	F	RA	31	28	23	-	-	-
4	78	F	OA	36	27	18	+	12	-
5	74	F	OA	45	35	13	+	6	-
6	81	M	OA	40	30	18	+	6	-
7	79	F	OA	20	22	17	+	6	-
8	62	F	RA	35	30	15	+	3	-
9	81	F	OA	39	30	20	+	6	-
10	72	F	OA	40	25	10	+	3	-
11	83	F	OA	35	20	14	+	3	-
12	62	F	OA	32	29	27	+	6	-
13	68	F	RA	30	25	15	+	6	+
14	67	F	RA	37	23	12	+	3	-
15	50	F	RA	25	23	30	+	3	-
16	76	F	OA	35	28	14	+	6	-
17	72	F	OA	40	20	10	+	3	-

M: male, F: female, OA: osteoarthritis, RA: rheumatoid arthritis, AP: anteroposterior, ML: mediolateral, RL: radiolucent line

Table 2
Clinical and Radiological values before and after surgery

	Preoperatively	1 year postoperatively	Final follow-up
Knee score	15.4±10.0	92.0±8.2*	91.7±8.5**
Function score	35.0±23.5	54.7±29.1	52.7±32.8
Knee flexion	106.2±17.3	112.4±12.5	113.2±15.1
Knee extension	-10.0±11.6	-4.4±9.0	-2.4±8.7
HKA angle	21.9±9.1	2.7±2.7*	3.2±3.0**

HKA: hip-knee-ankle

Means ± standard deviation; * denotes $p < 0.01$, Preoperatively vs. 1 year postoperatively; ** denotes $p < 0.01$, Preoperatively vs. Final follow-up.

Discussion

In this study, primary TKA using ASBG was performed on 17 knees with uncontained defects ≥ 10 mm in depth. Bone union was achieved in 94% of the knees at 96.4 months follow-up. In addition, knee score and HKA angle showed sustained improvement until the final follow-up when compared to the preoperative scores, and there were no major complications.

There are two types of bone defects in the proximal medial tibia: (i) contained defects showing that preservation of the cortical rim can support the tibial prosthesis, and (ii) uncontained defects without the cortical rim and cannot support the prosthesis. Uncontained defects are often observed in patients with severe varus deformity [5]. Dorr et al noted that prosthesis loosening and postoperative knee deformities are likely to occur in uncontained defects; they found that repairing the defect with bone cement was not adequate and promoted the use of bone graft as a useful treatment method [6]. Since then, although several authors reported satisfactory results following an autologous bone graft in primary TKA, most reports were of uncontained defects ≥ 5 mm in depth [6–8]. Generally, uncontained bone defects ≥ 10 mm in depth are treated using metal augmentation [1], and some reports [9, 10] recommend TKA with metal augmentation as a useful method. However, the use of additional metal augmentation requires further bone cutting, including the cortical rim and can make future revision TKA difficult. On the other hand, there are only a few studies on treatment with autologous bone grafts for uncontained tibial bone defects ≥ 10 mm in depth [2, 3], and no reports on primary TKA with allogeneous bone graft.

The advantage of a bone graft is that once incorporated, it becomes a part of the proximal tibia and is, therefore, durable. The load transfer to the underlying tibia is more physiologic if the bone grafts are successful compared to using metal custom components without a bone cement composite. Moreover, structural bone grafts are superior to morselized bone grafts in the initial fixation and are reported to yield

good results in primary TKA [5, 6, 11]. However, with the combined use of autologous bone graft from a resected femoral or tibial bone, it is difficult to obtain a bone block ≥ 10 mm thick and reconstruct the rim, including the cortex [3]. Allogeneous bone grafts can be freely sized and shaped, and it is possible to reconstruct a rim, including the cortex, with almost the same shape as bones used from the same site. In the present study, we were able to reconstruct the rim for any form of defect using ASBG.

Several authors [11–13] have associated allogeneous bone graft with an increased risk of transmission of infection, nonunion, and resorption. However, almost all reports are on revision TKA with allogeneous bone grafts. As primary TKA is less complicated with a shorter operation time than revision TKA, we considered that the risk of infection might be lower. In this study, we observed no infection and achieved bone union in 94% of the cases.

Generally, the grafted bone is fixed with screws [6, 8]. Although screws can achieve rigid initial fixation, insertion of multiple screws may lead to fragmentation of the grafted bone, resulting in early failure of knee replacement [5]. As a device that does not use screw fixing, Chon et al [2] used the oblique structural peg bone, while Yoon et al [7] applied a cement to the medial surface of the tibia to fix the grafted bone. We temporarily fixed the allogeneous grafted bone with Kirschner wires and withdrew them after fixation of the tibial component with extension stems. Extension stems may result in a future loss of bone stock when performing revision surgery. In addition, Scott et al [14] reported that extension stems might have disadvantages, including stress shielding along the length of the stem with associated reduction in bone density and a theoretical risk of subsidence and loosening, peri-prosthetic fracture, and end-of-stem pain. However, Rawlinson et al [15] used cadaver knees to biochemically confirm that using a tibial extension stem reduced bone stress and limited micromotion between the metal wedge and surrounding bone, and hence, recommended using a tibial extension stem. Baek et al [9] reported that bone grafting could not provide sufficient stability for severe bone defects ≥ 10 mm in depth in primary TKA; thus, requiring an extension stem, particularly for uncontained bone defects where fixation of the grafted bone was technically difficult. We did not fix the grafted bone because we considered that we could obtain the initial strength with a combination of the tibial extension stem and performing ASBG, including the rim; we did not observe dislocation of the ASBG and/or implant.

We acknowledge that the present study had certain limitations. First, this was a single-center study, and the study sample (17 cases) was small. Although Chon et al [2] and Sugita et al [3] reported 40 cases and 44 cases, respectively, in the literature using autologous bone graft for bone defects ≥ 10 mm, in this study, only 21 (4%) of 525 primary TKAs from January 2004 to December 2014 had a medial tibial defect ≥ 10 mm in depth; thus, such defects can be considered rare. Second, we have not been able to compare this with other methods, such as autologous bone graft or metal augmentation. Sugita et al [3] reported 14% non-progressive RL with autologous bone graft, Baek et al [9] and Tsukada et al [16] reported non-progressive RL in 10% and 33%, respectively, combined with metal augmentation. In this study, nonunion and presence of RL were 5.9% each, which did not differ from the other methods. Despite the absence of a control group, we believe that our findings are adequate; thus, important conclusions can be drawn from them.

Conclusions

The ASBG technique for uncontained tibial bone defects ≥ 10 mm in depth in primary TKA provided favorable clinical and radiological outcomes, thereby confirming its use as an acceptable procedure.

Abbreviations

TKA
total knee arthroplasty
ASBG
allogeneous structural bone graft
IRB
Institutional Review Board
HKA
hip-knee-ankle
RL
radiolucent line

Declarations

Ethical approval and consent to participate

This study was approved by the institutional review board of the Kitasato University Hospital (approval number B21-107) and performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments. The board waived the requirement for informed consent because of the retrospective study design.

Consent for publication

Not applicable.

Availability of data and materials

The datasets supporting the conclusions of this article are included within the article. The corresponding author can provide raw data on request.

Competing interests

All The authors declare that they have no competing interests.

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None.

Author's contributions

DI, YM, and YK designed the study and analyzed the data. DI wrote the manuscript. JI, KF, ST, MM, and KU participated in the data collection, analysis, and interpretation. GI and MT supervised the study. All authors read and approved the final manuscript.

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Figures

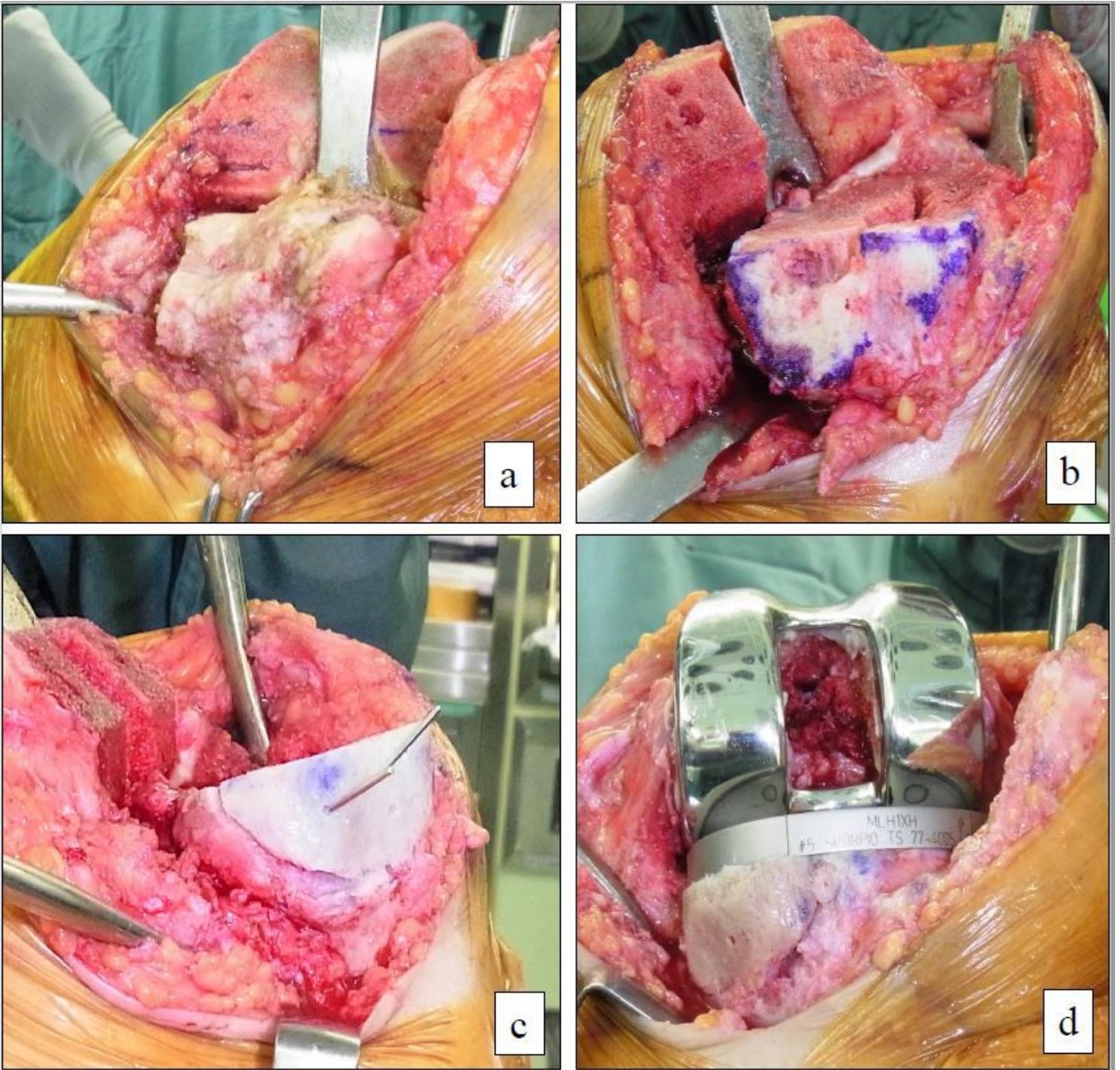


Figure 1

Bone-grafting technique for defect with no anteroposterior rim

(a) The bone defect before tibial osteotomy. (b) The host bone was cut obliquely to create a slope without anteroposterior rim after tibial osteotomy. (c) The allogeneous structural bone graft (ASBG) temporarily fixed to the host bone with Kirshner wires. (d) Kirshner wires were removed after cementing the tibial implant, and ASBG press-fitted to the host bone.

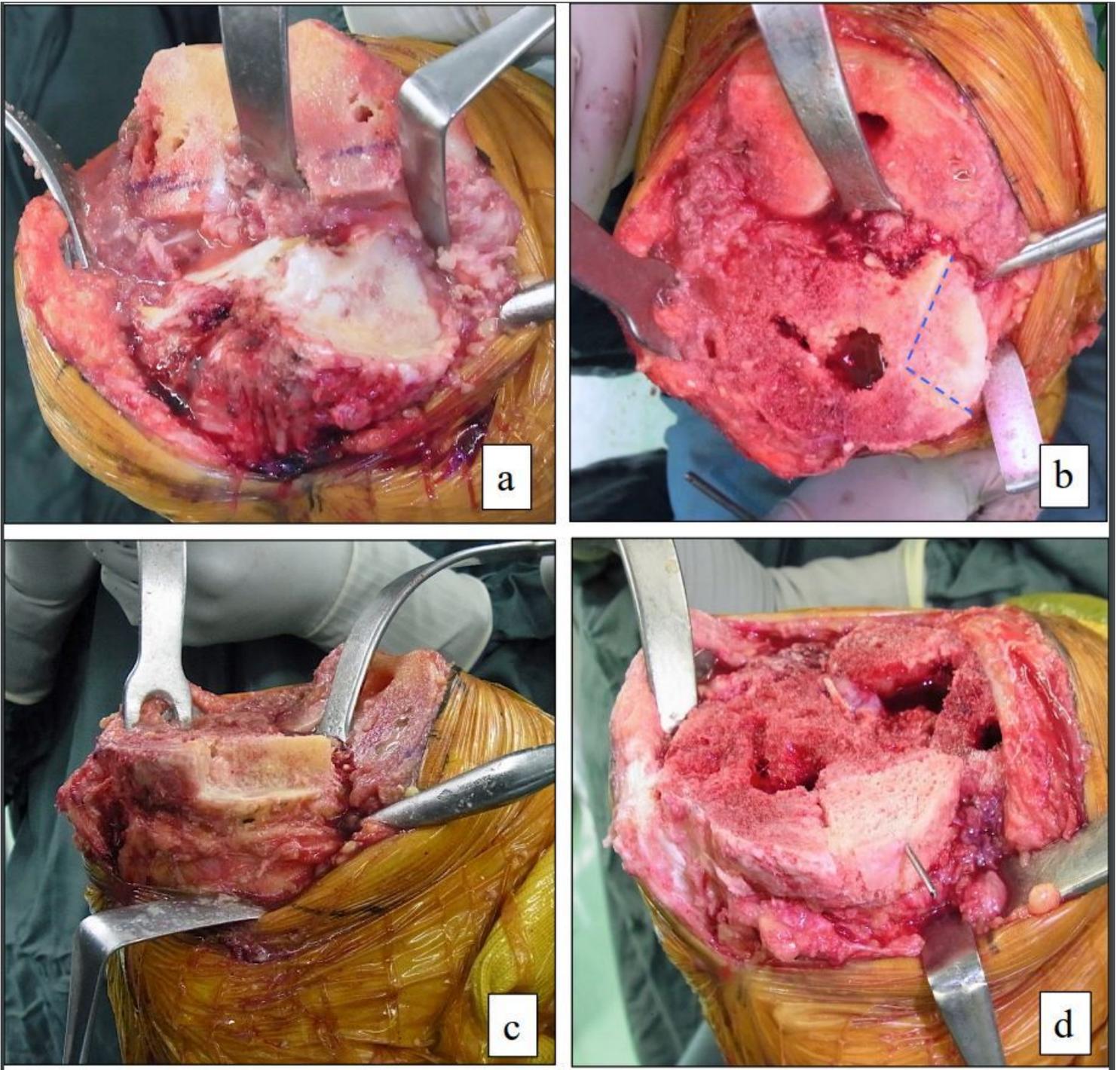


Figure 2

Bone-grafting technique for defect with residual anteroposterior rim

(a) The bone defect before tibial osteotomy. (b and c) The host bone was cut to create a basket shape with the residual anteroposterior rims after tibial osteotomy; the dotted line is the boundary of the defect. (d) The allogeneous structural bone graft (ASBG) was temporarily fixed to the host bone with Kirshner wire.

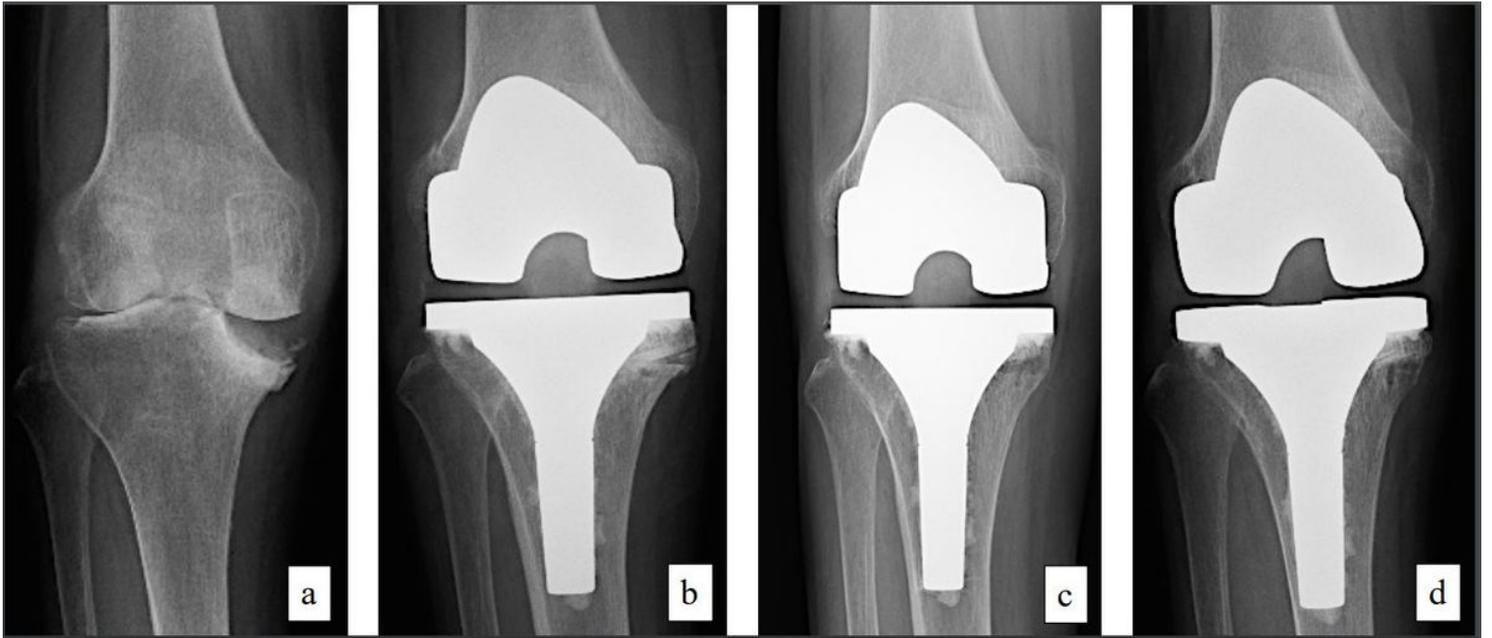


Figure 3

Pre- and postoperative follow-up radiographs of a 67-year-old female patient (case 14) (a) Preoperatively. (b) Immediately after surgery. (c) Three months postoperatively. (d) Final follow-up.