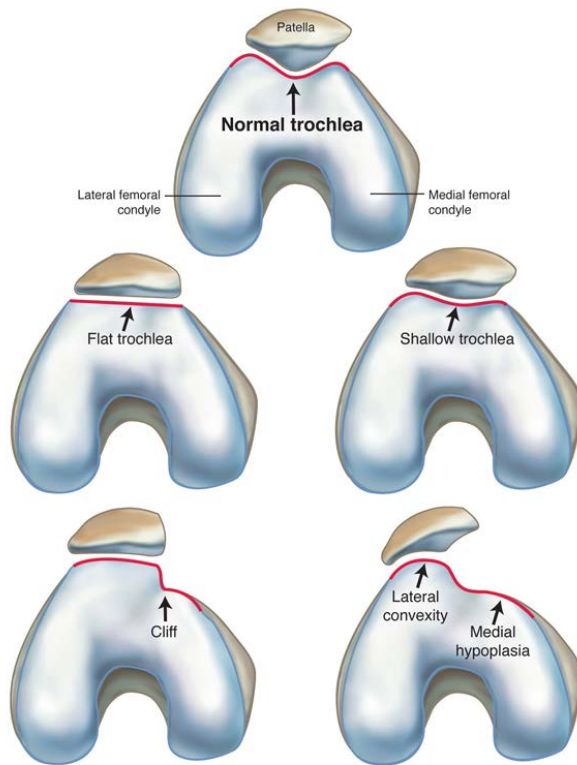


TTT and MPFLR

(Tibial Tubercle Transfer and Medial Patello-femoral Ligament Reconstruction)

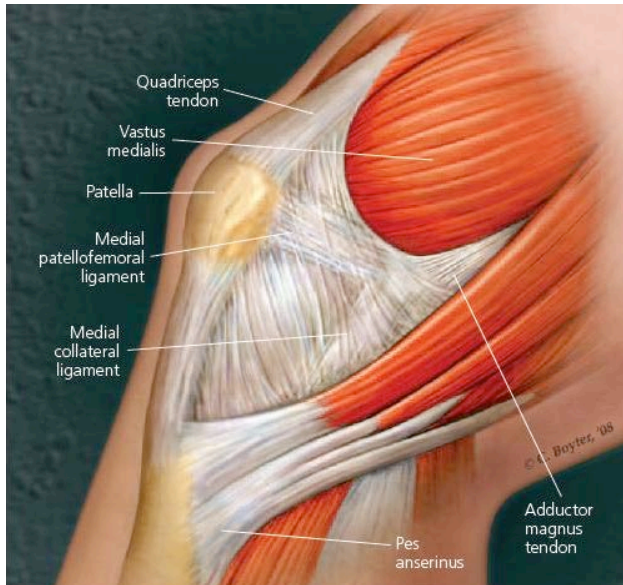
Patient Information Sheet



INTRODUCTION

The patella (kneecap) sits in the femoral trochlear (groove). The patella is attached via the quadriceps tendon at the top of the knee and the patella tendon at the bottom of the knee. As you walk, run, perform activities your patella moves along the groove in the femur. If you have an abnormally flat groove or have had a traumatic dislocation of the patella previously, you may be at risk of recurrent patello-femoral dislocations (where the patella dislocates from the femoral trochlear).

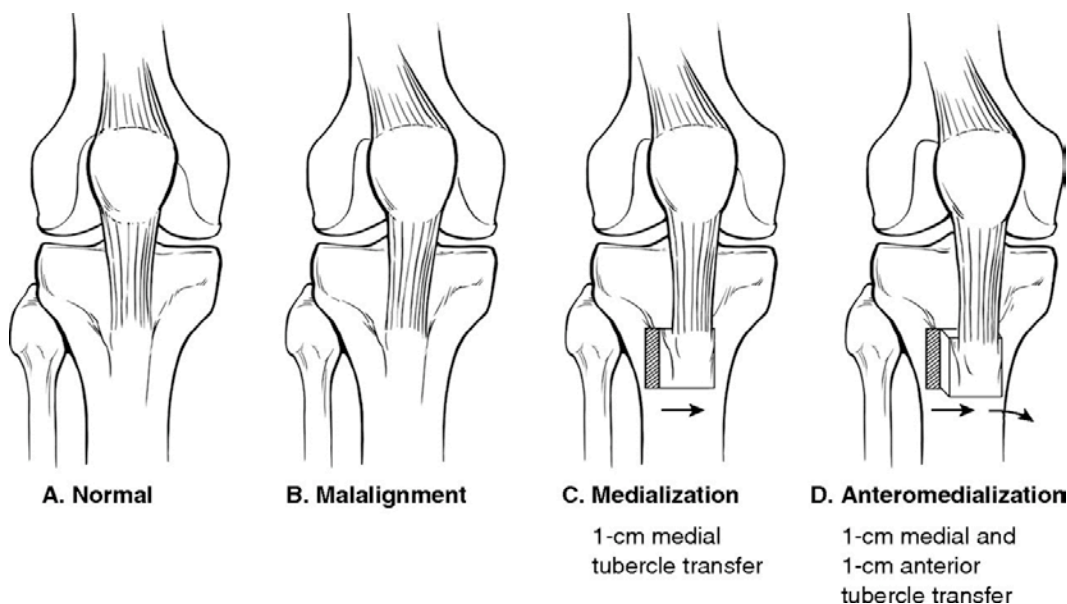
Some patients may be able to move the patella back into place, depending on the stretch of the tendons, other patients may require emergency treatment. Recurrent patello-femoral dislocations will ultimately lead to patello-femoral arthritis in the future.



In addition to the transfer, your Doctor will perform a medial patello-femoral ligament reconstruction. This ligament is either stretched or ruptured during a dislocation and the reconstruction will ensure the patella sits correctly in the femoral trochlear.

TREATMENT

The main goal of this procedure is to reduce or remove the incidence of recurrent patello-femoral dislocations. Your Doctor would have obtained several images to determine the measurements between the femoral trochlear groove and the natural seating position of the patella. Your Doctor will determine how much medialisation (moving towards the midline of the body) and/or distalisation (moving towards the feet) your tibial tuberosity needs to be moved. At the point where the patella tendon attaches to the tibial tuberosity, a bone block will be resected, measured, moved and fixed back down to the tibia with fixation screws.



To repair the medial patello-femoral ligament your Doctor will harvest one hamstring tendon from the same leg. This tendon will be passed through small holes made in the patella and fixed with screws to the inside of the knee.



RECOVERY

The most important aspects to remember are;

The First 6 weeks

1. You will be in a brace
2. You will be able to partially weight bear
3. You will need crutches
4. You may return to work if you have a sedentary workplace and you have discussed return to work options with your employer
5. You will begin some gentle physiotherapy exercises
6. You will need to take low dose aspirin to reduce the risks of DVT (clots).

After your 6 week visit

1. You will begin to come out of the brace
2. You will require an x-ray for confirmation of position
3. You will be given clearance to drive after your 6 week postoperative appointment
4. You may return to work, but restricted on physical activities. You must have discussed this with your employer.

GENERAL RISKS OF A PROCEDURE

1. Infection – is a serious complication. You may require antibiotics and possibly further surgery.
2. Bleeding – you may require further surgery to stop the bleeding
3. Lung collapse – small areas of the lungs may collapse while under the general anaesthetic, increasing the risk of infection, cardiac and respiratory complications. You may require antibiotics and physiotherapy.
4. Obesity – increased risk of infections, cardiac and respiratory complications and thrombosis.
5. Blood Clots – DVT (venous thrombus) can occur in the deep veins of the leg and travel to the lungs causing heart attack and death. This can occur within 10-14 days of surgery.
6. Death – is possible due to the surgical procedure.

RISKS OF THIS PROCEDURE

These are some risks specifically associated with this procedure;

1. Numbness – associated with the use of a tourniquet during surgery. Tourniquets can cause muscle and nerve damage at the site of application. This may be temporary or permanent. Injury to the nerves is uncommon, but it may lead to chronic regional pain syndrome.
2. Fracture of the osteotomy – this will require further surgery to repair the bone. Your rehabilitation regime will alter to give the fracture time to heal.
3. Necrosis of the skin – can occur due to the application of the tourniquet. Treatment may include further surgery and extensive dressings.
4. Instrument breakage – can occur, which may require larger incisions to remove the instruments. Broken instruments may require x-ray in order to assist with the removal of the broken instrument.
5. Pain and symptoms may not be fully resolved with the initial surgery and may require further surgery if indicated.
6. Scarring – keloid scarring can occur and may require further surgery. This scarring can cause pain and discomfort.
7. Stiffness – physiotherapy and/or manipulation under anaesthesia may be required.

PROBLEMS REPORT TO YOUR SURGEON IMMEDIATELY

1. A temperature higher than 38°C.
2. Persistent bleeding from the incision sites.
3. Severe pain and tenderness or increased swelling of the knee.
4. Nausea or vomiting.

NOTE: You will not be permitted to drive until your first post-operative visit