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Case report of septic arthritis of the stifle joint in a White German Shepherd dog – treatment with repeated arthroscopic lavage, antimicrobial therapy and implant removal
Koiran polvinivelen bakteeritulehdus, hoito tähystysavusteisin nivelhuuhteluun yhdistettynä antibioottihoitoon ja implanttien poistoon – tapausselostus

Bakteriell ledinfektion av knäleden hos en hund, behandling med upprepade artroskopiska spolningar, antibiotikabehandling samt borttagning av implantat – en fallrapport

SUMMARY

A 6-year-old, castrated male White German Shepherd dog weighing 41.5 kg was presented with lethargy and acute lameness of the left hind limb. The dog had a history of cruciate ligament rupture of the left stifle joint and had undergone several surgical and medical interventions. Tibial tuberosity advancement (TTA) surgery and a lateral suture operation on the left stifle had been performed 2.5 years and 2 years ago, respectively. On presentation at the Veterinary Teaching Hospital the dog was diagnosed with septic arthritis of the stifle joint based on the history, clinical signs, joint fluid cytology and bacteriologic culture. Surgical management of septic arthritis includes joint lavage, arthroscopic inspection or arthrotomy and possibly implant removal, whereas medical management includes local and/or systemic antibiotic therapy. A mild septic arthritis can be treated by large-bore needle irrigation and antibiotics but in more severe cases, arthroscopic lavage is recommended. Arthroscopic lavage removes more effectively fibrin and infectious material from the septic joint and allows good visual evaluation of the joint. The infection of this case was successfully treated with repeated arthroscopic lavage, antimicrobial therapy and removal of the implants. Lavage combined with intravenous

antibiotics can preserve the joint from arthritic degeneration and provide complete healing of the infection and good restoration of limb function with minimized cartilage damage as in this case.

YHTEENVETO

Potilaamme oli 41,5-kiloinen kuusivuotias kastroidu valkoinenpaimenkoirauros. Koira alkoi äkillisesti ontua vasenta takajalkaansa. Yliopistolliseen eläinsairaalaan tuotaessa se oli hyvin väsynyt. Koiran vasen polvi oli leikattu 2,5 vuotta aiemmin etummaisen ristisiteen vamman vuoksi TTA-tekniikalla (tibial tuberosity advancement) ja puoli vuotta TTA-leikkauksen jälkeen lateraalisutuurimenetelmällä. Lisäksi koira oli saanut useita nivelensisäisiä injektioita. Koiran historian, kliinisen yleistutkimuksen, nivelnestenäytteen sytologian ja viljelyn perusteella totesimme äkillisen ontuman syyksi vasemman polvinivelen bakteriellin niveltulehduksen. Hoitovaihtoehdot ovat kirurginen, lääkinnällinen tai niiden yhdistelmä. Kirurginen hoito tarkoittaa nivelhuuhtelua joko tähystämällä tai arthrotomialla ja tarvittaessa myös implanttien poistoa, kun taas konservatiivihoidon tarkoittaa paikallista ja/tai systeemistä antibioottilääkitystä. Lievää bakteriellia niveltulehdusta voidaan hoitaa neulojen läpi tehtävällä huuhtelulla sekä systeemisellä antibioottikurilla, mutta vakavammissa tapauksissa tähystysavusteinen nivelhuuhtelu on suositellumpaa. Tähystysavusteinen huuhtelu poistaa tehokkaammin fibriiniä ja muita tulehduspartikkeleita nivelestä sekä sallii samalla nivelen tutkimisen visuaalisesti. Tapauksen niveltulehdus hoidettiin menestyksellisesti toistetuilla tähystysavusteisilla nivelhuuhteluilla, antibiooteilla ja implanttien poistolla. Huuhtelun ja antibiootihoidon kombinaatio voi estää nivelrikon etenemistä parantamalla tulehduksen ja normalisoimalla raajan käytön mahdollisimman nopeasti, kuten tämä potilastapaus osoitti.

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MAIN POINTS

- Septic arthritis is destructive to joint cartilage and synovial membrane.
- It can result from a traumatic penetrating wound, hematogenous spread or iatrogenic origin.
- Criteria for bacterial infective arthritis are typical history and clinical signs and synovial fluid cytology consistent with infective arthritis. A positive bacteriologic culture confirms the diagnosis.
- Treatment of septic arthritis, which can be surgical or medical or a combination of those, should be initiated without delay.
- The duration of the treatment depends on the response of the patient and the laboratory values.

INTRODUCTION

Septic arthritis (bacterial arthritis, infective arthritis, suppurative arthritis) is a joint infection caused by bacteria or other microorganisms. While canine septic arthritis is rare, it should be suspected if a patient presents with severe pain and the joint is swollen and hot.¹ The dog is lame and usually shows systemic signs of clinical illness. Similar signs can also be seen in other types of arthritis such as immune-mediated arthropathies.¹ However, in these cases several joints are usually affected and no bacteria are seen in joint fluid cytology.

Infection can disseminate to a joint from adjacent soft tissue or osteomyelitis.²⁻⁵ Reports on the pathogenesis of bacterial infective arthritis in adult dogs suggest that a penetrating wound, including surgery, is the most common cause.^{2,3} Open-joint surgery is a bigger risk for septic arthritis than arthroscopy. About 1% canine patients undergoing arthroscopy develop septic arthritis.^{3,6} The most common reason for septic arthritis in puppies is hematogenous spread. In cases of infective arthritis of hematogenous origin, several joints can be affected.³ Adult dogs

can also be susceptible to the haematogenous spread of bacteria into the joint if the dog has an underlying immunosuppression, corticosteroid therapy or diabetes mellitus.² Osteoarthritis may also predispose to bacterial infective arthritis as well as an active infection in other organs, such as cystitis or periodontal disease.⁷

Infective arthritis is most commonly seen in the stifle, elbow and carpus.²⁻⁴ The diagnosis of bacterial infective arthritis is based on three criteria. First, a typical history and clinical signs such as severe lameness and joint effusion with or without pyrexia, anorexia and depression are seen. These signs can be acute or chronic.^{1,3,4} In addition, radiographs show a soft tissue reaction and joint effusion in an early stage of septic arthritis, and later osteoarthritic changes become more evident.⁴

Secondly, the cytological features of the synovial fluid are consistent with bacterial infective arthritis.³ The number of polymorphonuclear cells (neutrophils) is increased. This makes the synovial fluid turbid, alter the color and reduces fluid viscosity. Normal synovial fluid usually contains less than $3 \times 10^9/l$ cells, whereas in a septic joint, the cell count is $15-267 \times 10^9/l$, and may even be higher. Cytological analysis may reveal an increased number of neutrophils that may have phagocytized bacteria. Normally in the synovial fluid sample the proportion of neutrophils and mononuclear cells is less than 10% neutrophils and more than 90% mononuclear cells, whereas in an infectious fluid the proportion of neutrophils is greater than 90%.⁸ Moreover, the total protein concentration is high in septic joint fluid, being over 25 g/l.⁸ Thirdly, the diagnosis of septic arthritis is confirmed by a positive bacteriological culture. The most common bacteria isolated from septic joints are staphylococci and beta-haemolytic streptococci.^{2,4,9} However, positive bacterial cultures are obtained in approximately 50% of the cases.⁸ Even in cases where bacterial fluid has been inoculated into the joint space, later bacterial culture may be negative.¹⁰ One reason is thought to be the inactivation of bacteria by high enzyme activity in the joint fluid. Other possible reasons include previous antimicrobial

treatment, infection caused by non-culturable bacteria or bacteria requiring a special culture environment for growth. Treatment is indicated even if bacteria cannot be cultured, if history, clinical signs and cytological findings are consistent with septic arthritis.³

Untreated septic arthritis can destroy the joint cartilage and synovial membrane, leading to osteoarthritic changes.¹¹ There is no consensus on the treatment protocol for septic arthritis in human or canine medicine. Surgical management includes joint lavage, arthroscopic inspection or arthrotomy and possibly implant removal, whereas medical management includes local and/or systemic antibiotic therapy.¹ In equine patients, arthroscopic intervention has been shown to be superior to other treatment options.¹² In one canine study, arthroscopic lavage effectively improved the outcome in the dog.⁵

CASE

A 6-year-old castrated male White German Shepherd dog weighing 41.5 kg was presented for the first time to the Veterinary Teaching Hospital of the University of Helsinki due to lethargy and acute lameness of the left hind limb.

The owner reported the following history: The dog had undergone tibial tuberosity advancement (TTA) surgery on the left stifle 2.5 years earlier due to cranial cruciate ligament rupture. Three weeks after the surgery, soft tissue swelling around the stifle joint and dehiscence of the incision was noted. There was no obvious effusion of the joint and the microbiological culture of the joint fluid was negative. Ten months later, the dog was presented to another veterinarian because of lameness of the left hind limb. The lameness had persisted for 3 weeks. The left stifle joint was painful and unstable in orthopaedic examination. In an ultrasound examination, damage to the medial meniscus was seen. After this visit, the dog received several intra-articular medications, including local anaesthetics, antimicrobials, sodium hyaluronate and interleukin-1 receptor antagonist protein therapy (IRAP). Later, due to the persistent

instability of the stifle joint, an attempt to stabilize the joint was performed surgically with two lateral sutures using nylon leaders and metallic clamps.

At clinical presentation at the Veterinary Teaching Hospital, the dog was depressed and had a temperature of 39.9 °C. The lameness score of the left hind limb was 3 (scale 0–4). The left stifle joint was swollen and painful on palpation.

Craniocaudal and lateral radiographs of the left stifle joint showed joint effusion and osteoarthritic changes (figure 1A) and osteolysis of the proximal tibia (figures 1A and 1B).

The blood biochemistry profile and a complete blood count revealed mild leukocytosis ($17.7 \times 10^9/l$, reference range 5.4–17.4). The joint fluid was collected into an EDTA tube for cytological assessment and into a sterile plain tube for bacterial culture, which was performed immediately. The joint fluid in the left stifle was cloudy and the total nucleated cell count was $58.3 \times 10^9/l$, with 95.5% neutrophils and 4.5% mononuclear cells. The total protein concentration was 48 g/l. Treatment was initiated with meloxicam 0.1 mg/kg once a day, gabapentin 10 mg/kg twice a day and cephalexin 30 mg/kg three times a day.

The diagnosis of septic arthritis was confirmed by a pure culture of *Staphylococcus aureus* isolated from the synovial fluid. The bacterium was susceptible to oxacillin, amoxicillin-clavulanic acid, cephalothin, erythromycin, clindamycin, trimethoprim-sulfamethoxazole, tetracycline, fucidic acid, doxycycline, enrofloxacin and gentamicin, but resistant to penicillin G.

The stifle joint was arthroscopically lavaged to remove infectious material. The procedure was performed under general anaesthesia combined with nerve blocks. The antibiotics used were cefazolin 22 mg/kg and enrofloxacin 10 mg/kg. Postoperative pain medication consisted of meloxicam 0.1 mg/kg once a day and tramadol 2 mg/kg three times a day.

Routine stifle joint arthroscopic portals were utilized (figure 2). The joint was irrigated with 5000 ml of 0.9% sterile saline using a pressure bag (80 mm Hg).

The dog was hospitalized over the weekend and received intravenous fluids, intravenous antibiotics including cefazolin 22 mg/kg three times a day and enrofloxacin 7.5 mg/kg twice a day, meloxicam and tramadol as well as oral gabapentin. On day 4 after presentation, the dog was bright but still 3/4 lame in the left hind limb. The total nucleated cell count of the synovial fluid had increased to $178.0 \times 10^9/l$, but the proportion of neutrophils had decreased to 91.5%. The C-reactive protein (CRP) concentration in the blood was 20 mg/l (reference <10 mg/l). Arthroscopic lavage was repeated. Intravenous medications, as well as gabapentin, were continued.

On day 6, the total nucleated cell count had diminished to $67.2 \times 10^9/l$, with 93.5% neutrophils and 6.5% mononuclear cells. Arthroscopic lavage was repeated.

On day 8, the total nucleated cell count was only $18.1 \times 10^9/l$ in the joint fluid, with 94.5% neutrophils and 5.5% mononuclear cells. The joint was arthroscopically visualized. The crushed and cranially dislodged caudal part of the medial meniscus was removed by using a 3.5 mm arthroscopic shaver. All the implants from the former TTA surgery and the lateral sutures were removed to eliminate the risk of the implants acting as a nidus for infection (figure 1B). Finally, the joint was lavaged with 5000 ml of sterile saline.

The dog was discharged from the hospital on day 10. Medications at home included cephalixin 24 mg/kg three times a day, enrofloxacin 7 mg/kg twice a day, tramadol 1–2 mg/kg one to three times a day, gabapentin 10 mg/kg twice a day and meloxicam 0.1 mg/kg once a day.

At the control visit on day 12, the dog was doing clinically moderately well. However, the lameness score for the left hind limb was still 3/4. The stifle joint was painful both in extension and flexion, but no effusion was noted. The body temperature was 38.1 °C and CRP was 13 mg/l. The bacterial cultures from the screws and the nylon sutures removed from the joint showed no bacterial growth.

A week after implant removal (day 19), the dog presented with acute non-weight-bearing

lameness. Radiographs revealed a fracture of the tibial tuberosity (figure 1C). Joint fluid analysis showed a total nucleated cell count of $6.2 \times 10^9/l$, with 77% neutrophils and 23% mononuclear cells and a total protein concentration of 31 g/l. The fracture was repaired using implants and an autogenous full-thickness bone block from the ilium to maintain the advancement of the original TTA operation (figure 1D). Medication was continued as before. Two weeks later (day 33), the dog was bright and the lameness score was 1/4. Antibiotic medication was discontinued. The dog's static weight bearing was 6 kg and 11 kg for the left and right hind limb, respectively, and circumference of the thigh was 43 cm and 46 cm for left and right, respectively. Manual physiotherapy and water treadmill exercises were instituted. Continuous progression of healing could be seen in follow-up radiographs obtained at 1, 2 and 4 months post-operatively. Osteoarthritic changes did not increase. At the control visit after 4 months, the dog was no longer lame and the static weight bearing and the thigh circumference had improved. The passive range of motion in the left and right stifle joints were 30–150° and 20–160°, respectively. Normal exercise was allowed. At the 1-year follow-up visit, we saw no signs of infection and the dog was no longer lame. The dog was able to sit with both stifles flexed in a normal position. The functional and radiographic outcome was good.

DISCUSSION

Septic arthritis is detrimental to the joint and potentially a life-threatening condition. In our case the septic arthritis could have been a consequence of the TTA or lateral suture operations or intra-articular injections. Arthroscopic lavage combined with intravenous antibiotics and removal of the implants proved to be an effective treatment, in which clinical presentation, joint fluid cytology and bacterial culture confirmed the diagnosis of septic arthritis. Arthroscopic intervention of septic arthritis has previously proven successful in humans and horses,¹²⁻¹⁵ and

should be encouraged in canine medicine.

The treatment of bacterial arthritis aims at preserving cartilage and the earlier pain-free range of motion of the limb. Optimal treatment includes antibiotic therapy and surgical treatment, mainly joint lavage. The joint lavage can be performed by irrigation with large-bore needles, arthroscopically, via arthrotomy or, in some cases, by continuous drainage.¹ In humans, 91–100% of the infected joints improve with arthroscopic lavage and systemic antibiotic therapy.^{13–15} In contrast, in another human study, fever lasted longer in patients treated with needle irrigation and they needed intravenous antibiotic therapy longer than those treated arthroscopically.¹⁶ Further, a recent study on foals demonstrated that needle irrigation is not sufficient to resolve the infection.¹² Arthroscopic lavage is superior to joint irrigation performed through a needle, because it allows large volumes of fluid to be used and the fluid can be directed to the joint recesses. Arthroscopically, it is possible to remove larger particles and fibrinous material and to perform synovectomy to reduce the number of bacteria lodged in the synovial tissue.⁵ Arthroscopic lavage is repeatable, causes less postoperative morbidity and allows visualization of the cartilage than open arthrotomy.^{1,5,17} Arthrotomy causes greater tissue injury, which predisposes to surgical site infection. Furthermore, with open arthrotomy, all joint recesses cannot be thoroughly lavaged.¹⁸ Since our previous attempts to treat septic arthritis with needle irrigation or arthrotomy did not produce satisfactory outcomes, we used arthroscopic intervention, which is common practice in equine medicine and strongly encouraged in humans.

Arthroscopic surgery of the stifle joint is performed by using the craniolateral portal and two medial portals.¹⁹ These portals have also been used for arthroscopic lavage. To our knowledge, the optimal volume of fluid needed for sufficient irrigation or the sufficient number of arthroscopic lavages have not been determined. The number of treatments should correspond with the severity of the initial infection and the clinical response.¹³ Arthrocentesis and

examination of joint fluid cytology are usually repeated at intervals of a few days. If needed, arthroscopic lavage is repeated.⁷ In foals with a septic coxofemoral joint, arthrocentesis is repeated 2–6 days after the first lavage and the arthroscopic lavage is repeated 1–3 times.¹² In two human studies, the arthroscopic lavage was repeated a median of three times.^{7,14} In our case, we took joint fluid samples at 2–3-day intervals and lavaged the joint four times.

In addition to lavage, optimal treatment includes systemic antimicrobial therapy. Benzioni et al suggested that systemic antibiotics alone are effective, but the response can be slow and their study included no control group.²⁰ The suggested duration of antimicrobial treatment is at least 28 days.^{1,3} One human study recommends 4–6 weeks, with intravenous administration in the first 2–3 weeks.¹⁶ However, in another study, well-absorbed antimicrobials were given for less than 2 weeks and the duration was considered sufficient.²¹ Our patient received intravenous antimicrobials for 1 week followed by oral antimicrobial therapy for 3 weeks. While bacterial culture and sensitivity results are pending, an empirically chosen antibiotic, such as a first-generation cephalosporin, should be used. As soon as complete bacteriological results are available, treatment should be adjusted accordingly. We should have discontinued enrofloxacin therapy as soon as the result of a cephalexin-susceptible *Staphylococcus aureus* was confirmed. Intra-articular antibiotics can be considered when systemic antibiotic therapy and surgical intervention are insufficient to resolve the infection.¹⁷ In contrast, intravenous administration of antibiotics in humans produces sufficient concentrations in the synovial fluid, which makes intra-articular therapy unnecessary.¹³

Implants are recommended to be removed if signs of contamination are seen, if they are no longer functional or if signs of infection persist, despite adequate treatment. In our case, we decided to remove the implants, when we saw bone lysis in radiographs (figures 1A and 1B). Additionally, the lateral suture did not provide anatomical stabilization after the TTA operation

and thus did not have any clinical relevance. Although the fork of the TTA could be detached easily and there was grayish discharge coming from the holes, bacterial culture of the implants was negative. The negative culture can be due to several days of intravenous antibiotic therapy before culture and to the fact that implants were extra-articular.

We considered the left stifle joint unstable after the TTA surgery. Osteotomy techniques rely on change in mechanics of the stifle joint. The stifle joint will be dynamically stabilized by muscle forces after the surgery.²² Osteotomy techniques in cruciate ligament surgery do not aim for passive stabilization of the joint, in contrast to the techniques that replace the cruciate ligament, such as the lateral suture. However, recent research suggests that stabilization of the stifle joint is not reliably achieved with the lateral suture technique.²³ Therefore, the second operation to stabilize the joint by lateral suture was in vain. Meniscal damage is reported to occur in 5.8–27.8% of patients after TTA surgery in cruciate ligament deficient joint.^{24,25} Treatment for the damaged meniscus would have been removal of the damaged part of the meniscus after the first operation.

The end result for the degree of lameness after treated septic arthritis depends on the pre-existing problem in the joint. Bacterial arthritis causes cartilage damage, which worsens the underlying problem. The initial severity of the infection has an impact on the treatment response and outcome.^{11,13} Early diagnosis and treatment can preserve the joint from arthritic degeneration.^{11,15}

Untreated septic arthritis is devastating to the joint cartilage and synovial membrane. Arthroscopic intervention of septic arthritis has been proven to be superior to other treatment options in other species. It was also effective in our canine case, when combined with intravenous antibiotic therapy and implant removal. Arthroscopic irrigation is encouraged to be considered when treating septic arthritis. Future studies on the optimal protocol for arthroscopic treatment of septic arthritis in dogs are needed.

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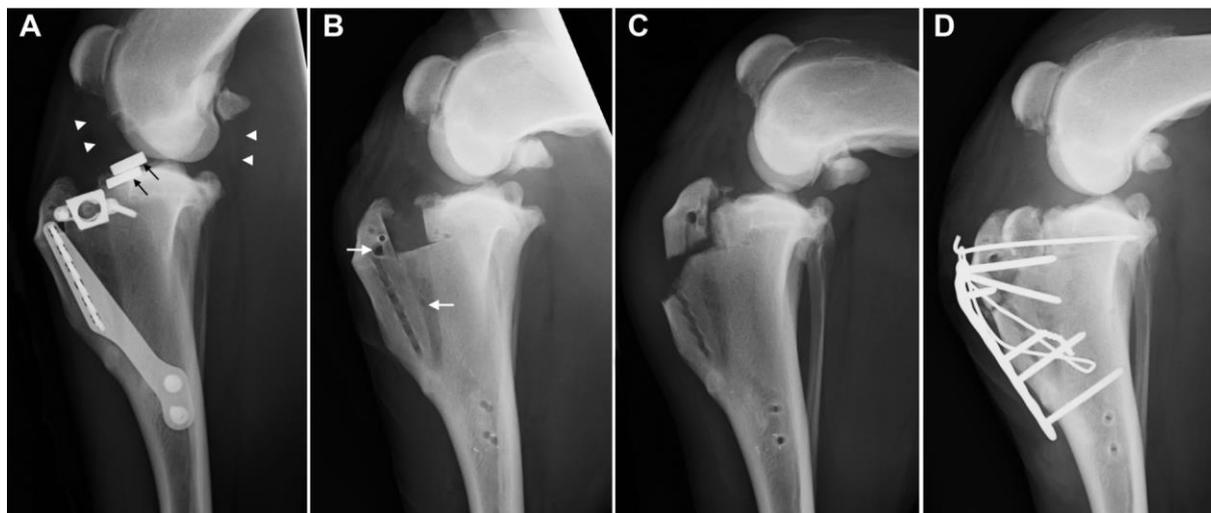


FIGURE 1 KUVA

A) A radiograph of the left stifle joint taken on day 0. Joint effusion (paired white arrowheads on both sides of the knee joint indicating the joint capsule margins) and osteophytes on joint margins are seen. The cruciate ligament surgeries had previously been performed elsewhere. Black arrows point to the crimp tubes used to fix the extracapsular lateral sutures. Distally, the TTA cage and plate are seen. B) A radiograph after implant removal on day 8. Left arrow points to the osteolytic hole in the tibial tuberosity originally drilled for lateral sutures. Right arrow indicates an osteolytic area in the proximal tibia. C) Day 18, the tibial tuberosity fractured due to the lack of support after implant removal. The infection was under control. D) The fracture of the tibial tuberosity was repaired using a bone block harvested from the ipsilateral iliac crest. The bone block and tibial tuberosity were stabilized with a Kirchner wire and a tension band wire. The fixation was additionally supported by a cranially placed 2.0 mm LCP fixed with locking screws.

A) Vasemman polven septisen artriitin röntgenkuva diagnoosipäivänä (päivä 0): polvinivelessä täyttymistä (parilliset nuolenpääet nivelen molemmin puolin rajaavat täyttyneen nivelkapselin) ja nivelpinnan reuna-alueiden luupiikkejä. Etummaisen ristisiteen korjausleikkaukset oli tehty muualla aiemmin. Mustat nuolet osoittavat lateraalisututuroiden kiinnittimiä. Sääriluun

yläpäässä näkyvät TTA-leikkauksessa asennettu TTA-häkki ja -levy. B) Röntgenkuva implanttien poiston jälkeen (päivä 8). Vasen nuoli osoittaa sääriluun kyhmy alueella lateraalisuturan kiinnitysreikää, jossa on luukatoa. Oikeanpuoleinen nuoli osoittaa luukatoaluetta sääriluun yläpäässä. C) Sääriluun kyhmy murtui implantin poiston jälkeen (päivä 18). Polvinivelen infektiio oli silloin jo parantunut. D) Sääriluun kyhmy defekti täytettiin vasemmasta suoliluusta otetulla luusiirteellä. Luusiirre ja sääriluun kyhmy kiinnitettiin paikoilleen Kirschner-piikillä ja jännitesidoksella sekä 2.0 mm lukkolevyllä.

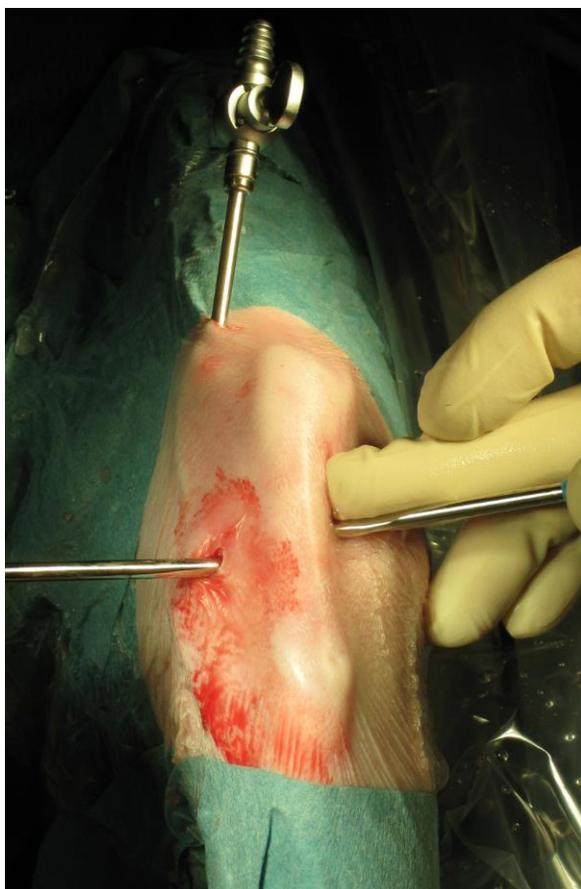


FIGURE 2 KUVA

Routine stifle joint arthroscopic portals were used for arthroscopic lavage of the left stifle joint. Inflow cannula for fluids and for the scope (2.7 mm 30° oblique telescope) was placed lateral

to the patellar tendon. Two outflow cannulas were introduced medially into the proximal patellar pouch and medial to the patellar tendon.

Vasemman polvinivelen tähytysavusteinen nivelhuuhtelu tehtiin käyttäen tavanomaisia niveltähytysportteja. Nestevirtauskanyyli ja niveltähytin (2.7 mm 30° viisto optiikka) vietiin niveleen polvilumpion suoran siteen ulkosivulta. Nesteen ulosvirtauskanyyleistä toinen pistettiin nivelen sisäisivulle polvilumpion yläpuoliseen nivelpussiin ja toinen polvilumpion suoran siteen kohdalle nivelen sisäisivulle.