



Arthroscopic Management of Synovial Chondromatosis of the Knee Joint

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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Case Report

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ABSTRACT

Synovial Chondromatosis is a rare and it is a benign condition characterized by multiple cartilaginous nodules in synovial facet spaces. Synovial Chondromatosis affects most commonly the knee joint. This is a case report of a 30-year-old male patient presented with pain and swelling over the left knee joint. On evaluation MRI shows loose bodies, for which he underwent, arthroscopic exploration. Viscous fluid and loose bodies were identified and showed synovial hyperemia. Synovial debridement was done and loose bodies were removed and sent to histopathological examination. The result signify that arthroscopy is efficient method both in diagnostic as well as therapeutic management of synovial chondromatosis.

Keywords: Synovial chondromatosis; knee joint; arthroscopy; loose bodies.

1. INTRODUCTION

Synovial chondromatosis furthermore called as synovial Osteo-Chondromatosis, is a rare and benign disorder characterized by multiple cartilaginous nodules deemed to be loose bodies within the synovium of joints [1,2]. Synovial

chondromatosis affects single large joints, knee being more common, subsequently hip, elbow, shoulder and ankle [3] are also reported. But also affects the small joints as well, especially in distal radio-ulnar, tibio-fibular, metacarpo-phalangeal and metatarso-phalangeal joints [4-7]. Clinical features may vary from being completely

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asymptomatic to symptomatic with subtle history of pain, associated with swelling, joint crepitus or may also present with typical history of locking of the knee joint [8]. Diagnosis is mainly based on radiological investigations such as x-ray, computed tomography (CT) scans. Magnetic resonance imaging (MRI) and Histopathological examination are the definitive tool for diagnosis. Clinical management involves excision of loose bodies using arthroscopic technique [9] to avoid further joint destruction [10]. We a case of synovial chondromatosis of the knee in adult patient with pain in knee joint for past one year.

2. CASE REPORT

A 30-year-old male patient with past history of trauma 1-year back presented with pain in the left knee aggravated for past 1 month. Pain was insidious at onset, intermittent (initially) and progressive and severe since 1 month. Symptoms aggravates on climbing stairs associated with swelling and pain of the left knee

and the patient experienced difficulties in activities of daily living like squatting, walking and several episodes of locking of the knees. On clinical examination, there was a swelling associated with local tenderness at the front and back of the left knee. The range of movements was not restricted. MRI scans identified loose bodies in anterior inter-condylar region.

Patient was posted for Arthroscopic removal of loose bodies. Under Spinal anesthesia, under tourniquet control standard Antero-medial and Antero-lateral portals were used. With the help of Probe hooks, joint spaces and structures were initially assessed in all directions. Articular cartilages were examined as well. Intra operatively it was observed that there was hyperemia and edema in the medial and lateral recesses. Partial synovectomy performed. Irregular cartilage-like bodies of ~16x7 mm, identified and subsequently removed with forceps. Synovial membrane and the loose bodies were sent to Histopathological analysis.

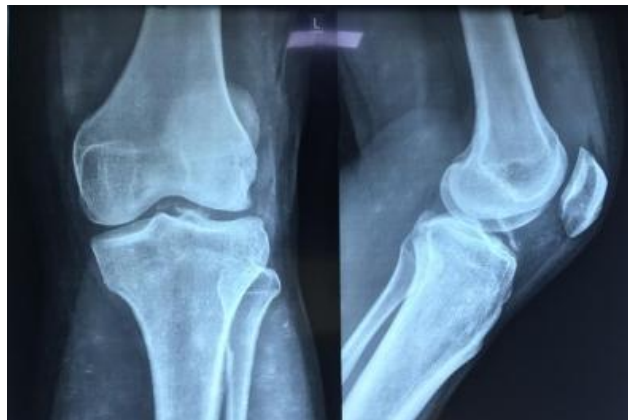
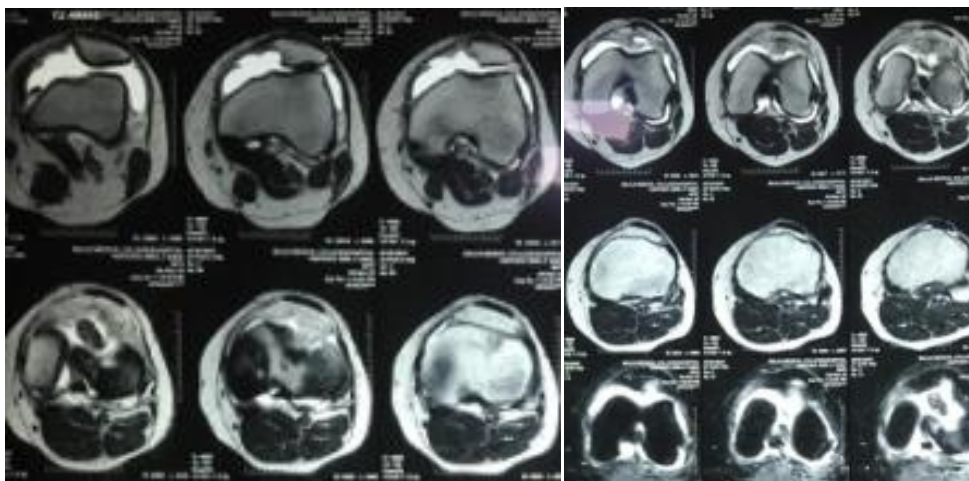


Fig. 1. X-Ray image of knee



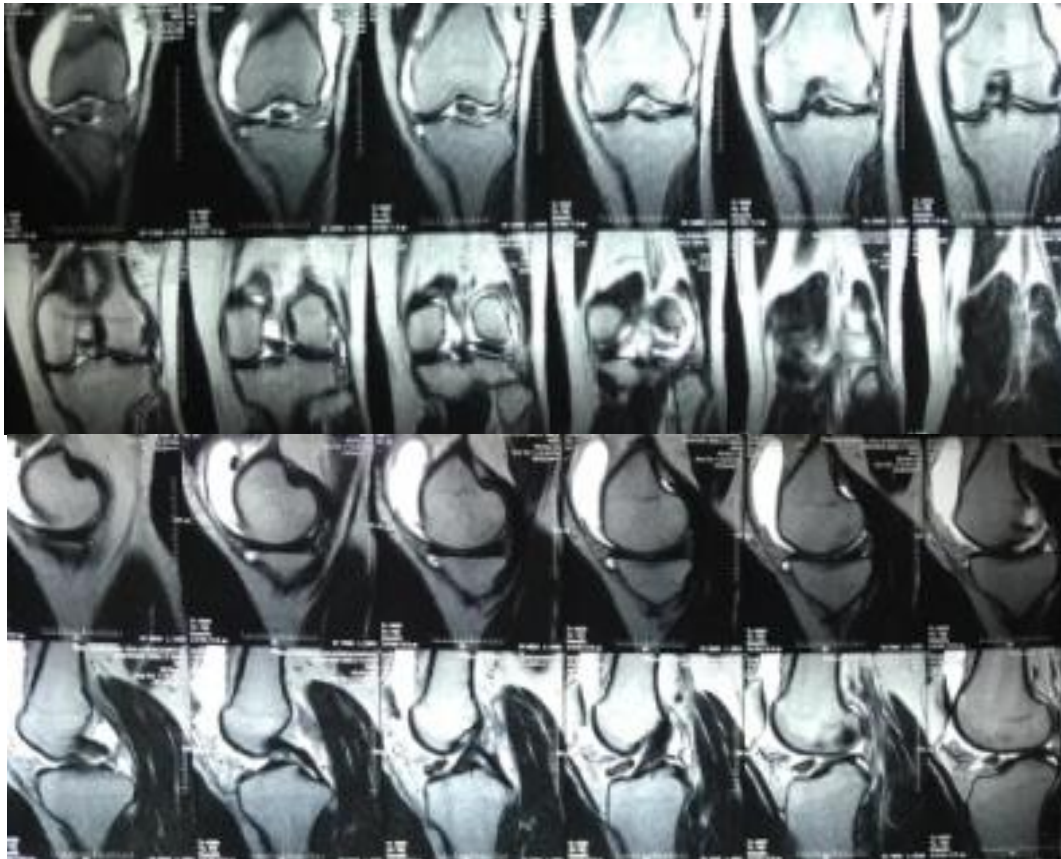


Fig. 2. MRI scans showing loose bodies

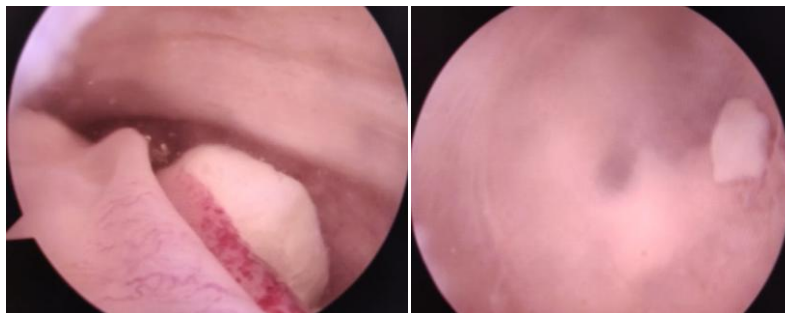


Fig. 3. Arthroscopic image showing recess Arthroscopic image showing loose body

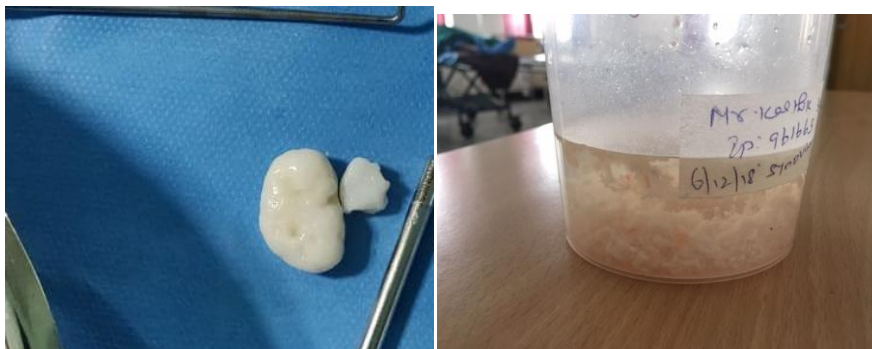


Fig. 4. Histopathological analysis – cartilage bodies



Fig. 5. Post operative X-ray image

Pathological gross specimen showed multiple white loose bodies and was reported as synovial hyperplasia with cartilage bodies, which was consistent with synovial chondromatosis.

The Patient underwent standard postoperative protocol with antibiotics, analgesics and physical therapy. Postoperative period was uneventful. The Patient improved symptomatically and terminal pain was relieved. The Patient could sit crossed legs and squat without pain.

3. DISCUSSION

Synovial chondromatosis is a condition that has an underlying etiology pertaining to synovial metaplasia [11]. The cartilaginous nodules in the synovium or in joints leads to formation of sub-intimal fibroblasts in tendons and bursae [12]. These extrudes from synovium to become loose bodies found to be floating in the synovial spaces or extend to the extra articular soft tissue [13].

Milgram's classified, synovial osteochondromatosis in three stages based on gross and pathological findings. Stage I, referred to active lesions of the synovium, without loose bodies and synovial cartilage metaplasia. Stage II, referred to transitional lesions with active intra-synovial proliferation with free loose bodies. Loose bodies may remain within proliferated membrane. Stage III, referred to multiple loose bodies in joint space and synovitis subsides [2]. Partial or total synovectomy has done during stages II and stage III free body removal and I. This patient was found to be in stage III.

Synovial chondromatosis mostly seen in patients aged between 30-50 years [14]. Radiological investigations, including AP and lateral X-ray, and MRI scans are mandatory for diagnosis. Multiple irregular loose bodies were identified in x-ray and MRI, with minimal effusion. Arthroscopy has better clinical outcome compared to arthrotomy, in view of post-operative early recovery, less operative time period, minimal incision and complete instrumentation and arthroscopy is a more effective treatment than loose body removal alone [15,16]. According to Urbach et al [17] loose body removal with local synovectomy, eliminates abnormal synovial tissue and prevent recurrence [18-29].

4. CONCLUSION

This case report concludes that arthroscopic technique is safe and effective method in the treatment of synovial chondromatosis with loose bodies.

CONSENT AND ETHICAL APPROVAL

As per university standard guideline, patient's consent and ethical approval have been collected and preserved by the authors

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Chiba S, Koge N, Oda M, Yamauchi R, Imai T, Matsumoto H and Yokogushi K: Synovial chondromatosis presenting with cervical radiculopathy: A case report. *Spine (Phila Pa 1976)*. 2003;28:E396-E400.
2. Milgram JW. Synovial osteochondromatosis: A histopathological study of thirty cases. *J Bone Joint Surg Am*.1977;59:792-801.
3. Roberts D, Miller TT, Erlanger SM. Sonographic appearance of primary synovial chondromatosis of the knee. *J Ultrasound Med*. 2004;23:707-709.
4. Von Schroeder HP and Axelrod TS: Synovial osteochondromatosis of the distal radio-ulnar joint. *J Hand Surg Br*. 1996;21:30-32.
5. Batheja NO, Wang BY, Springfield D, Hermann G, Lee G, Burstein DE and Klein MJ. Fine-needle aspiration diagnosis of synovial chondromatosis of the tibiofibular joint. *Ann Diagn Pathol*. 2000;4:77-80.
6. Warne BA, Tigrani DY, Ward CM. Metacarpophalangeal joint synovial osteochondromatosis: A case report. *Iowa Orthop J*. 2008;28:91-93.
7. Tagliavero G, Moro S, Stecco C, Pennelli N. Bilateral synovial chondromatosis of the first metatarsophalangeal joint: A report case. *Reumatismo*. 2011;55:263-266. (In Italian).
8. Evans S, Boffano M, Chaudhry S, Jeys L and Grimer R: Synovial chondrosarcoma arising in synovial chondromatosis. *Sarcoma*. 2014:647939.
9. Yu GV, Zema RL and Johnson RW: Synovial osteochondromatosis. A case report and review of the literature. *J Am Podiatr Med Assoc*. 2002;92:247-254.
10. Neumann JA, Garrigues GE, Brigman BE, Eward WC. Synovial Chondromatosis. *JBJS Rev*. 2016;4: pii: 01874474-201605000-00005.
11. Narasimhan R, Kennedy S, Tewari S, Dhingra D and Zardawi I: Synovial chondromatosis of the elbow in a child. *Indian J Orthop*. 2011;45:181-184.
12. Surwade A, Chaudhary A, Mahale Y. Synovial chondromatosis of the knee: Management with arthroscope-assisted synovectomy and removal of loose bodies: A case report. *IJHSR*. 2016;6:388-391.
13. Birchall D, Khangure MS, Spagnolo DV. Vertebral synovial osteochondromatosis with compressive myelopathy. *Spine (Phila Pa 1976)*. 1999;24:921-923.
14. Jesalpura JP, Chung HW, Patnaik S, Choi HW, Kim JI and Nha KW: Arthroscopic treatment of localized synovial chondromatosis of the posterior knee joint. *Orthopedics*. 2010;33:49.
15. Samson L, Mazurkiewicz S, Treder M and Wiśniewski P. Outcome in the arthroscopic treatment of synovial chondromatosis of the knee. *Ortop Traumatol Rehabil*. 2005;7:391-396.
16. Ogilvie-Harris DJ and Saleh K: Generalized synovial chondromatosis of the knee: A comparison of removal of the loose bodies alone with arthroscopic synovectomy. *Arthroscopy*. 1994;10:166-170.
17. Urbach D, McGuigan FX, John M, Neumann W, Ender SA. Long-term results after arthroscopic treatment of synovial chondromatosis of the shoulder. *Arthroscopy*. 2008;24:318-323.
18. Varol A, Sencimen M, Gulses A, Altug HA, Dumlu A and Kurt B: Diagnostic importance of MRI and CT scans for synovial osteochondromatosis of the temporomandibular joint. *Cranio*. 2011;29:313-317.
19. Xie S, Nevis J and Lezmi S: Pathology in practice. Chondro-osseous metaplasia consistent with synovial chondromatosis in a great horned owl. *J Am Vet Med Assoc*. 2014;245:767-769.
20. Jiang W. Clinical observation of combined treatment of traditional chinese medicine and western medicine in 35 cases with traumatic synovitis of knee joint. *World Health Digest*. 2012;433-433.
21. McQueen FM. The MRI view of synovitis and tenosynovitis in inflammatory arthritis: Implications for diagnosis and management. *Ann N Y Acad Sci*. 2009; 1154:21-34.
22. Mannami K: Influence of intraarticular continuous perfusion of physiological saline on chondrocytes. *Nihon Seikeigeka Gakkai Zasshi*. 1985;59:573-580 (In Japanese).
23. Outerbridge RE. The etiology of chondromalacia patellae. *J Bone Joint Surg Br*. 1961;43-B:752-757.
24. Parvizi J, Azzam K and Rothman RH: Deep venous thrombosis prophylaxis for total joint arthroplasty: American Academy

- of Orthopaedic Surgeons guidelines. J Arthroplasty. 2008;23(7Suppl):S2-S5.
25. Collins NJ, Misra D, Felson DT, Crossley KM and Roos EM. Measures of knee function: International knee documentation committee (IKDC) subjective knee evaluation form, knee injury and osteoarthritis outcome score (KOOS), knee injury and osteoarthritis outcome score physical function short form (KOOS-PS), knee outcome survey activities of daily living scale (KOS-ADL), lysholm knee scoring scale, oxford knee score (OKS), western ontario and McMaster universities osteoarthritis index (WOMAC), activity rating scale (ARS), and tegner activity score (TAS). Arthritis Care Res (Hoboken). 2011;63(Suppl 11): S208-S228.
26. Kistler W. Synovial chondromatosis of the knee joint: A rarity during childhood. Eur J Pediatr Surg. 1991;1:237-239.
27. Sato J, Notani KI, Goto J, Shindoh M and Kitagawa Y. Synovial chondromatosis of the temporomandibular joint accompanied by loose bodies in both the superior and inferior joint compartments: Case report. Int J Oral Maxillofac Surg. 2010;39:86-88.
28. Frick MA, Wenger DE and Adkins M: MR imaging of synovial disorders of the knee: An update. Radiol Clin North Am. 2007;45:1017-1031.
29. Rehm J, Zeifang F and Weber MA. Imaging of the elbow joint with focus MRI. Part 2: Muscles, nerves and synovial membranes. Radiologe. 2014;54:279-294.

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