Larger Chondral Lesions Treated with Collagen Membrane – Matrix-Induced Autologous Chondrogenesis – Show Larger Increase in Clinical Scores

Lesões condrais maiores tratadas com uso de membrana de colágeno – condrogênese autóloga induzida por matriz – apresentam maior aumento nos escores clínicos

Mateus Kenji Christo Miyahira1, João Victor Novaretti2, Diego Costa Astur2, Camila Cohen Kaleka1, Joicemar Tarouco Amaro1, Moisés Cohen2

1 Cohen Institute of Orthopedics, Rehabilitation and Sports Medicine, São Paulo, SP, Brazil
2 Department of Orthopedics and Traumatology, Escola Paulista de Medicina, Universidade Federal de São Paulo, São Paulo, SP, Brazil

Address for correspondence Mateus Kenji Christo Miyahira, Instituto Cohen, Av Lineu de Paula Machado, 660, Cidade Jardim, São Paulo, SP, 05601-000, Brazil (e-mail: kenjimiyahira23@hotmail.com).


Abstract

Objective To evaluate clinically and radiologically the results of the treatment of chondral lesions using collagen membrane - autologous matrix-induced chondrogenesis (AMIC).

Methods This is a series of observational cases, in which 15 patients undergoing AMIC were analyzed. The clinical evaluation was made by comparing the Lysholm and International Knee Document Committee (IKDC) scores in the pre- and postoperative period of 12 months, and radiological evaluation using the Magnetic Resonance Observation of Cartilage Repair Tissue (MOCART) score in the same postoperative period.

Results The mean age of the patients was 39.2 years old, and the mean size of the chondral lesions was 1.55cm². There was a significant improvement in clinical scores, with a mean increase of 24.6 points on Lysholm and of 24.3 on IKDC after 12 months. In the radiological evaluation, MOCART had a mean of 65 points. It was observed that the larger the size of the lesion, the greater the improvement in scores.

Conclusion Evaluating subjective clinical scores, the treatment of chondral lesions with the collagen membrane showed good results, as well as the evaluation of MOCART, with greater benefit in larger lesions.

Keywords ► articular cartilage ► chondrogenesis ► collagen ► knee injuries

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Introduction

The biomechanical function of the matrix of proteoglycans and collagen fibers of the cartilage is to absorb compressive and tension loads that act on the joint. Cartilage injuries are seen in up to 11% of arthroscopies, half of which are related to trauma or osteochondritis dissecans. Most are related to trauma or osteoarthritis. One of the greatest challenges for the orthopedic surgeon remains the treatment of chondral injuries. Due to the low healing potential, and the degree of discomfort that these lesions cause, surgical intervention has been widely used in an attempt to fill cartilage defects. Mesenchymal cells are the source for regeneration.

Pridie, in 1959, was the first to stimulate repair using blood from the bone marrow. Steadman et al., in 2001, introduced the microfracture technique. Microfracture is a technique for recruiting mesenchymal cells, as the clot provides a favorable medium for cartilage repair tissue. The “fibrocartilage-like” scar tissue prevents osteoarthritis and improves patient symptoms.

As the formed clot does not have good mechanical resistance, the use of the collagen membrane has been proposed. Autologous matrix-induced chondrogenesis (AMIC) is a technique that combines microfractures with the collagen membrane. While microperforations are indicated for defects < 2 cm², AMIC is indicated for larger defects.

The objective of the present study is to evaluate clinically and radiologically the results of the treatment for chondral lesions of the knee using the collagen membrane – AMIC.

Methodology

The present study is an observational case series of patients with chondral injuries of the knee, operated between 2015 and 2018 using collagen membrane by the AMIC technique, and approved by the ethics committee of the institution.
After debridement of the chondral defect, removal of degenerate and unviable cartilaginous tissue, curettage of the lesion bed was performed, removing the whole calcified layer and preserving the subchondral bone (Fig. 1).

Using a metallic template, the size and shape of the lesion was precisely defined, and the porcine type I/III collagen membrane (Chondrogide; Geistlich Pharma AG, Wolhusen, Switzerland) that would cover the defect was cut out. Then, microperforations were made in the subchondral bone, freehand, with 2 to 4 mm of distance between them. The membrane was then placed over the defect and provisionally fixed with two needles. The definitive fixation of the membrane was made with absorbable monocryl 5.0 thread and complemented with fibrin glue at the edges of the lesion.

Rehabilitation

Despite the different surgical procedures associated with the use of the collagen membrane, the rehabilitation protocol started with three weeks of immobilization with joint brace and without weight unloading on the operated limb.

In order to reduce the inflammatory condition, until the 5th week, an increase in the range of motion and activation of the quadriceps muscle was initiated. After that, until the 8th week, the patient was encouraged to walk without using an orthosis, progressively, until the gait normalized. Between 6 and 8 months, the patient was allowed to play contact sports.

Data Collection

Demographic data such as age, gender, laterality, size and location of the chondral lesion, and associated procedures were collected from the database. The preoperative clinical evaluation was performed using the Lysholm20 and the International Knee Document Committee (IKDC)21 scores, and the 1-year postoperative follow-up, through Lysholm, IKDC, and the Magnetic Resonance Observation of Cartilage Repair Tissue (MOCART) radiological score.22 This score is a rating system that seeks to assess the repair tissue in its extent, signal strength, defect filling, integration with the adjacent cartilage, among others.

Statistical analysis

Initially, all variables were analyzed descriptively. For quantitative variables, this analysis was performed by observing the minimum and maximum values, and calculating means, standard deviations (SDs) and quartiles. For qualitative variables, absolute and relative frequencies were calculated. For the comparison of means of two evaluation moments, the paired Student t test was used.23 To study the correlations between the deltas of the scores and variables evaluated in the study, the Pearson correlation coefficient was used. The software used for the calculations was SPSS Statistics for Windows, Version 17.0 (SPSS Inc., Chicago, IL, USA). The level of significance used for the tests was 5%.

Results

A total of 15 patients aged between 15 and 54 years old (mean of 39.2 years old) were evaluated, 3 women and 12 men. The lesions affected the femoral trochlea in six cases, the patella in five cases and the femoral condyles in four cases. Table 1 presents the frequency distribution of the lesion site.

The size of the lesions ranged from 0.6 cm² to 2.34 cm², measured using preoperative MRIs, and the body mass index (BMI) ranged from 21.6 kg/m² to 32.5 kg/m², as shown in Table 2, with the descriptive values of these variables.

The Lysholm and IKDC scores were assessed before and after surgery, at 12 months. There was a significant increase in the means of the Lysholm score (55.9 versus 80.5) and of the IKDC score (51.6 versus 75.9) from pre- to postoperative (p < 0.001) (Figures 2 and 3).

The Tegner and MOCART scores were evaluated in a single moment and are described in Table 3. Through the results obtained with MRI scans after 1 year, it was shown that all patients maintained the filling of the chondral lesion with repair tissue, with good integration of the edges. The average MOCART score was 65 points, ranging from 50 to 75.

For the study of possible correlations between variables, and the pre- and postoperative variation of the scores, the delta of variation of the scores presented in Table 4 was calculated.

In Table 5, the correlation coefficients between age, lesion size, BMI and the deltas of variation of the Lysholm and IKDC scores are presented. There is a positive and significant correlation between the size of the lesion and the delta of variation of the IKDC score. Therefore, the greater the lesion size, the greater the delta of variation of the IKDC score.
Table 1: Frequency distribution of the lesion site for the 15 patients evaluated

<table>
<thead>
<tr>
<th>Lesion site</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MFC + LFC</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>MFC R</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Patella R</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Patella L</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Trochlea R</td>
<td>4</td>
<td>26.7</td>
</tr>
<tr>
<td>Trochlea L</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Abbreviations: L, left; LFC, lateral femoral condyle; MFC, medial femoral condyle; R, right.

Table 2: Descriptive values of lesion size and body mass index of the 15 patients

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>15</td>
<td>1.55</td>
<td>0.58</td>
<td>0.60</td>
<td>2.34</td>
</tr>
<tr>
<td>BMI</td>
<td>15</td>
<td>27.6</td>
<td>2.6</td>
<td>21.6</td>
<td>32.5</td>
</tr>
</tbody>
</table>

Abbreviations: BMI, body mass index; SD, standard deviation.

The most important finding of the present study was that patients with larger chondral lesions had a greater increase in clinical scores, therefore a greater benefit with the treatment. These results show agreement with the previous study published by our group. There was no significant impact of age and BMI on the results found in the present study.

The AMIC technique has been used by several surgeons, being established as an option in the treatment of cartilage defects. Previous studies have shown the ability of micro-fractures in the subchondral bone to take mesenchymal cells from the bone marrow to the cartilage region, promoting the supply of growth factors and cytokines. In vitro tests have already shown that the collagen membrane can retain mesenchymal cells, which can improve the regenerative capacity of the microfracture technique.

A 2008 study compared the results of treating chondral lesions with microfractures, using or not the collagen membrane in acetabular lesions. It was shown that a more sustained improvement in clinical scores was achieved with the use of the membrane.

Compared with other surgical procedures to treat cartilage defects, the combination of microfractures with the collagen membrane is a good option, with a low-cost surgical time, without morbidity of a healthy donor area or need for cell proliferation in vitro, as in autologous osteochondral transplantation and autologous chondrocyte transplantation, respectively. The same technique of the present study, performed arthroscopically, has already been described by Piontek et al., presenting promising results. Schagemann et al., in 2018, compared the AMIC arthroscopic technique with the mini open technique, similar to our work, concluding that there is no difference in the results in the medium term, with 2 years of follow-up.

Dholland et al. have already reported satisfactory improvements 2 years after the operation, but with a tendency to deterioration of the repair tissue, analyzed.

**Table 1** Frequency distribution of the lesion site for the 15 patients evaluated

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</thead>
<tbody>
<tr>
<td>Size</td>
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<td>1.55</td>
<td>0.58</td>
<td>0.60</td>
<td>2.34</td>
</tr>
<tr>
<td>BMI</td>
<td>15</td>
<td>27.6</td>
<td>2.6</td>
<td>21.6</td>
<td>32.5</td>
</tr>
</tbody>
</table>

Abbreviations: BMI, body mass index; SD, standard deviation.

Fig. 2 Mean and standard deviation of the Lysholm score in the pre- and postoperative period.
by MRI. In our series of cases, the improvements were
good or excellent. Through imaging exams, no repair tissue
thinning or overgrowth was observed. Other studies have
already shown that there is no clinical improvement at the
same pace as the repair tissue evolution observed by MRI
scans. We believe that the radiological evaluation can be
indicative of treatment failure, but not an indication of
success.

Table 3 Descriptive values of the Tegner and Mocart scores of
the 15 patients

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tegner</td>
<td>15</td>
<td>3.9</td>
<td>1.1</td>
<td>2.0</td>
<td>6.0</td>
</tr>
<tr>
<td>MOCART</td>
<td>15</td>
<td>65.0</td>
<td>7.8</td>
<td>50.0</td>
<td>75.0</td>
</tr>
</tbody>
</table>

Abbreviations: MOCART, Magnetic Resonance Observation of Cartilage
Repair Tissue; SD, standard deviation.

Table 4 Descriptive values of the delta scores of variations of
the Lysholm and International Knee Documentation
Committee scores of the 15 patients

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lysholm</td>
<td>15</td>
<td>24.6</td>
<td>9.0</td>
<td>11.0</td>
<td>41.0</td>
</tr>
<tr>
<td>IKDC</td>
<td>15</td>
<td>24.3</td>
<td>7.1</td>
<td>12.6</td>
<td>33.4</td>
</tr>
</tbody>
</table>

Abbreviations: IKDC, International Knee Documentation Committee;
SD, standard deviation.

There are limitations that must be considered when
evaluating the present work. The small number of patients
reflects a reality for the surgeons of the country, due to the
access to the necessary material for the procedure. Because
of this, the lesions are described in different parts of the joint,
with various concurrent procedures, making the sample
more heterogeneous.

Conclusion
Evaluating subjective clinical scores, the treatment of chondral
lesions with the collagen membrane showed good
results, as well as the MOCART evaluation, and that there is a greater benefit in larger lesions.

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There was no financial support from public, commercial, or non-profit sources.

Conflict of Interests
The authors have no conflict of interests to declare.

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