

Osteocondrite del ginocchio

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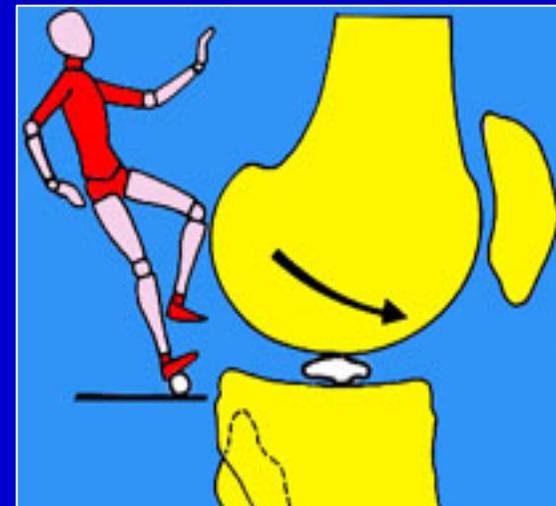
Osteocondrite dei condili femorali

- Comparsa verso i 10 anni
- Ragazzi soprattutto
- Condilo interno ++
- Più raro al condilo esterno ed alla rotula
- Necrosi avascolare localizzata dei bambini

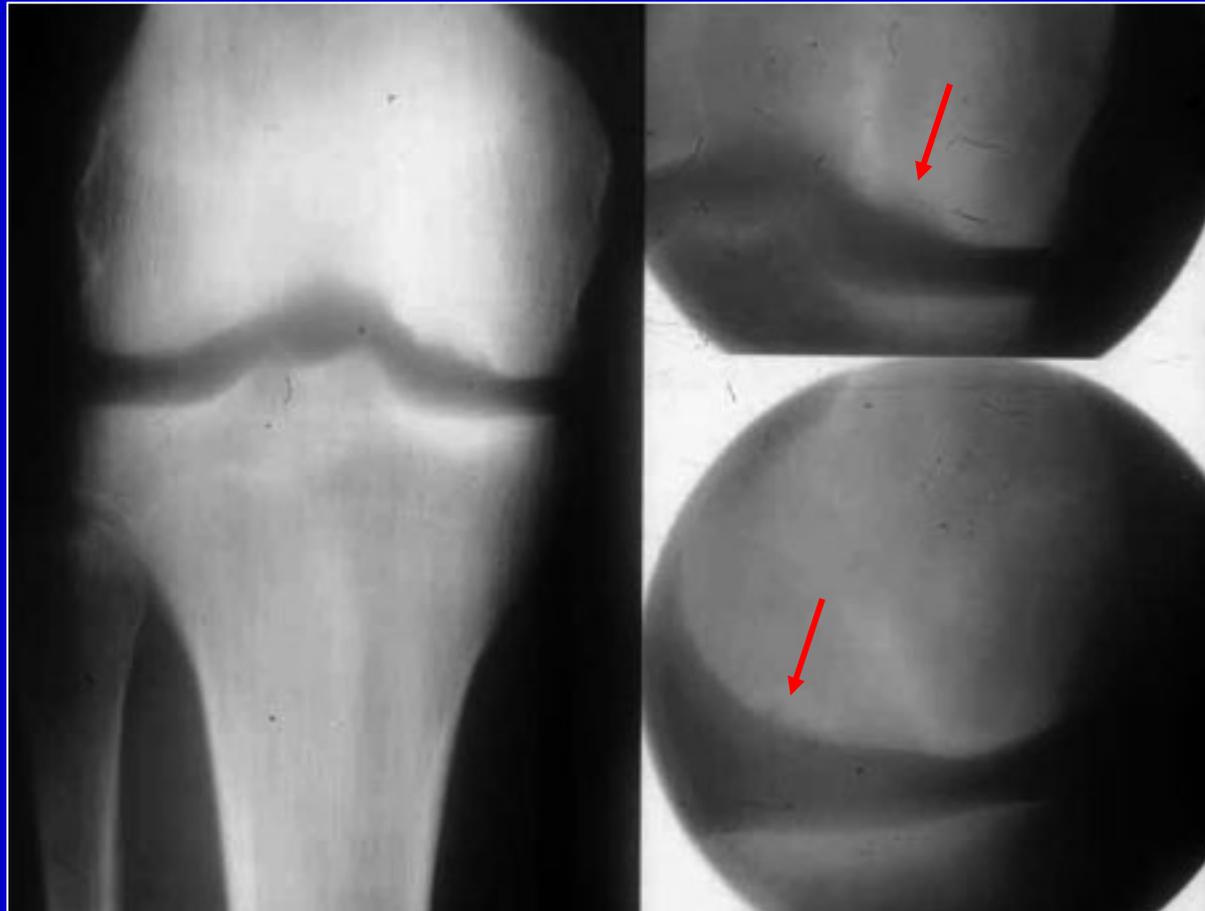
Dolori, idrartrosi, sono i sintomi abituali

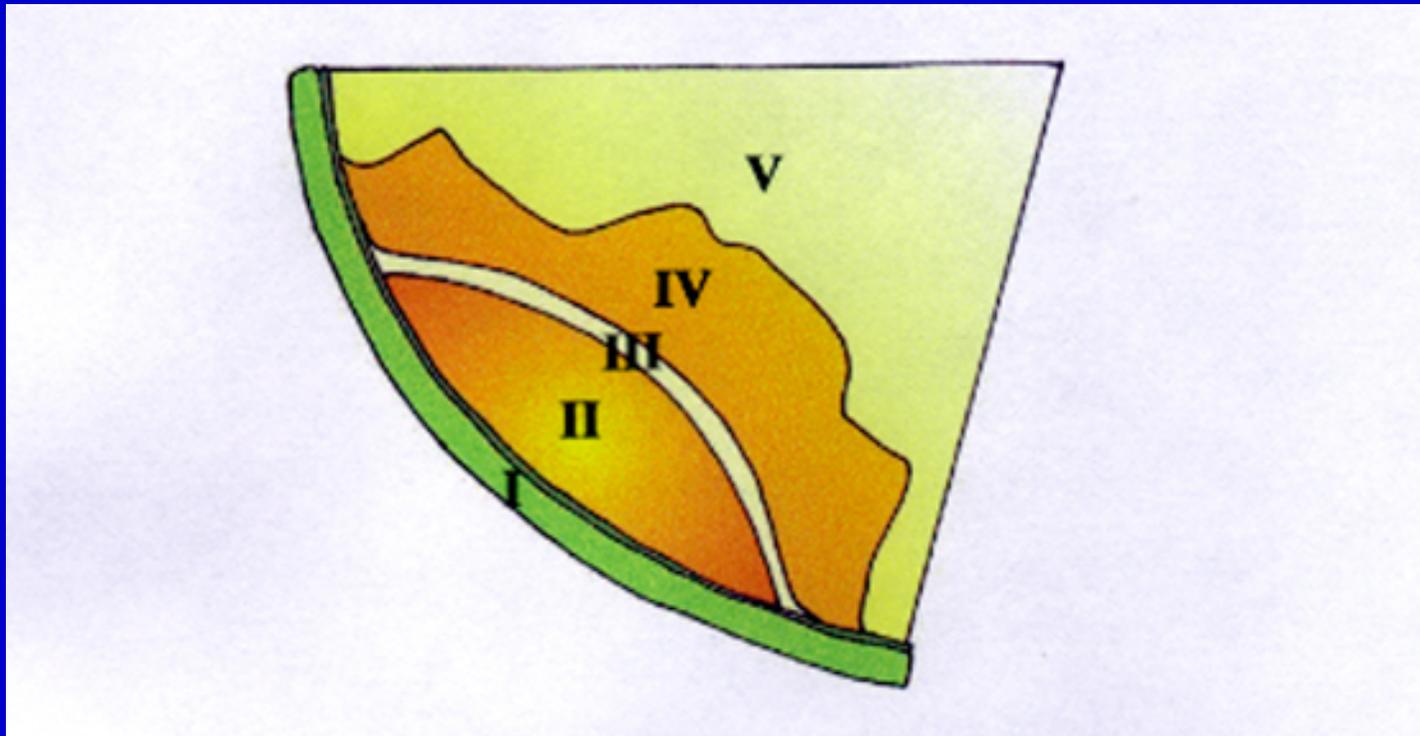
L'instabilità corrisponde alla mobilità del frammento (micro-movimenti sul frammento staccato ma ancora in posizione, o corpi estranei mobili nell'articolazione)

Blocchi possibili



Radiografie semplici





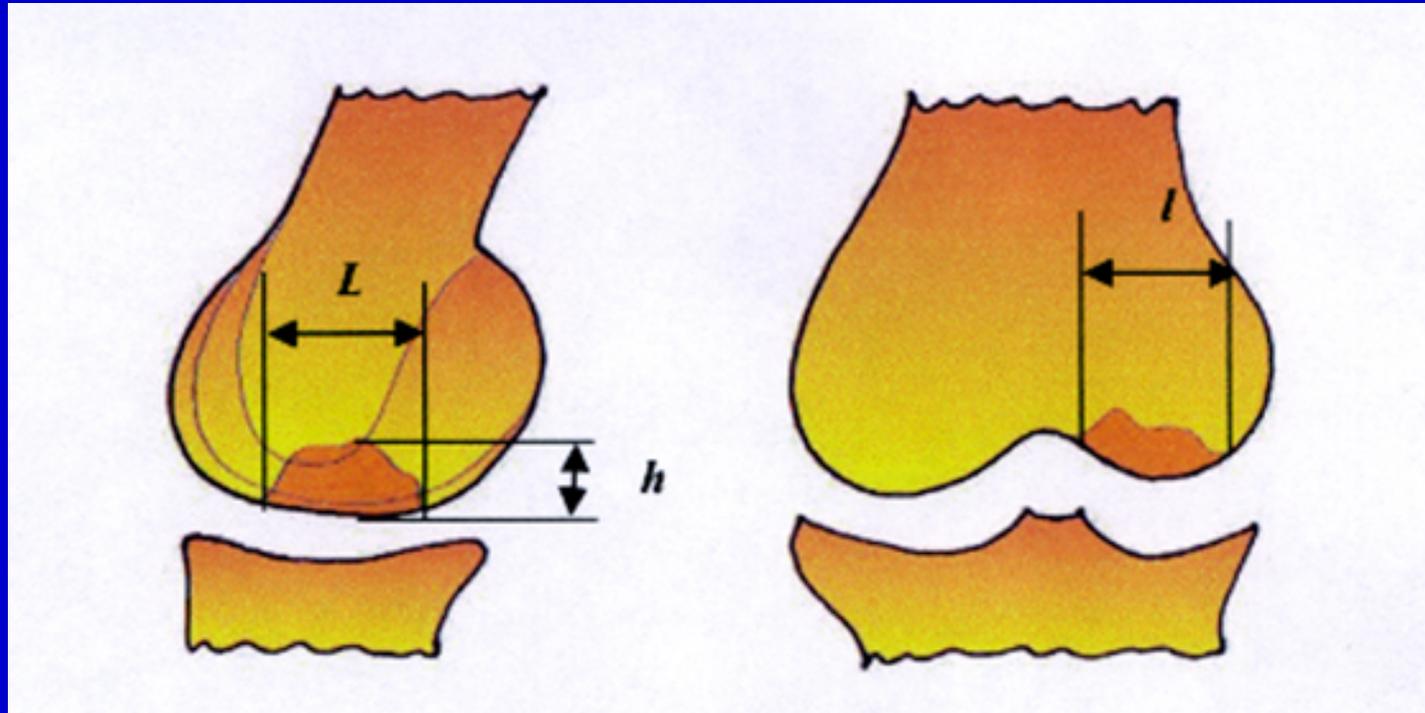
I : Cartilagine

II : osso necrotico separato

III: tessuto fibroso

IV : zona necrotica

V : Osso normale



Determinare la larghezza e la profondità della zona necrotica

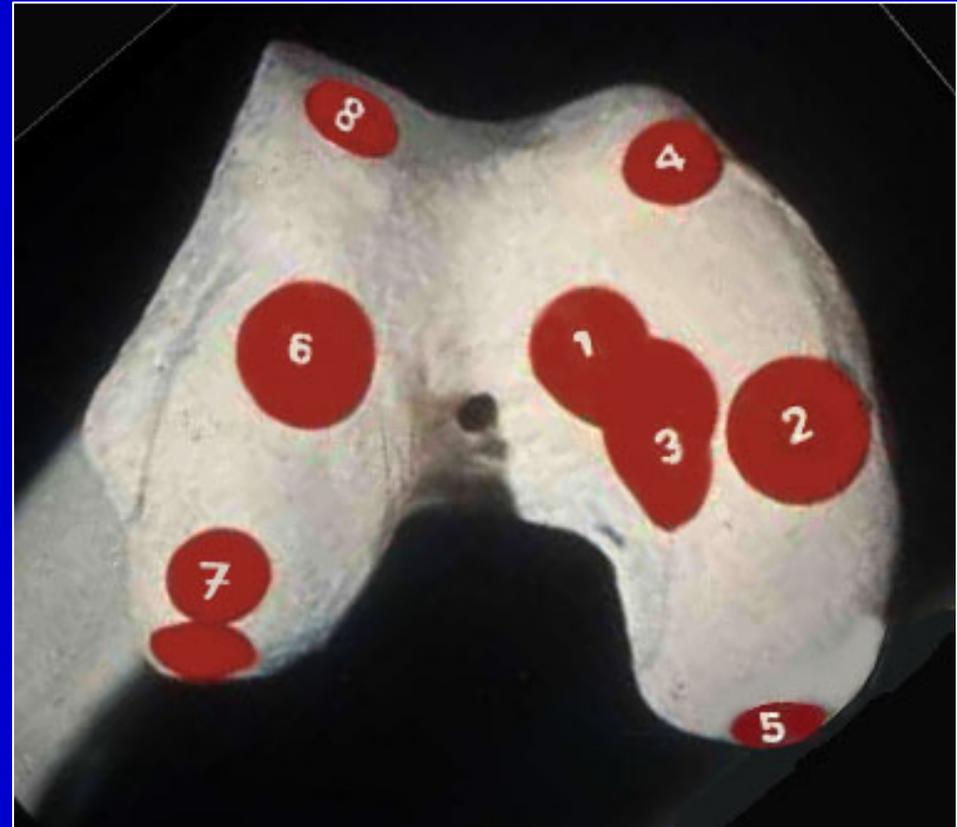
Localizzazioni

Condilo interno : 75 %

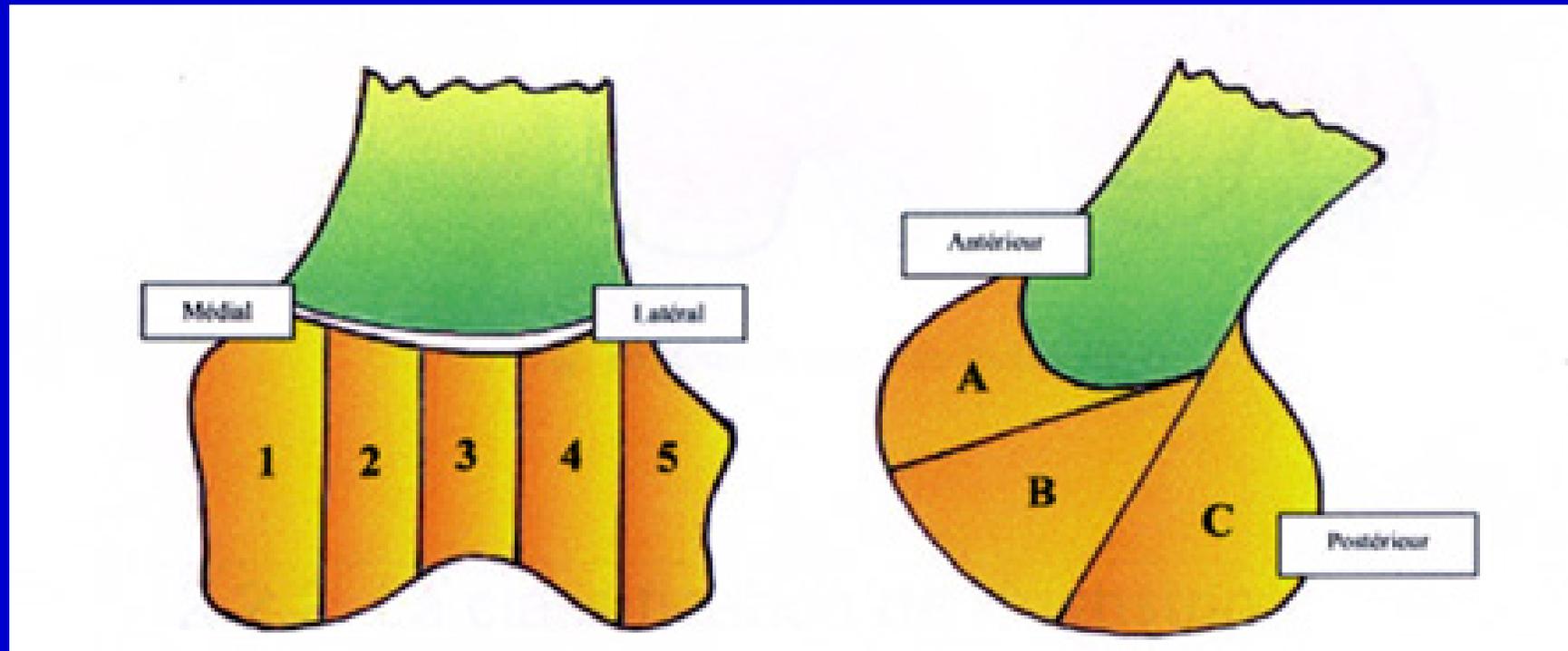
- 1 = 50 % luogo di elezione
- 2 = 30 % sede infracentrale
- 3 = 18 %
- 4 = 1 % anteriore
- 5 = 1 % posteriore

Condilo esterno : 25 %

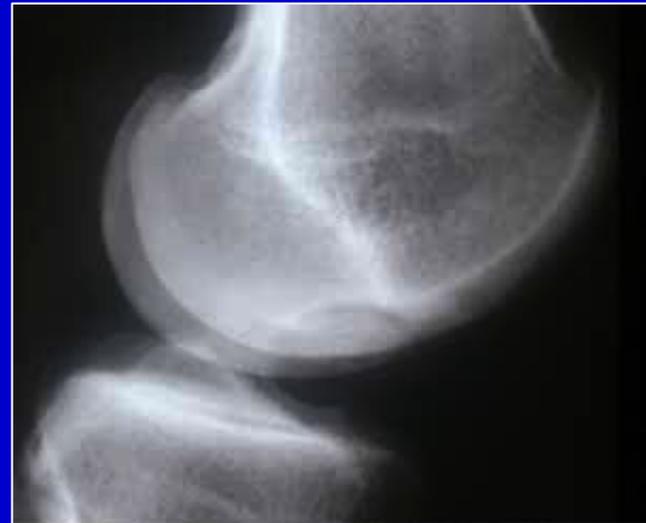
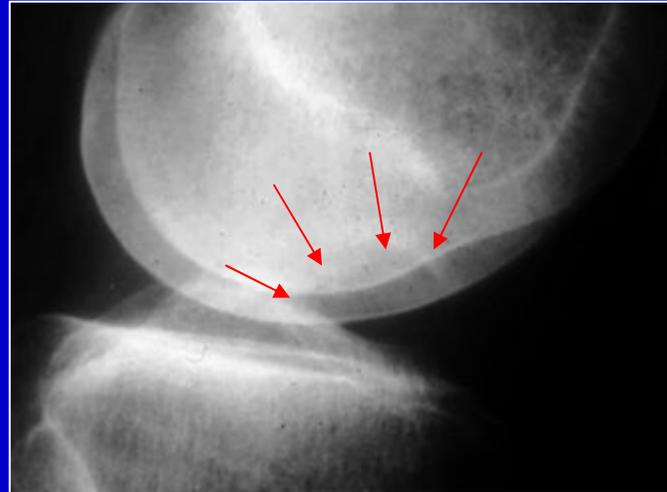
- 6 = 85 % infracentrale
- 7 = 14 % posteriore
- 8 = 1 % anteriore



Localizzazione



Radiografie semplici





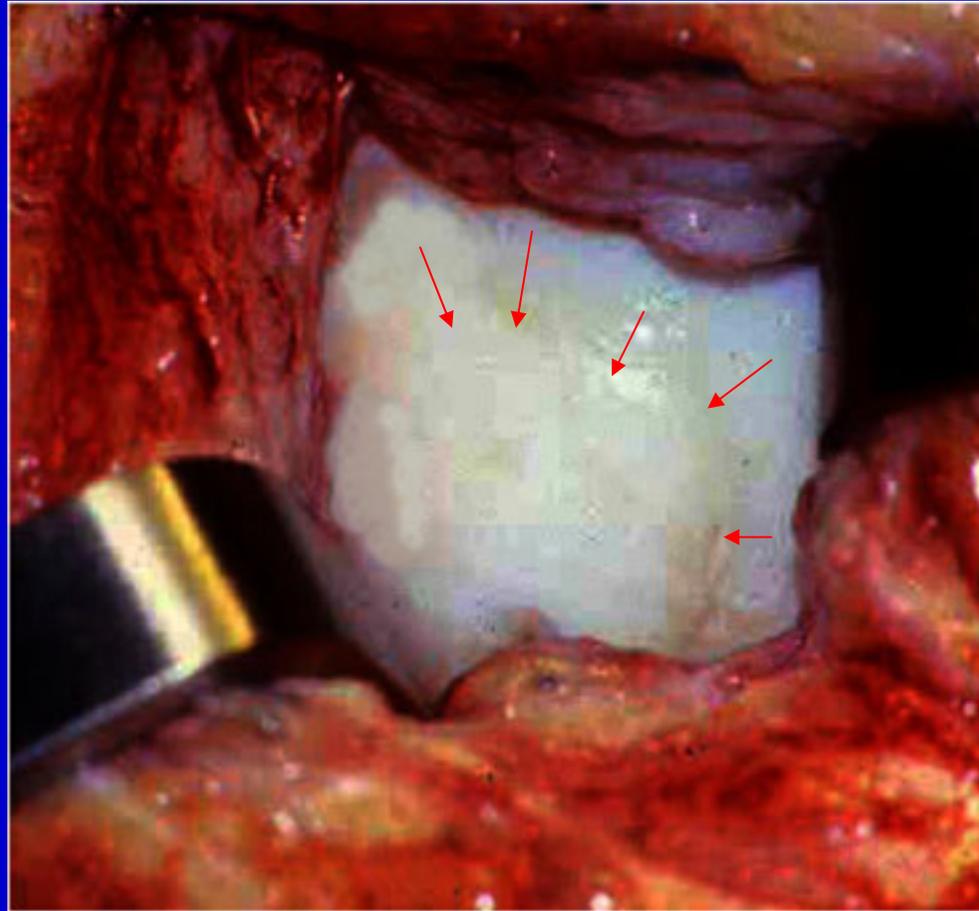
Radio



RMN

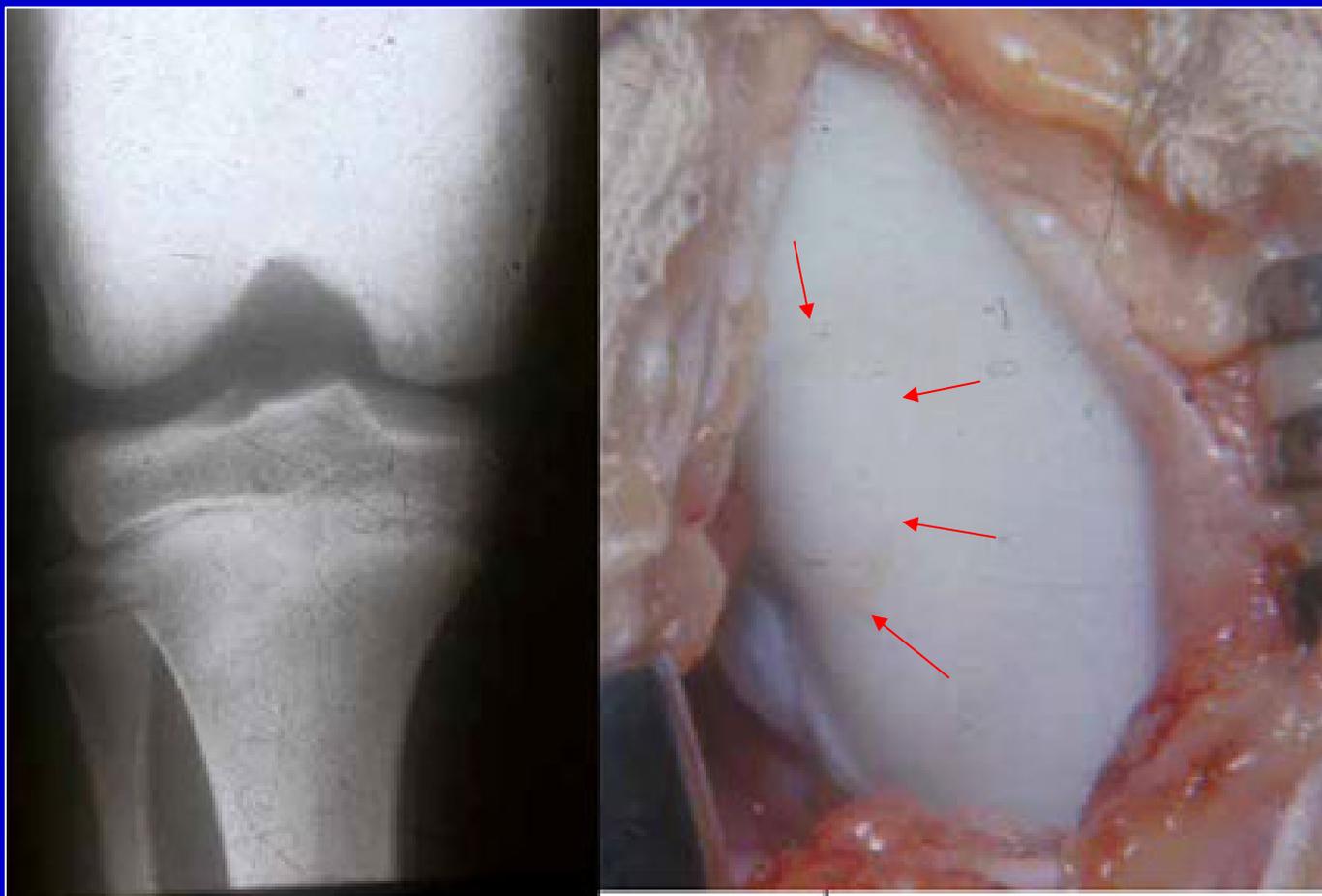


L'osteocondrite é ferma

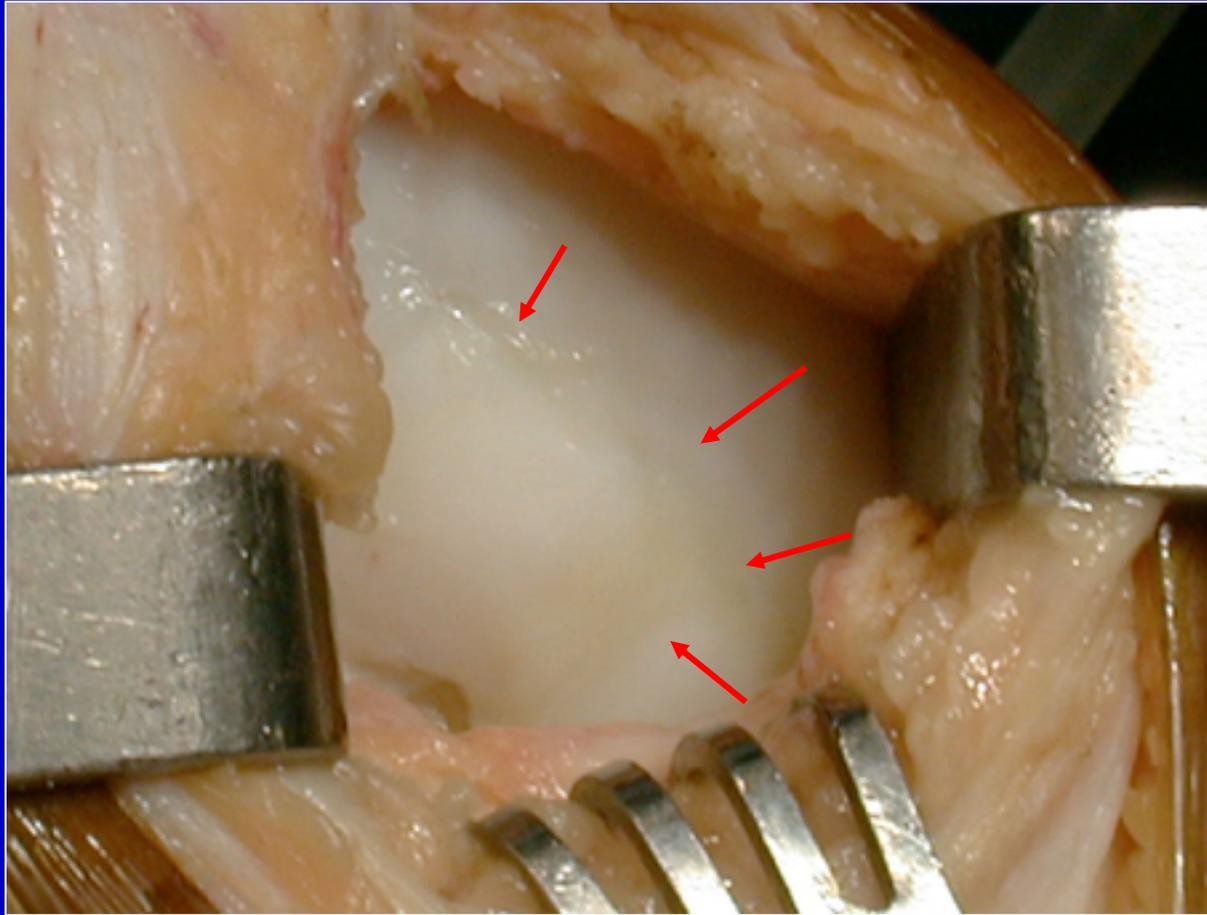


Importanza della visione diretta per verificare lo stato della cartilagine: artroscopia o artotomia e RMN o TAC

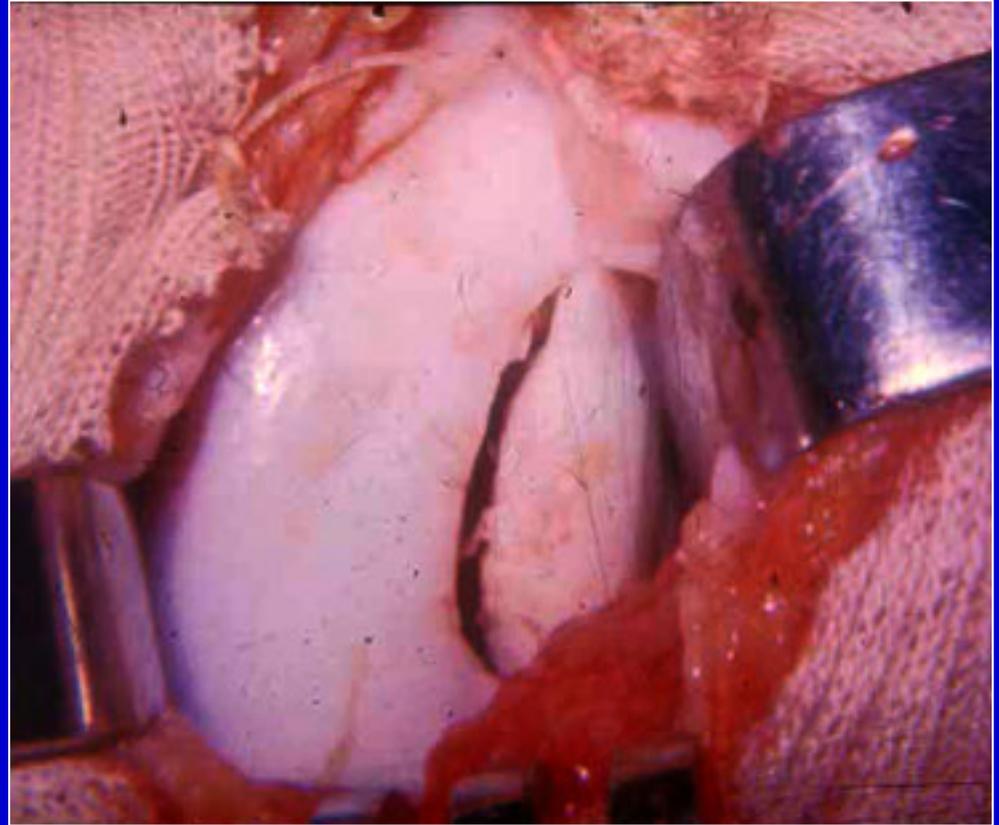
Proiezione rx-grafica della gola intercondilica



L'osteochondrite é ferma ,uno scalino é visibile sotto la cartilagine

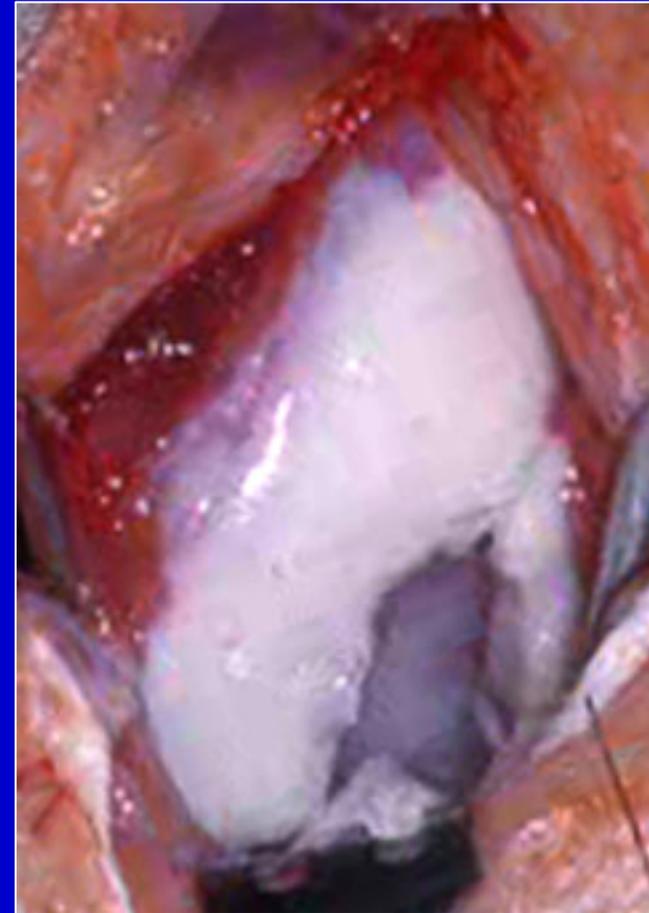
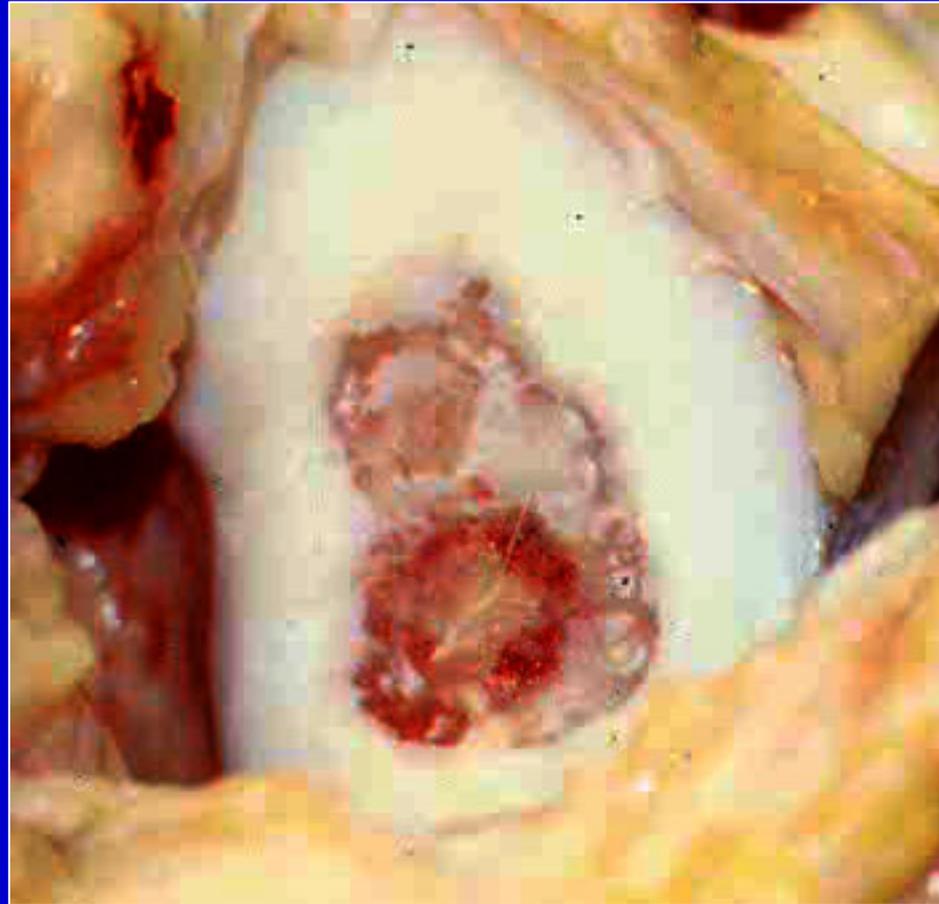


Osteocondrite aperta ,il frammento è ancora in posizione

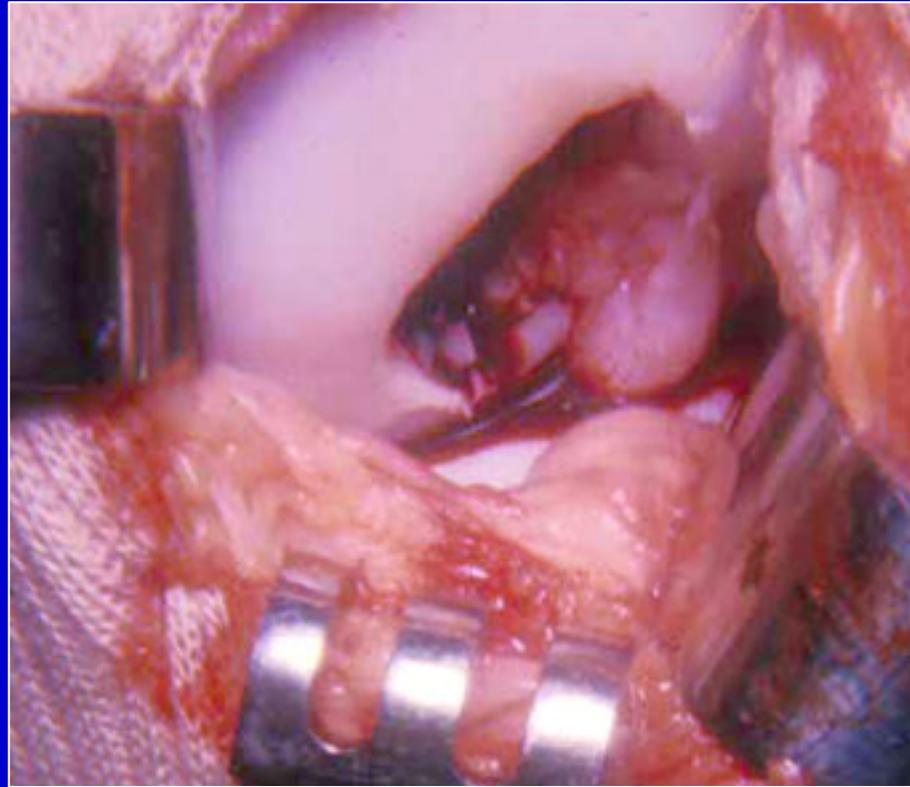


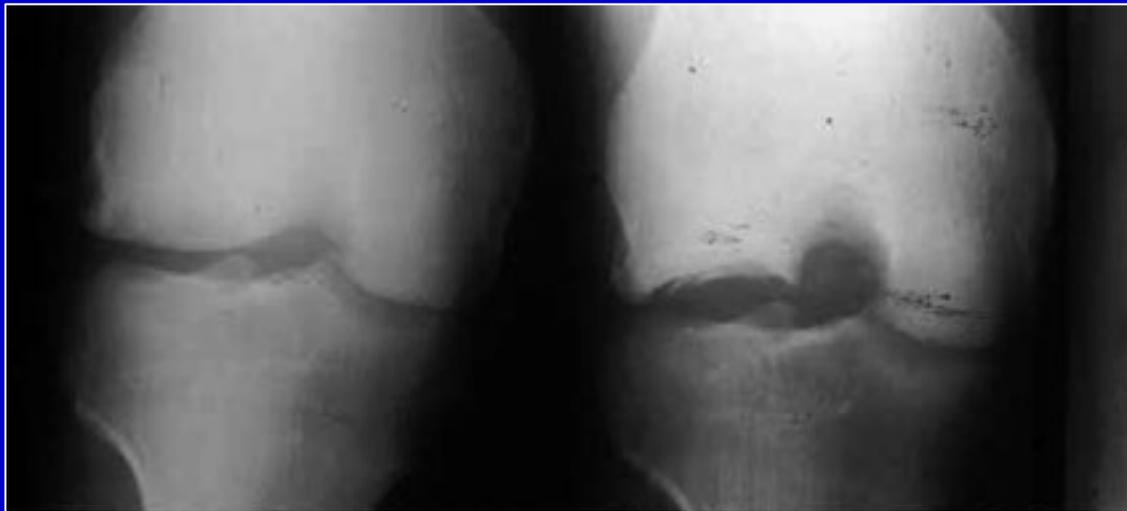
Osteocondrite aperta ,il frammento è ancora in posizione





La nicchia , spesso, é coperta da tessuto fibroso





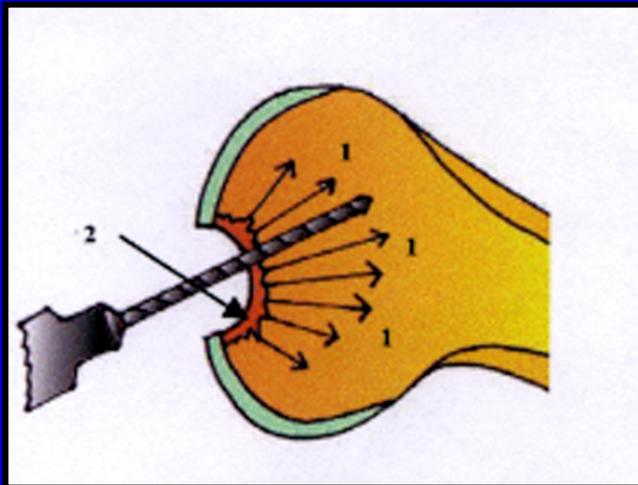
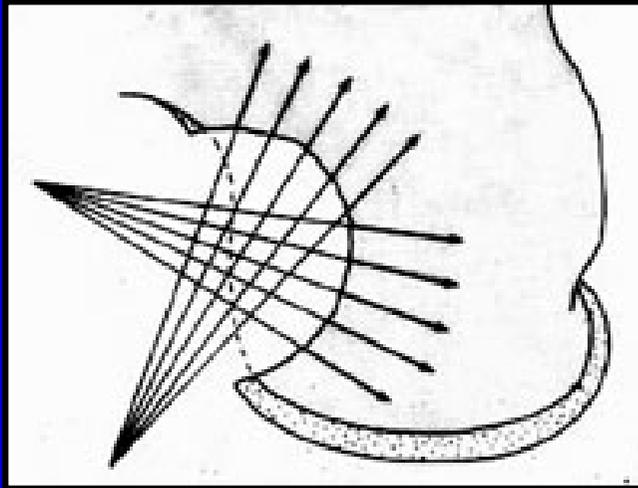
Aspetto dei corpi estranei osteocartilaginei



Evoluzione

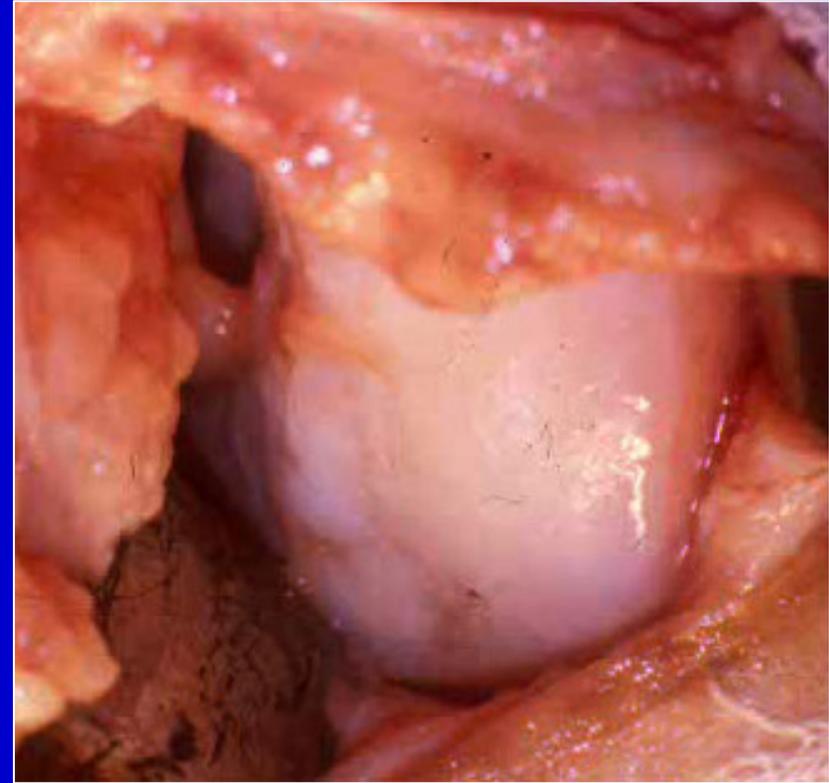
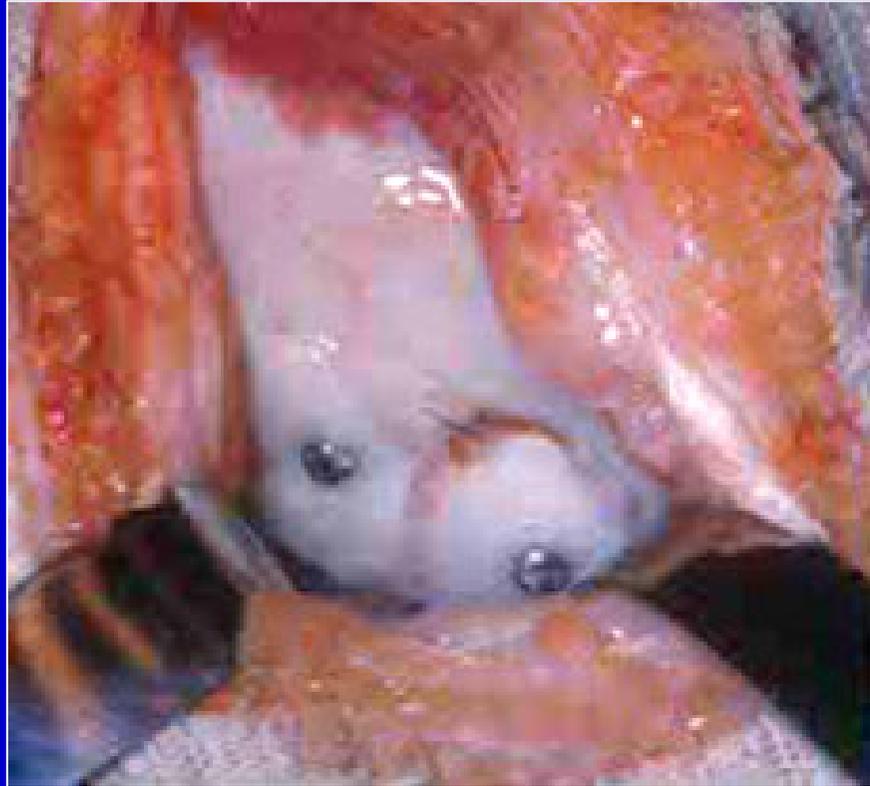
- La maggior parte delle osteocondriti guarisce normalmente
- Sorveglianza radiologica ed arresto delle attività sportive
- Trattamento chirurgico riservato ai frammenti mobili od ai casi ad evoluzione sfavorevole

A volte il frammento é distaccato e non reinseribile



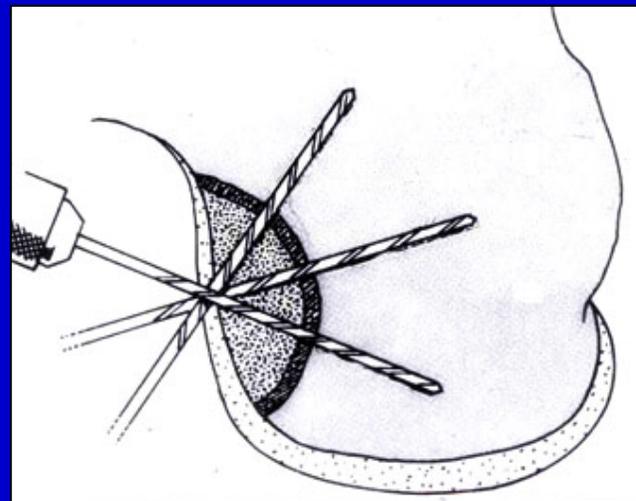
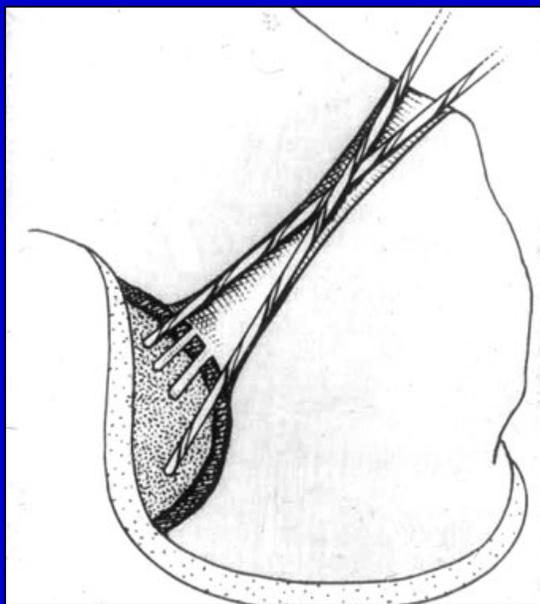
Perforazioni di Pridie nel fondo della nicchia per stimolare il riempimento con del tessuto fibro-cartilagineo

**Avvitamento del frammento osteo-cartilagineo dopo
ravvivamento della nicchia ± trapianto di osso nel
fondo**



**Risultati 18 anni più tardi, in
seguito ad un intervento
complementare.**

Trattamento chirurgico dell'osteocondrite dissecante con la cartilagine integra



**Si possono fare delle perforazioni attraverso il frammento
dall'esterno o dall'interno**

Si possono anche mettere dei fili per fissare il frammento (45 gg)

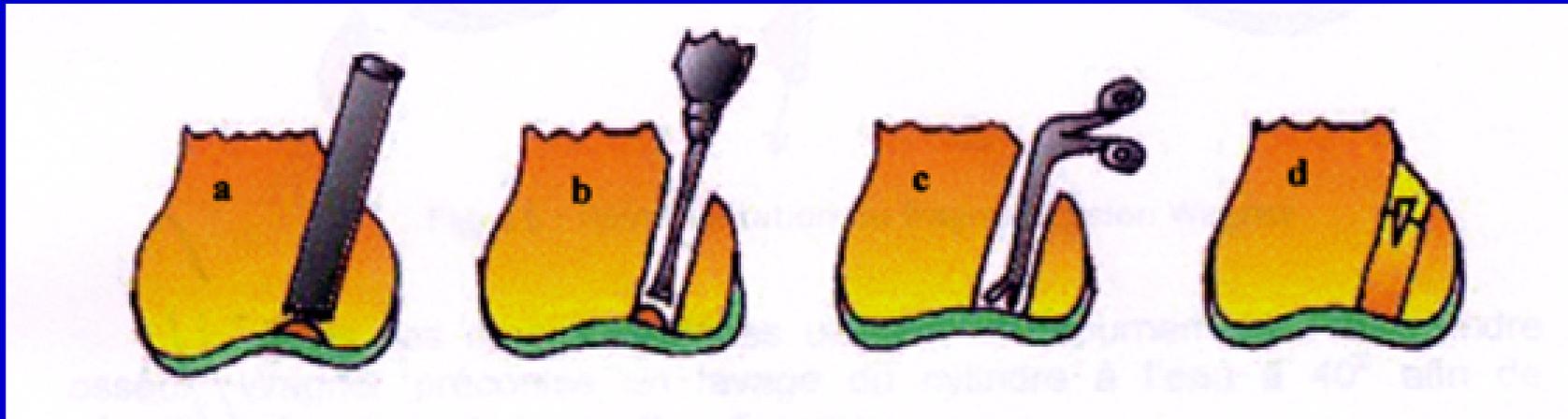
Tecnica di infibulamento dall'alto (Smillie)



Trattamento con perforazioni semplici. Risultati dopo 1 anno



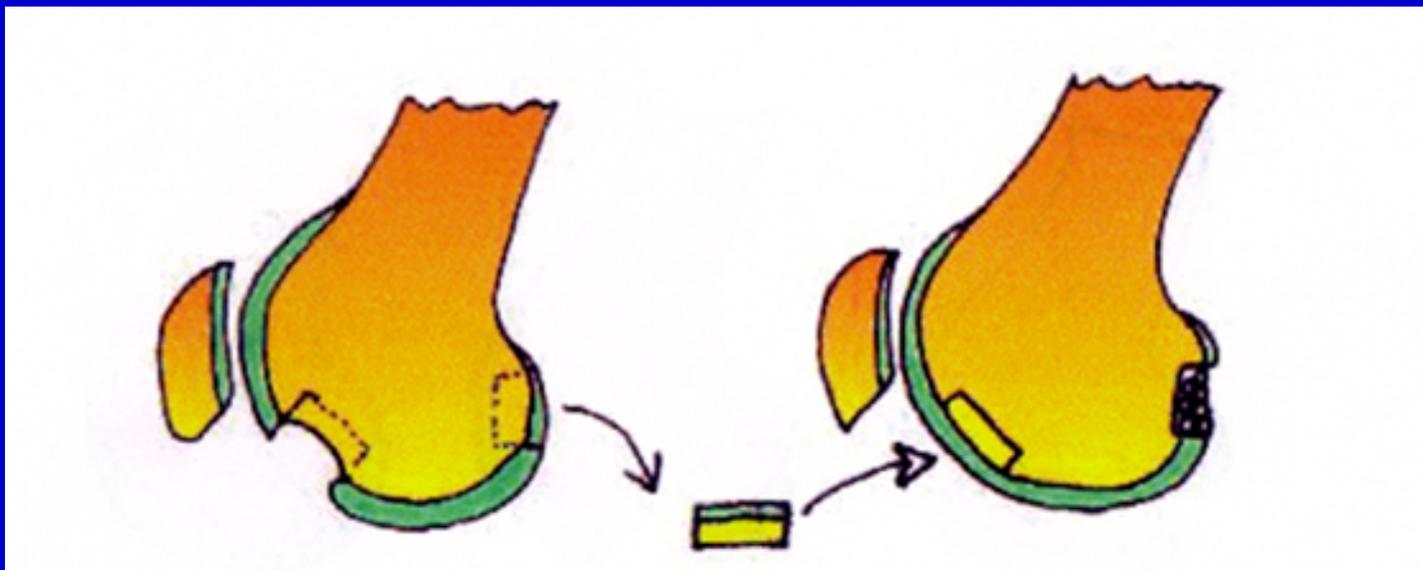
Perforazione dell'osso dall'alto risparmiando la cartilagine e trapianto osseo del tunnel (Wagner)



Perforazione dell'osso dall'alto risparmiando la cartilagine e trapianto osseo del tunnel (Wagner)

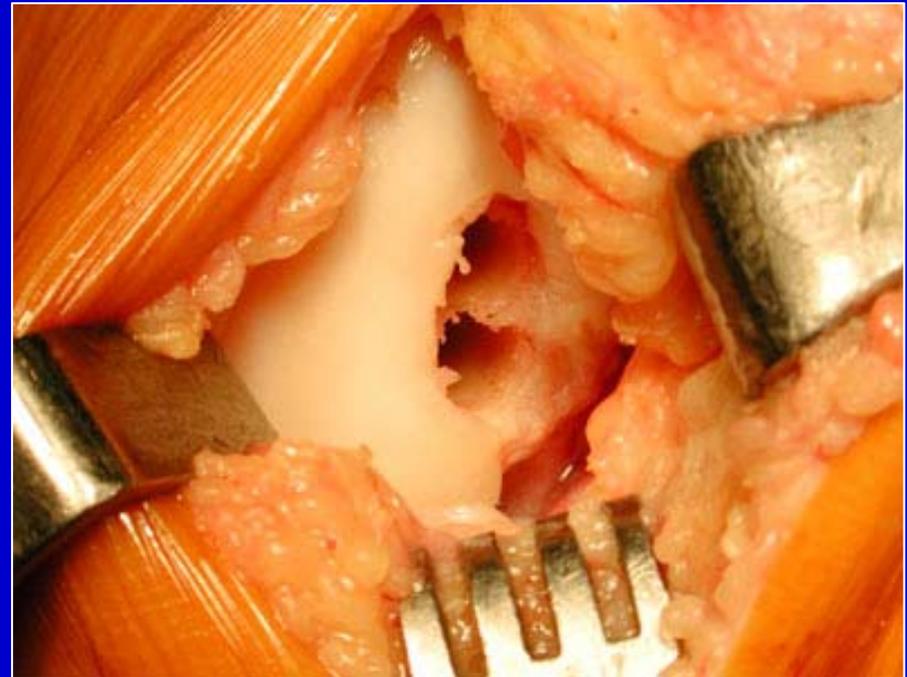


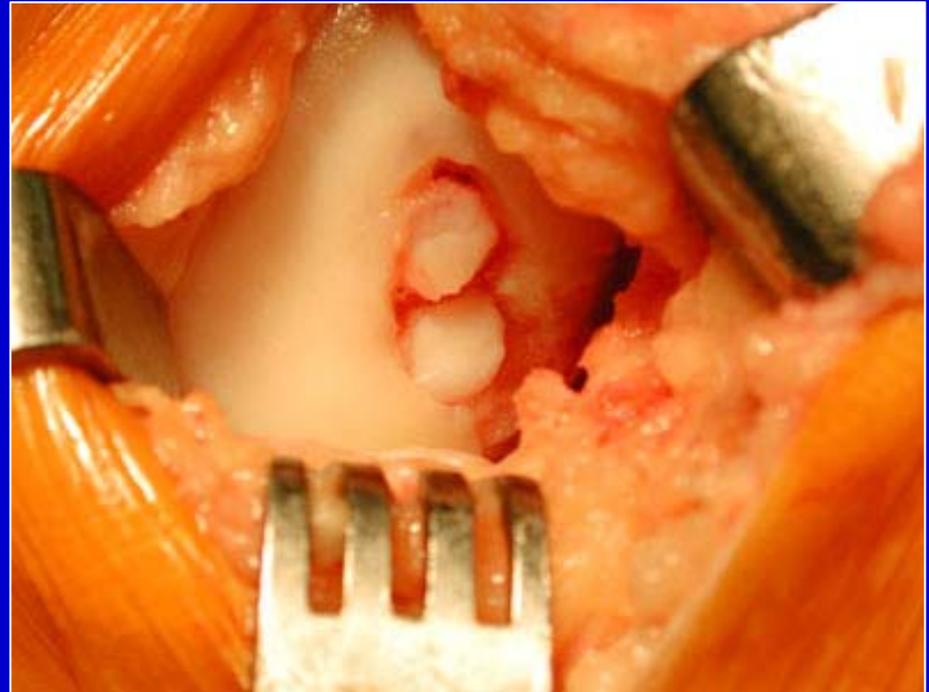
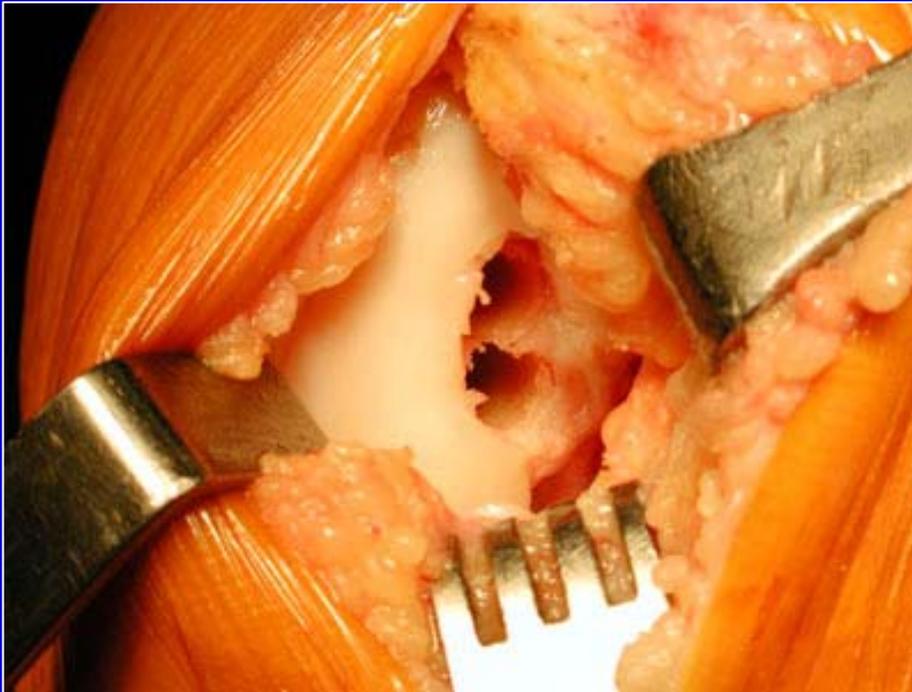
+ 2 anni



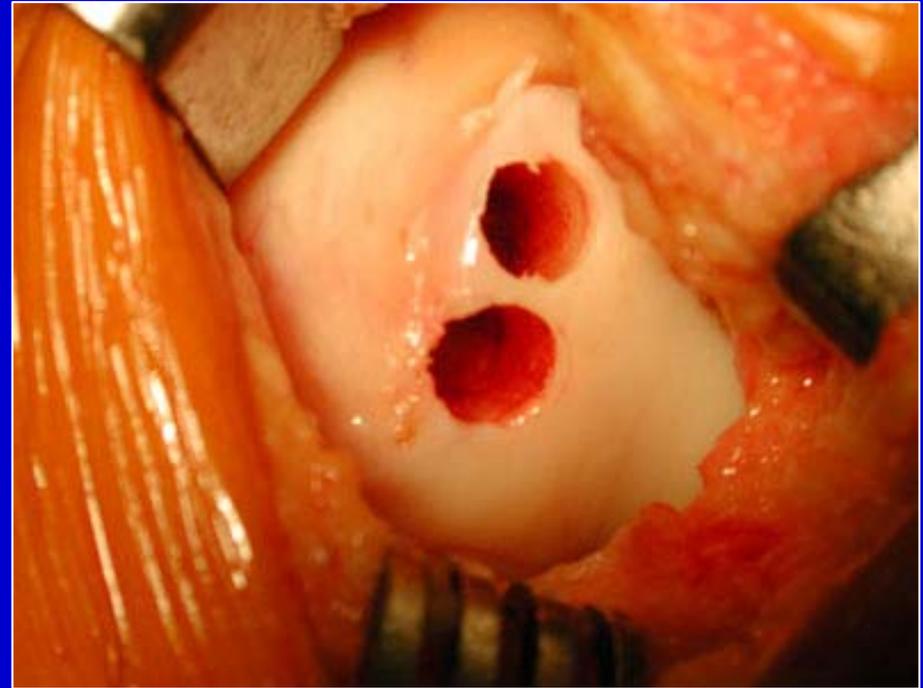
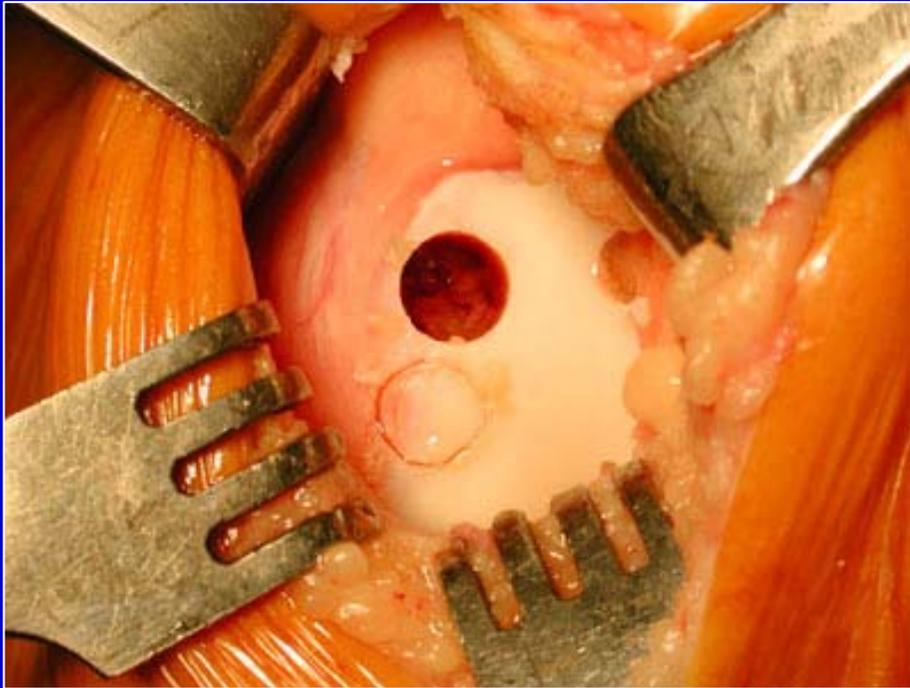
**Trapianto osteo-cartilagineo prelevato
dalla parte posteriore**

Trapianto a mosaico





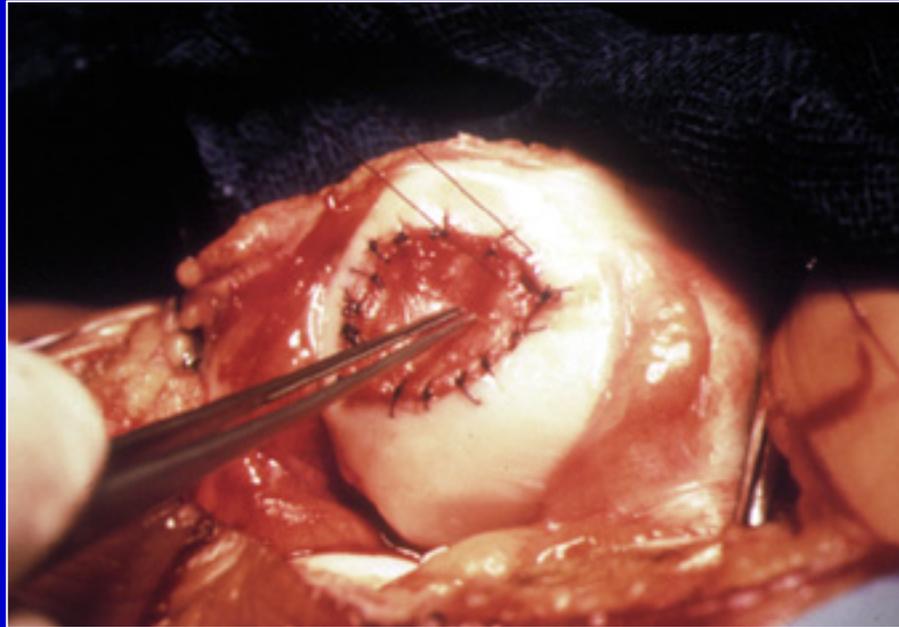
2 fori nella nicchia sono riempiti con 2 carote di tessuto osteo-cartilagineo



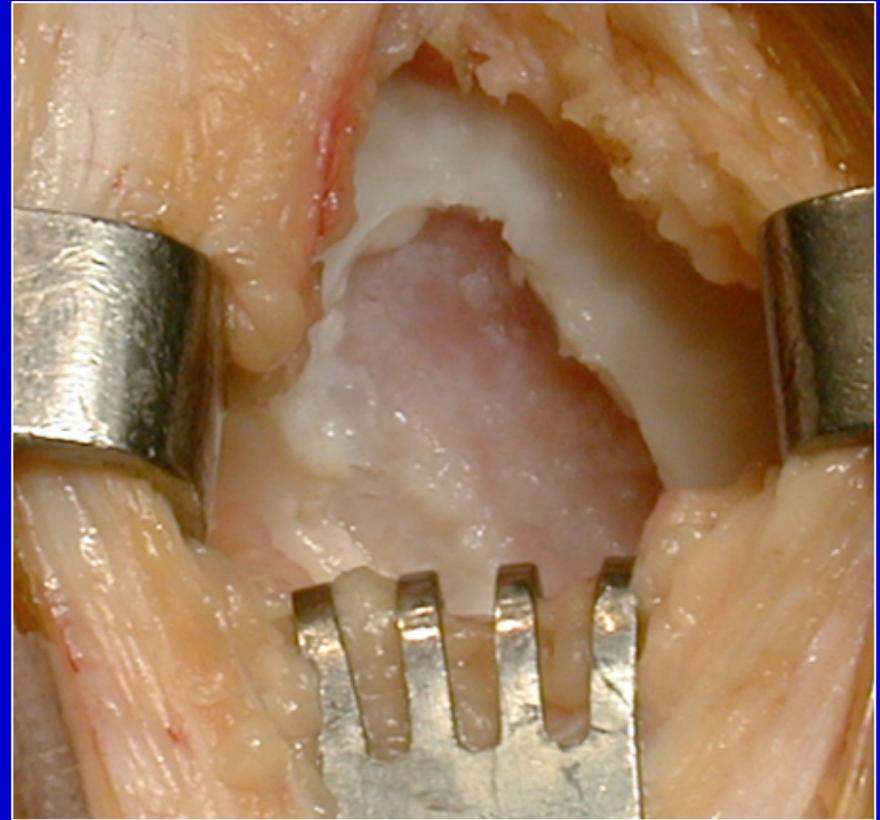
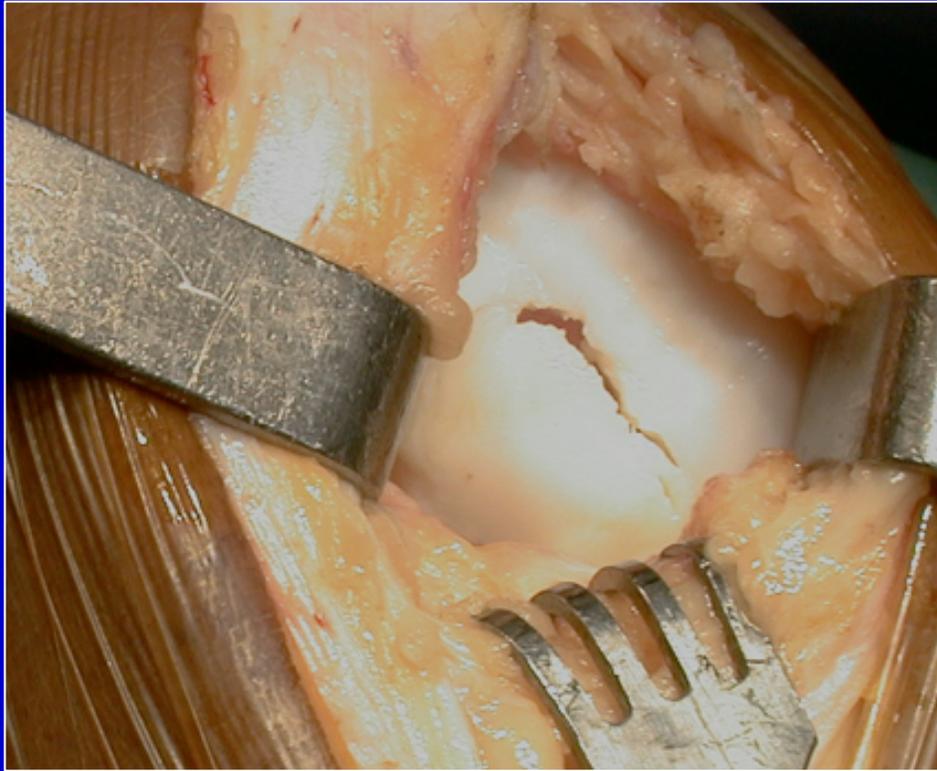
Prelievo dal bordo esterno della troclea



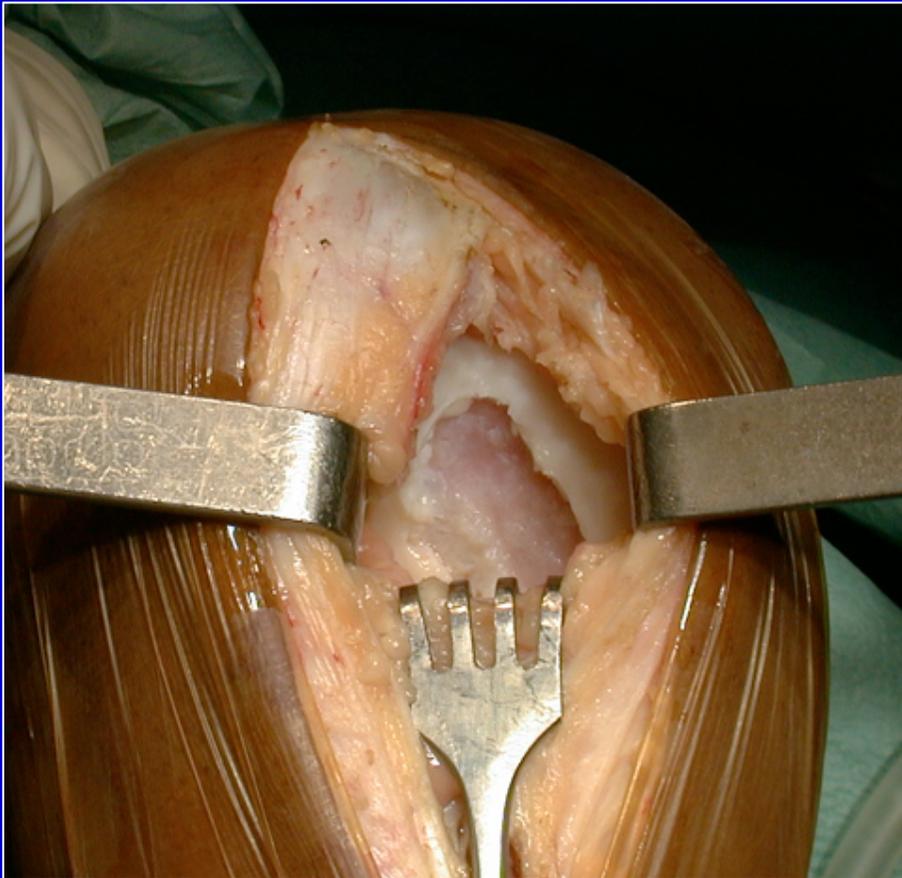
Trapianto di cartilagine



Autotrapianto di condrociti coltivati, disposti nella zona del difetto e coperti con un lembo di sinoviale o di periostio



Trapianto a mosaico







Dopo 1 anno

OSTEOCHONDROSES DE CROISSANCE

- Poly ostéochondrose des condyles fémoraux (localisations multiples)
- Ressemble à l'ostéochondrite disséquante
- Impacts répétés

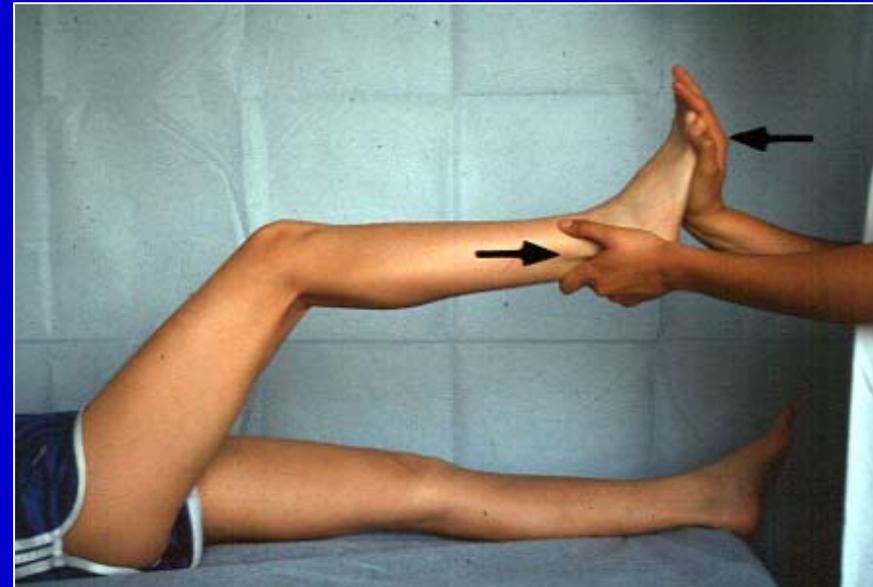
Pathogénie

- **Facteurs traumatiques**
- **Facteurs vasculaires**
- **Fragilité constitutionnelle**

Signes cliniques

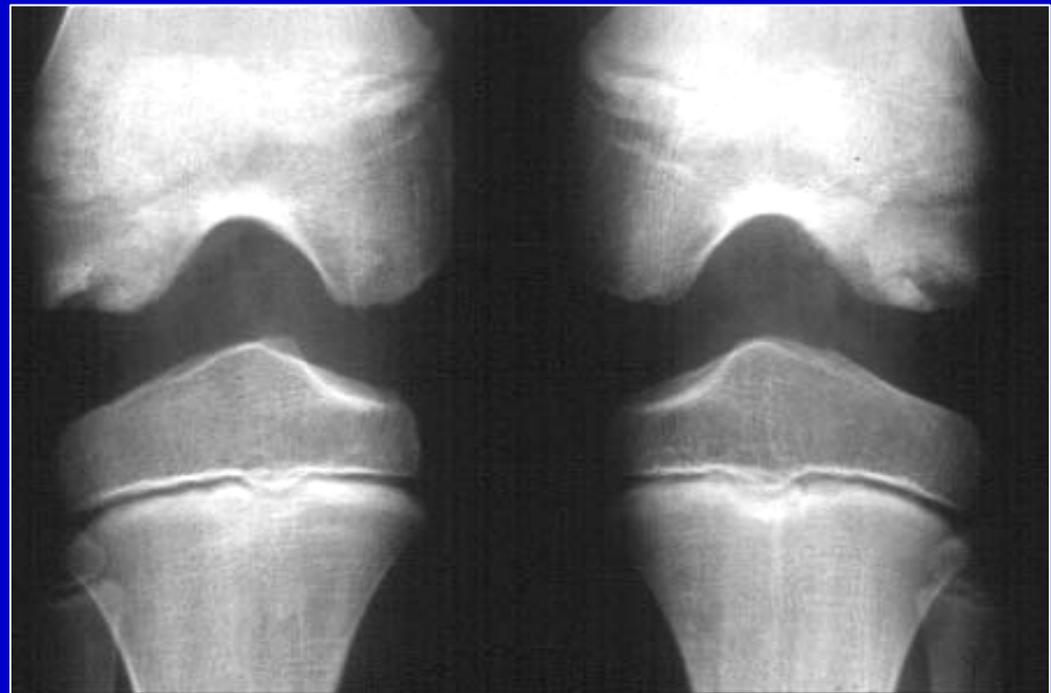
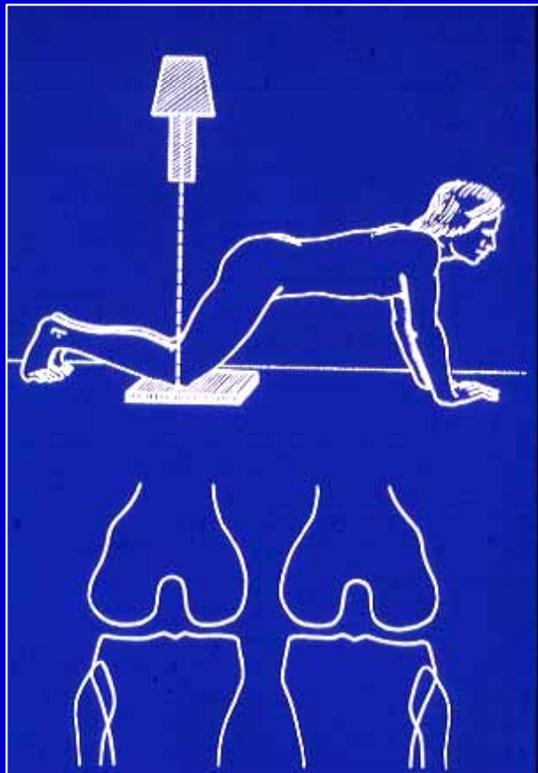


Douleur à la palpation
des condyles

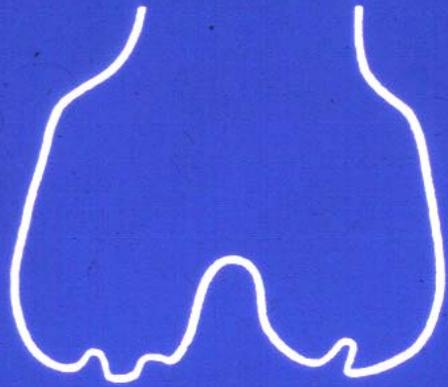


Douleur à l'extension
avec contre-appui

Poly ostéochondrose des condyles

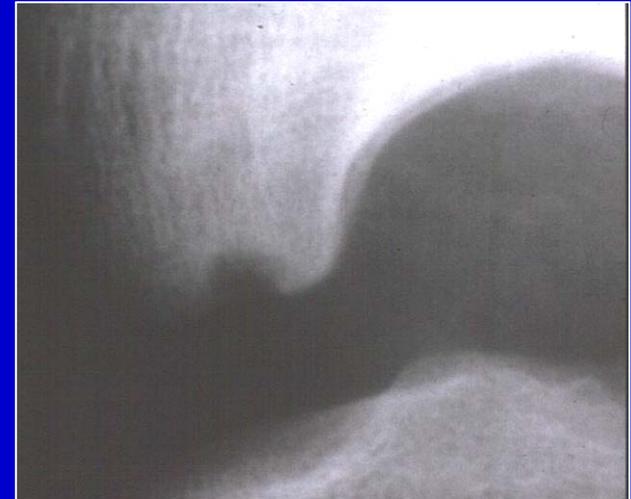


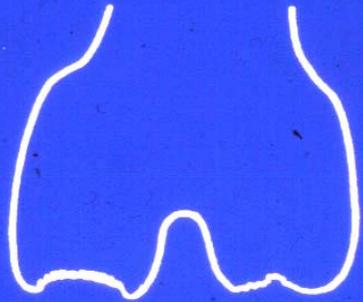
Incidence radiologique dite de l'échancrure intercondylienne



TYPE I :

lacune(s) simple(s)
de petite taille

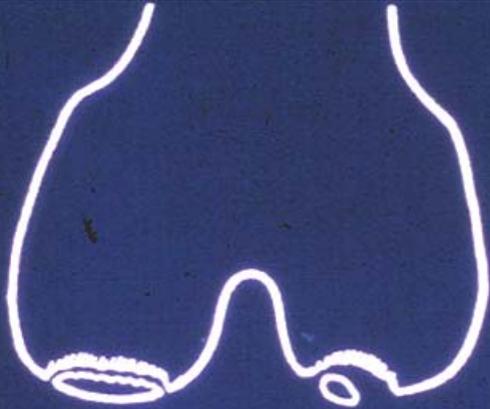




TYPE II

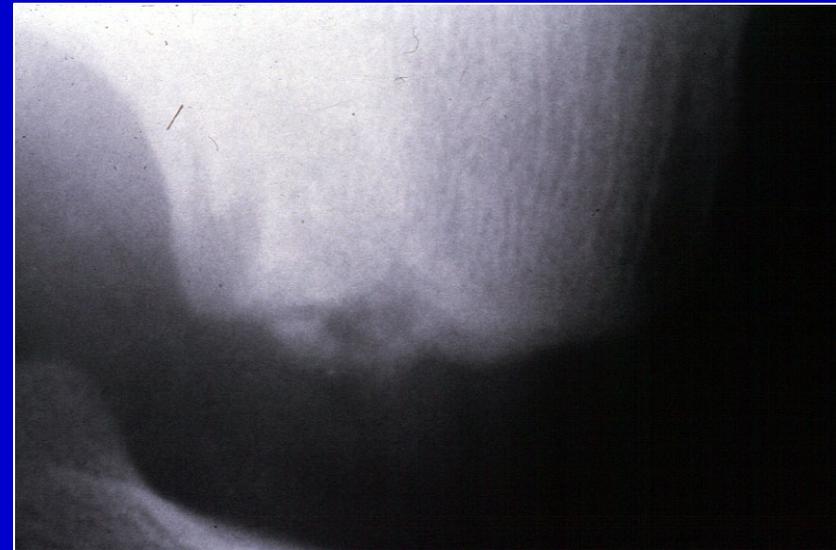
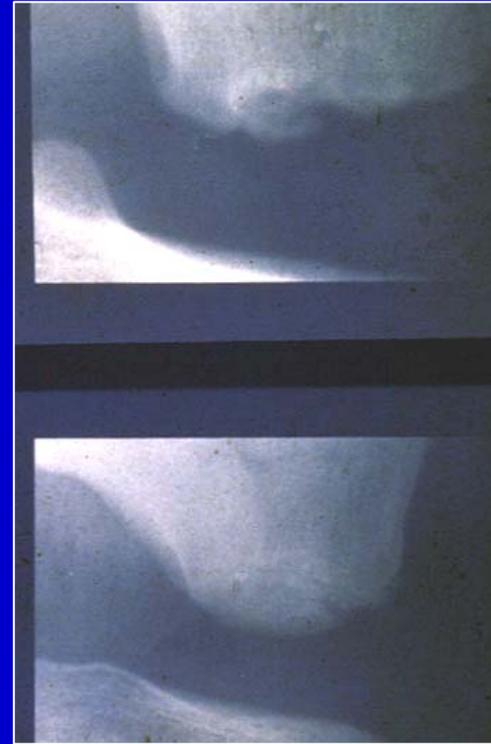
vaste lacune
irrégulière ou
cernée par un liseré
de condensation





TYPE III :

lacune identique au
type II, + comblée par
un noyau osseux
congruent ou incongruent



IRM : la lacune correspond à du cartilage non ossifié

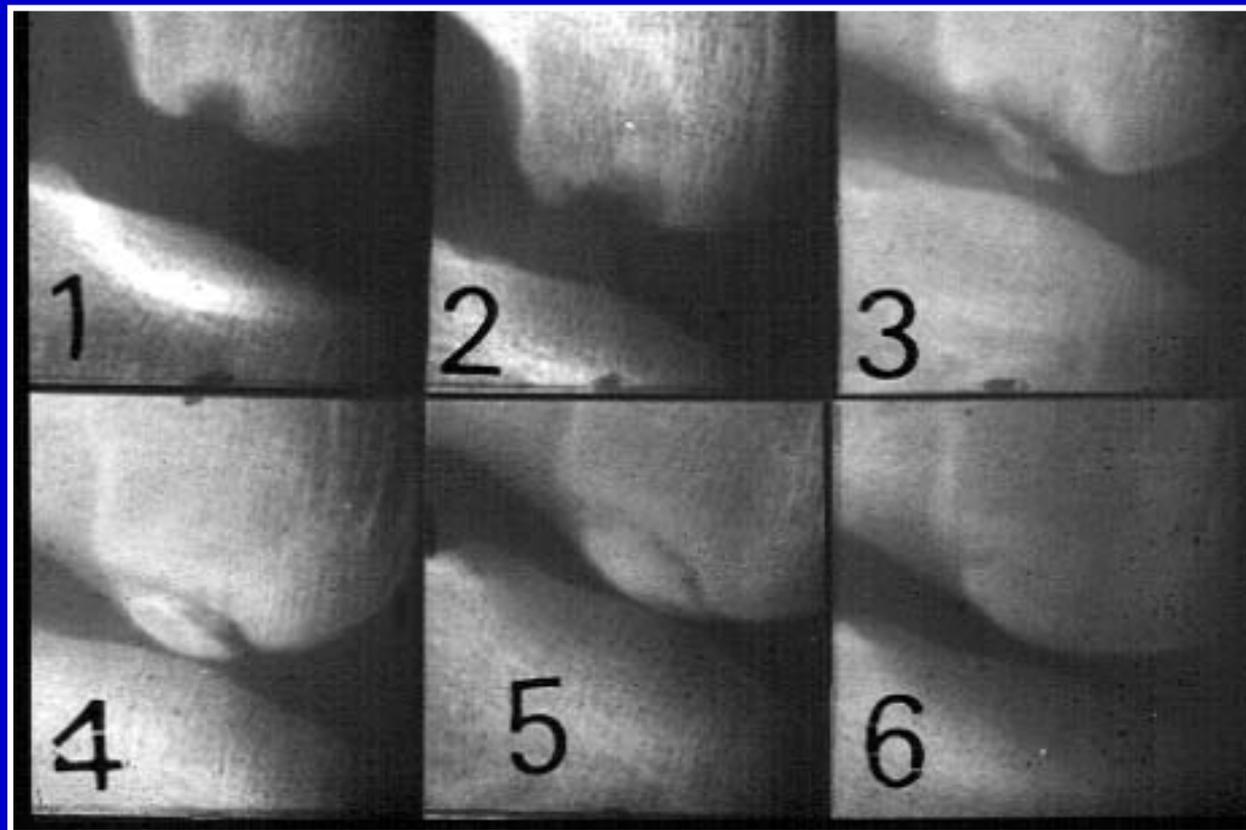


Evolution

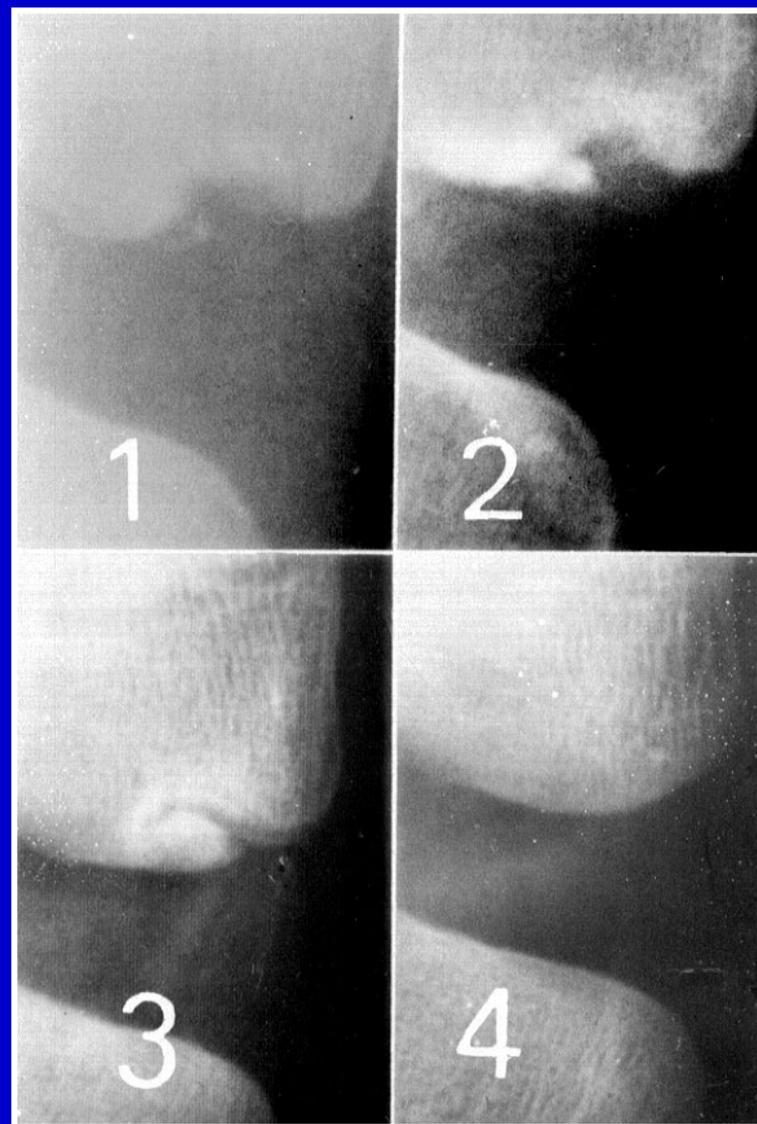
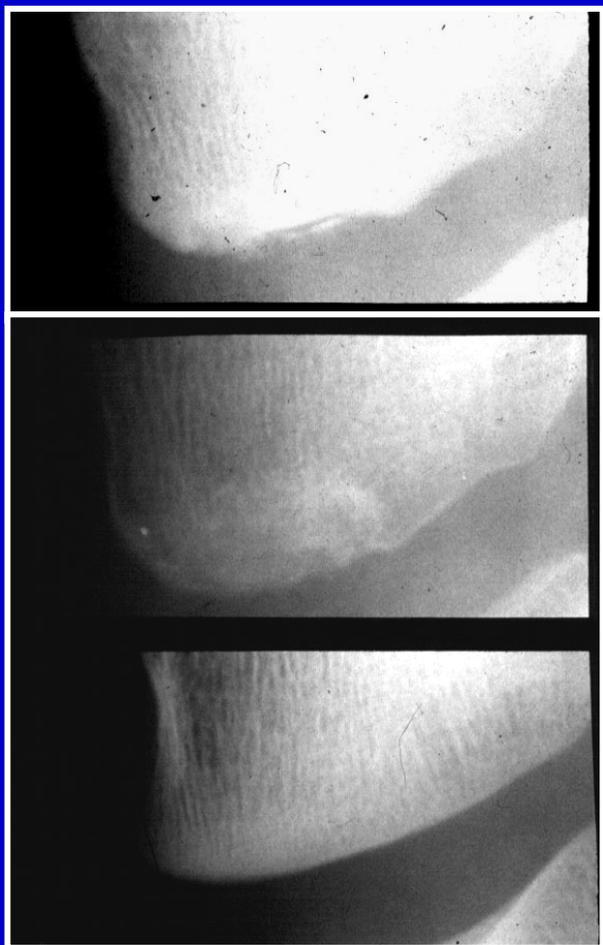
- 6 mois à 2 ans
- Plus courte en cas d'immobilisation
- Contrôles radiologiques réguliers
- Reprise des sports en décharge dès la disparition des signes cliniques

Evolution

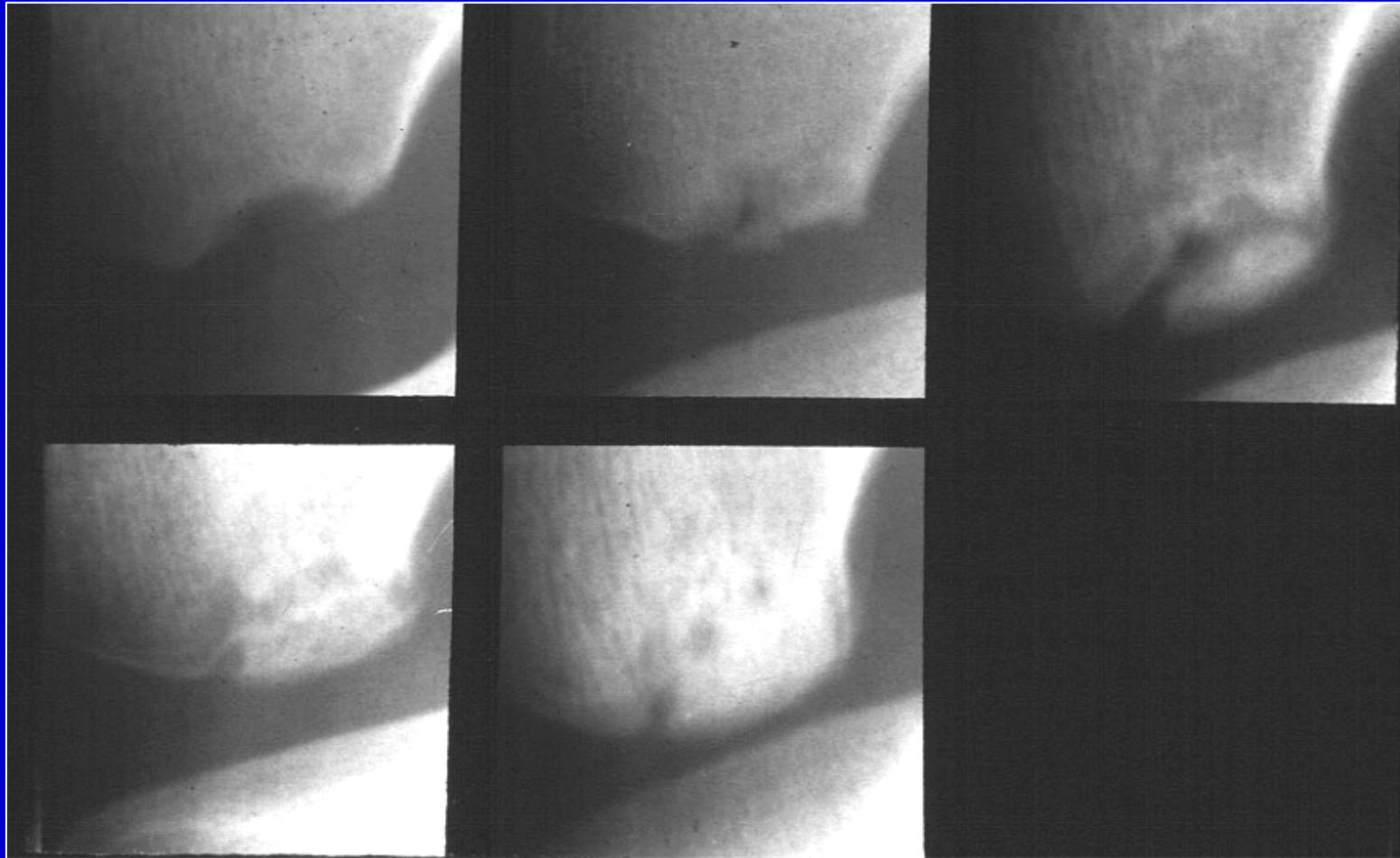
plusieurs modalités possibles



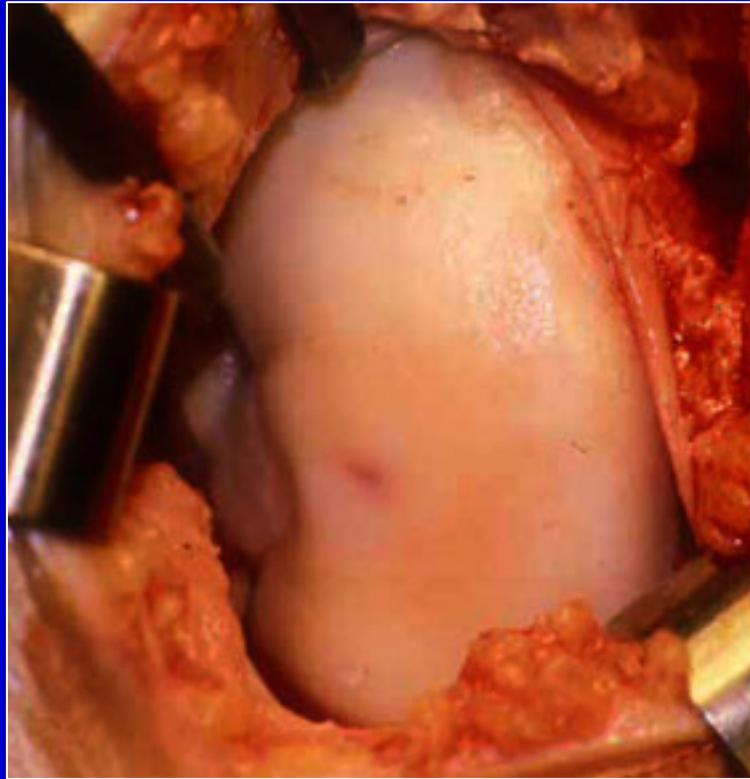
Evolution favorable



Guérison complète



Necrosi del condilo femorale nell'adulto

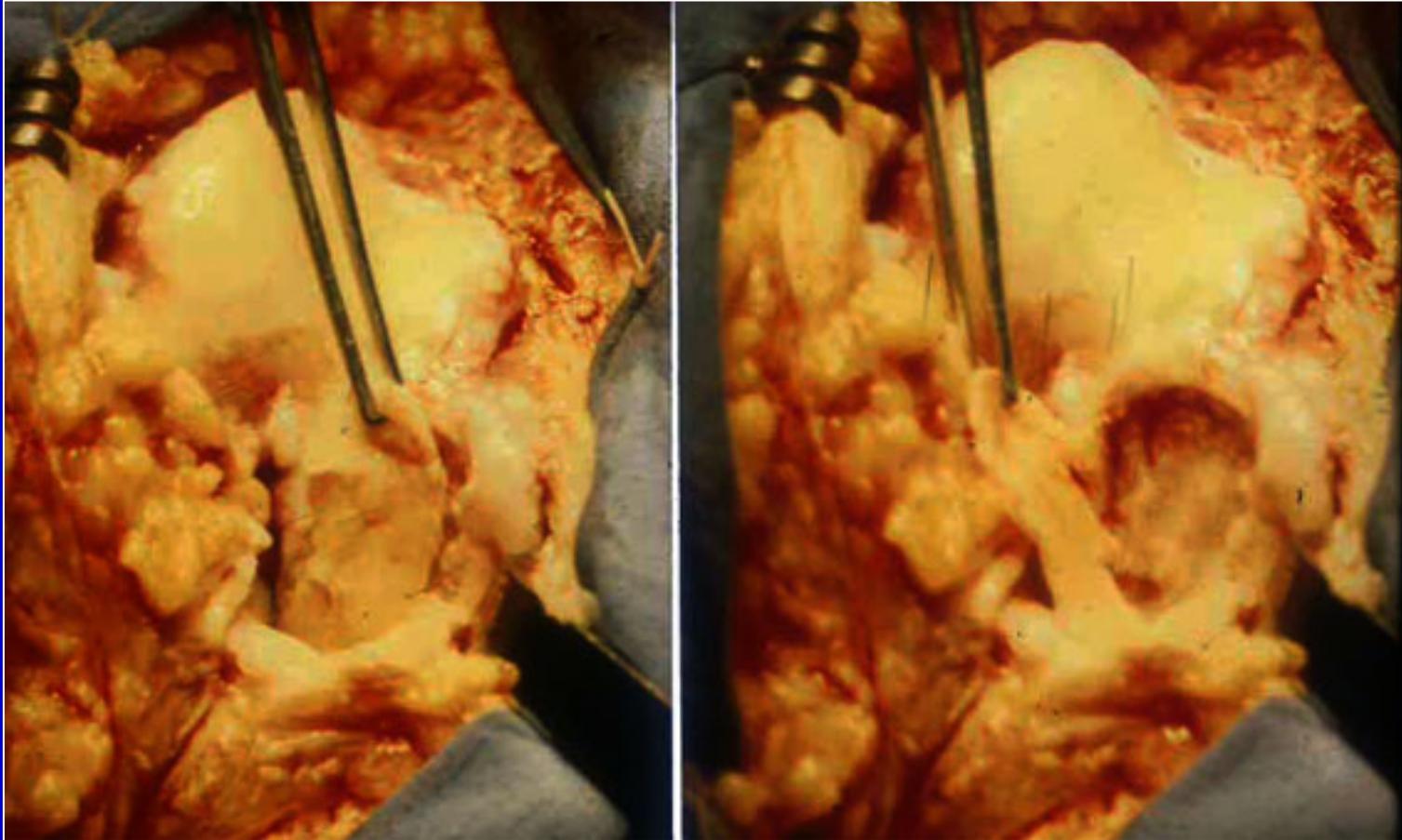


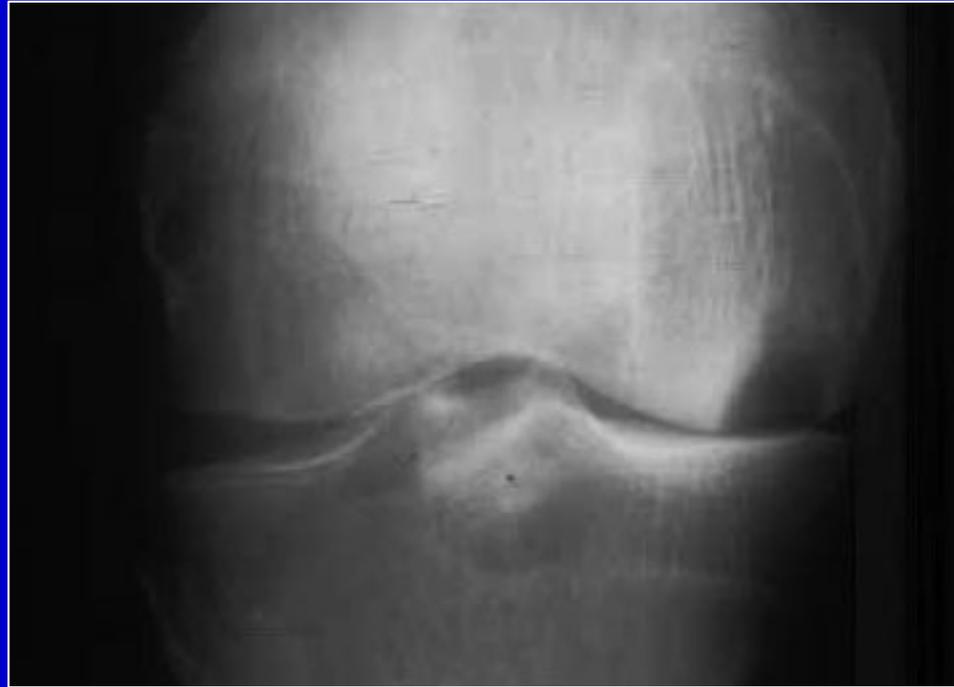
Aspetto all'inizio



**L'evoluzione é sempre verso l'affossamento
del condilo**

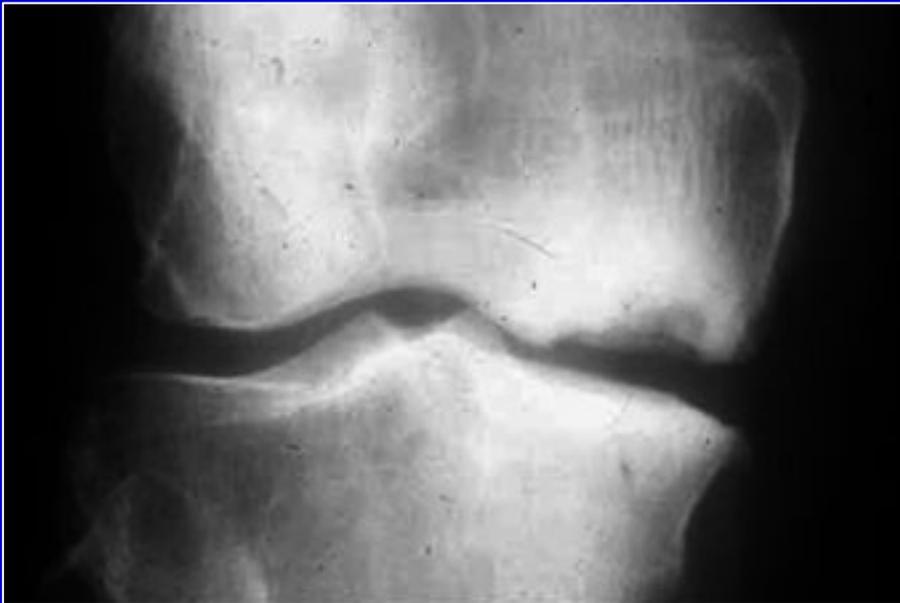
Necrosi del condilo interno





**La necrosi si accompagna in questo caso con
l'artrosi del compartimento interno**

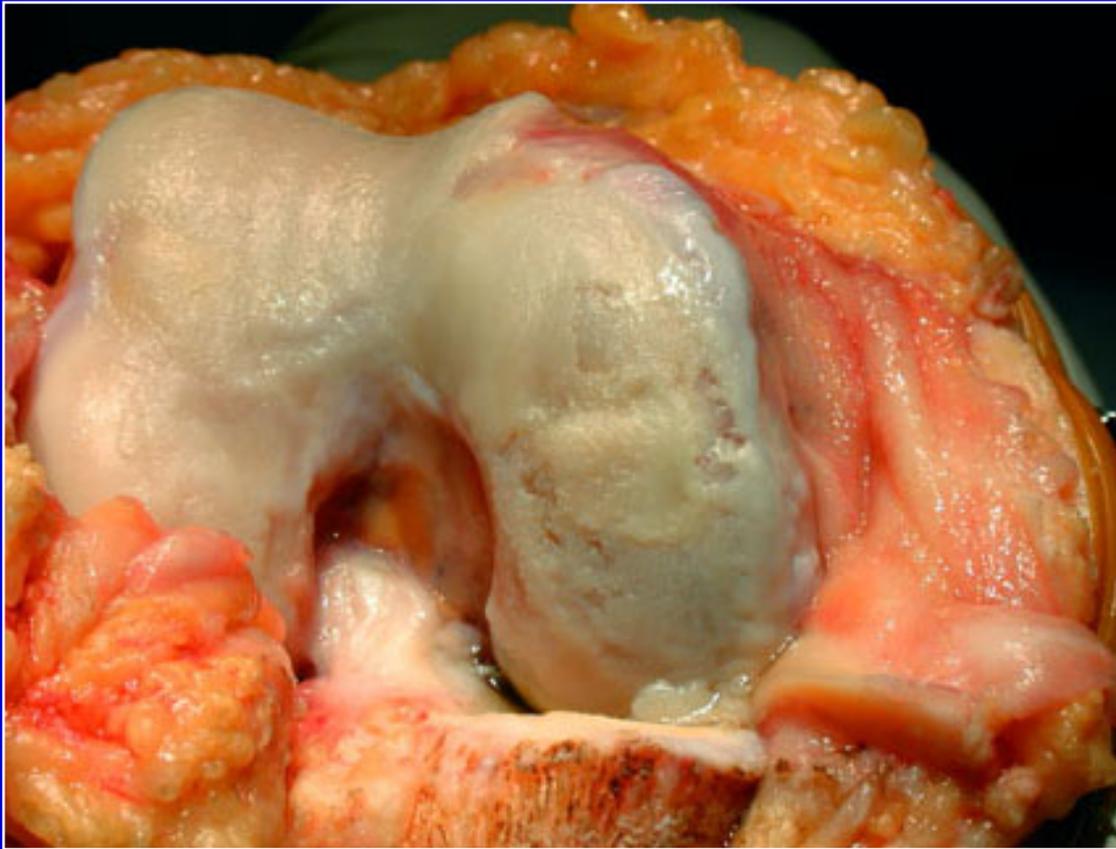
Tentativo di trattamento con delle perforazioni di Pridie associate ad una osteotomia di scarico



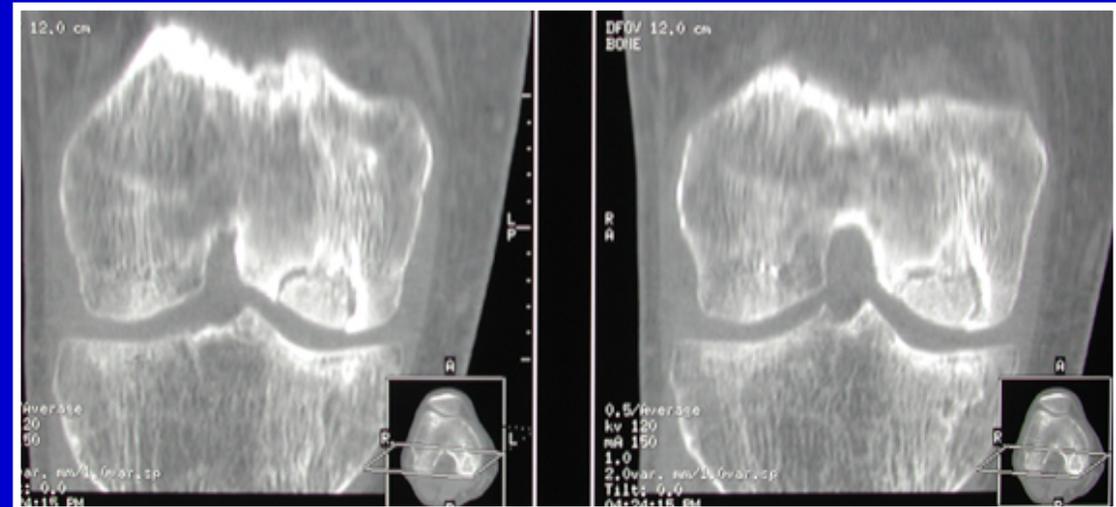
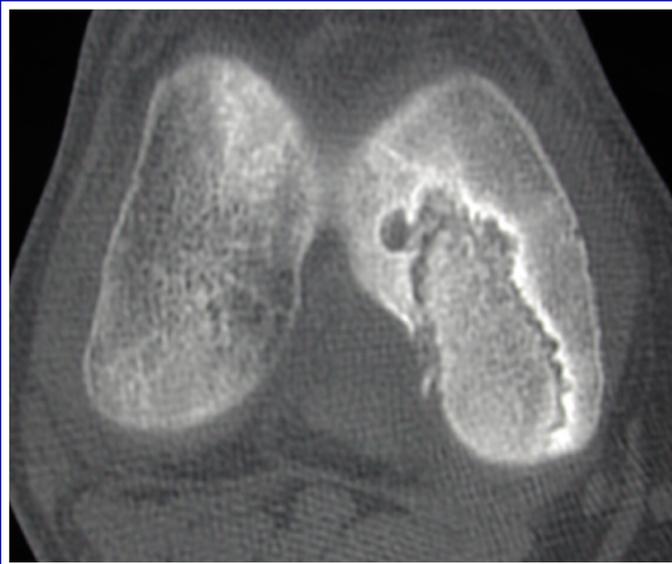
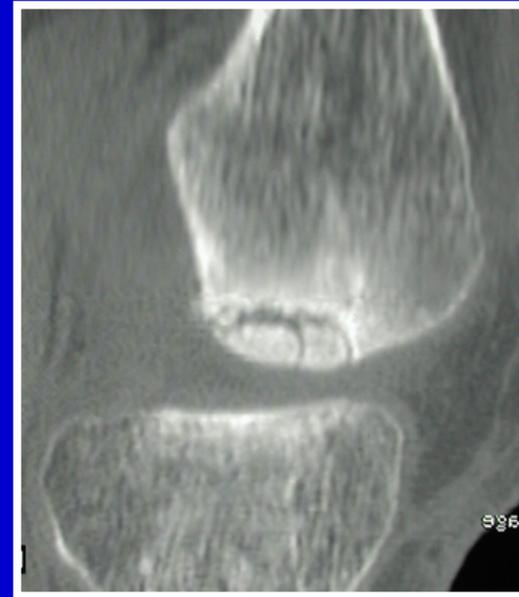
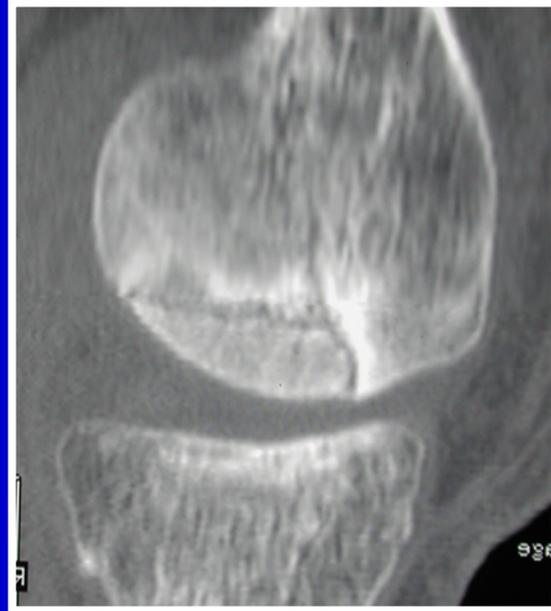
Adulto giovane

**Nei soggetti con più di 65 anni :
Protesi unicompartimentale o totale**

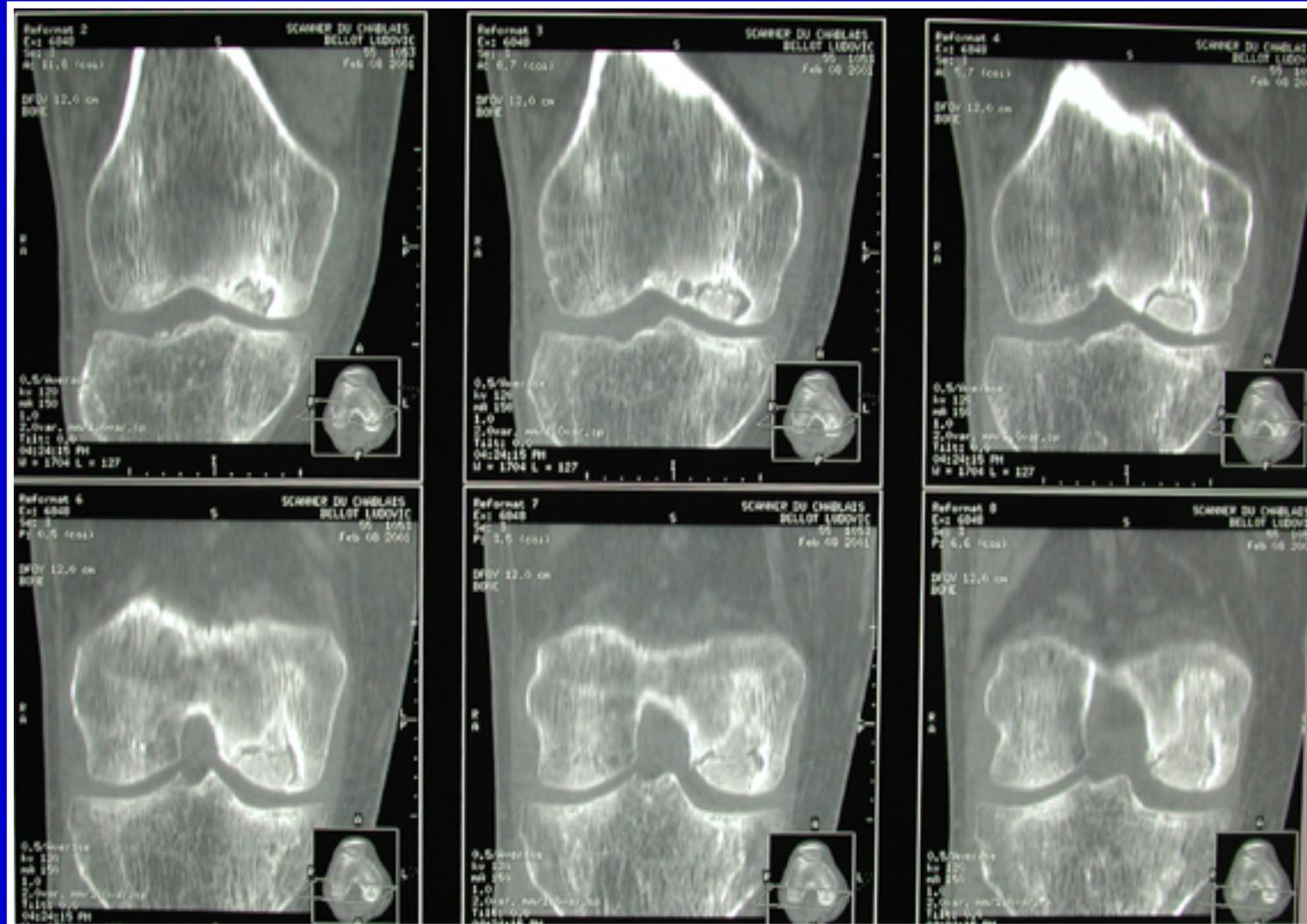


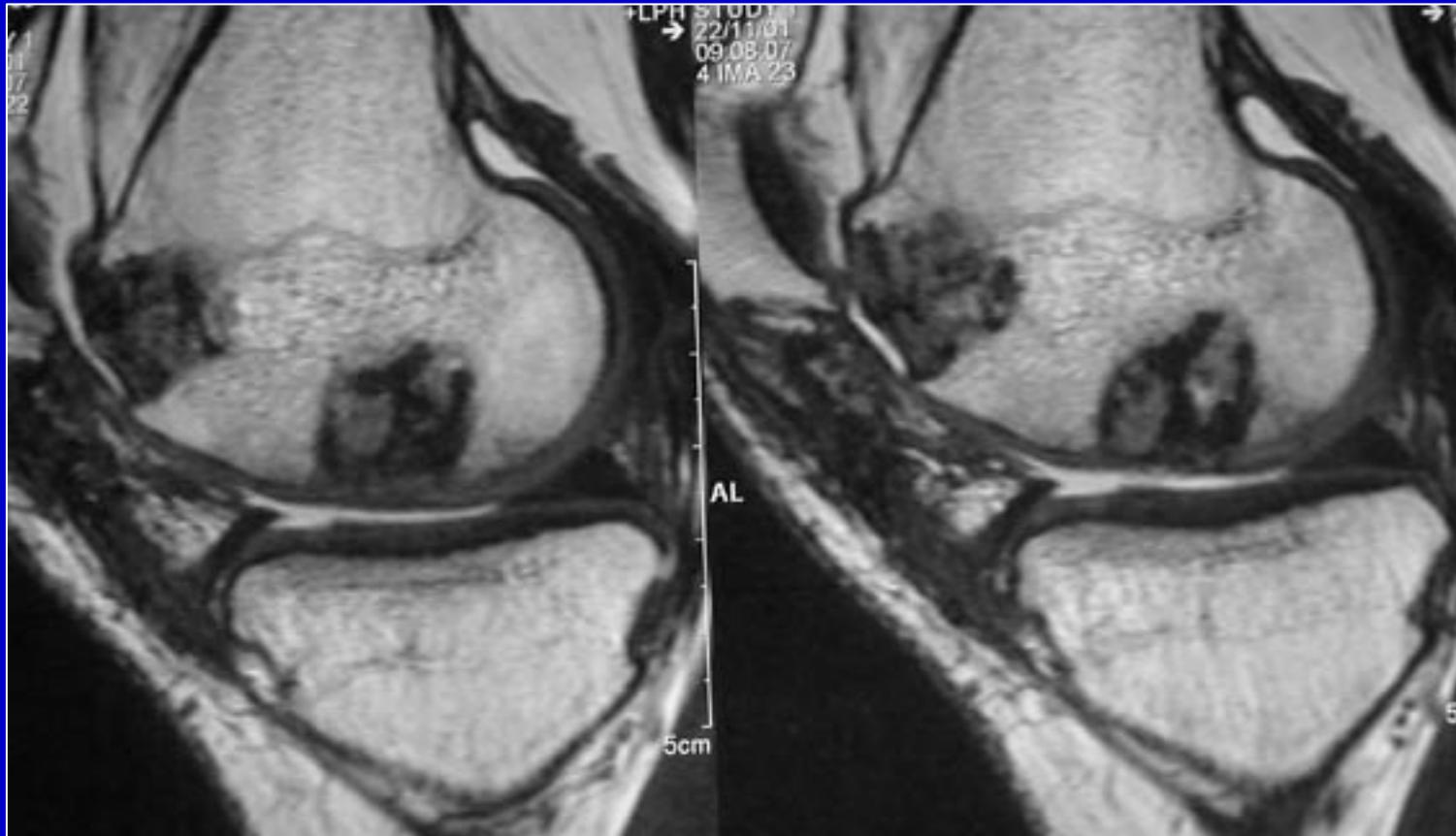


Necrosi del condilo femorale

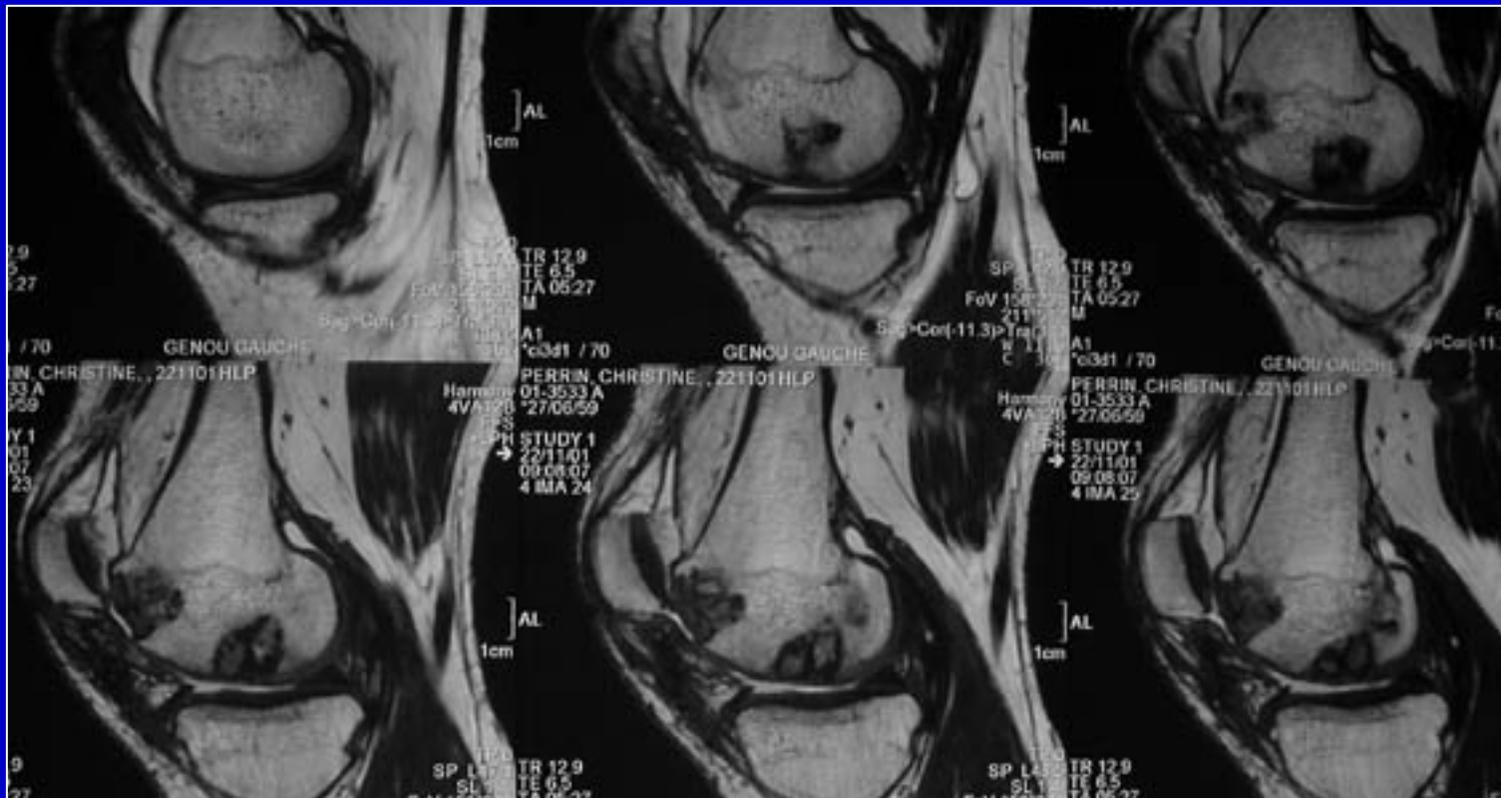


Necrosi del condilo femorale





**Necrosi del condilo femorale
Del.. Greffe en mosaïque**

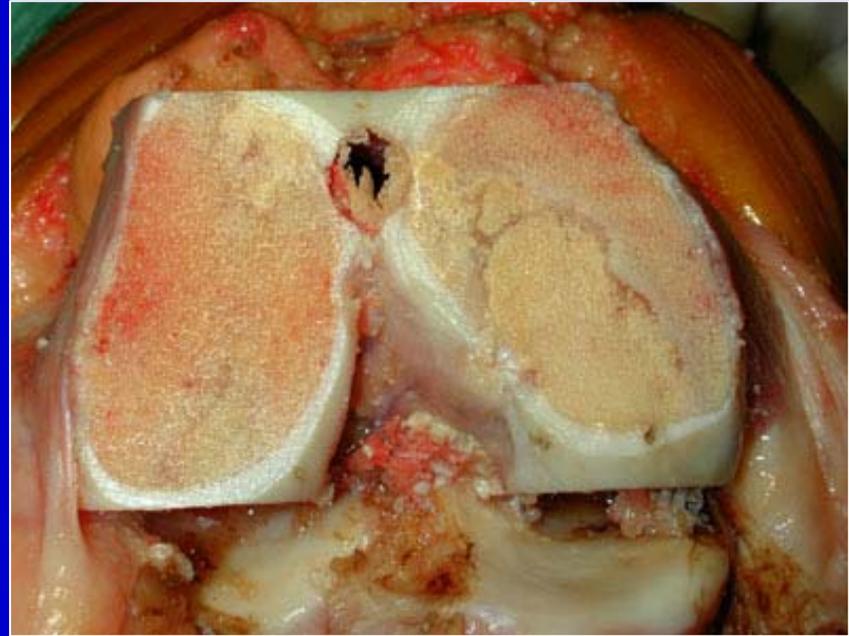


Trapianto a mosaico

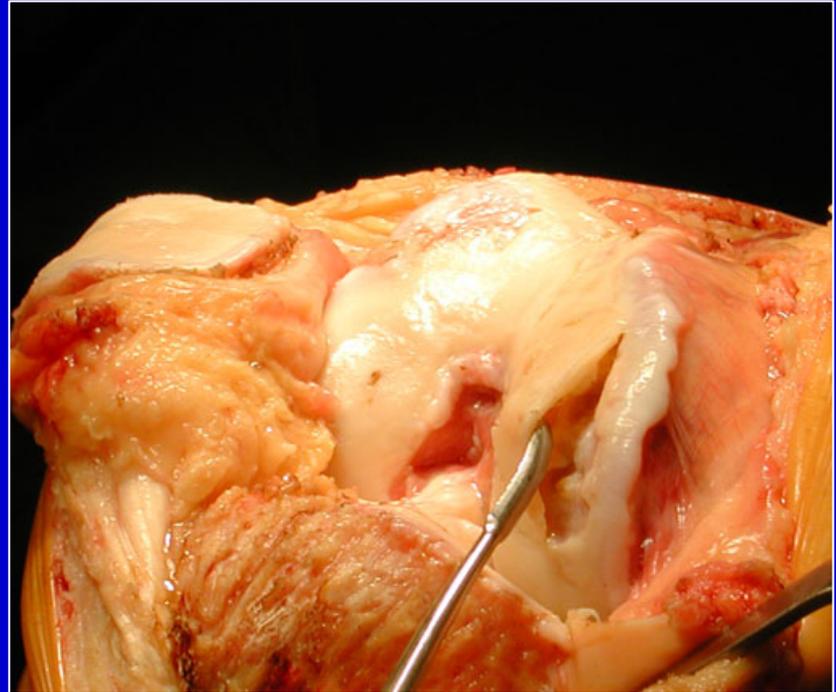
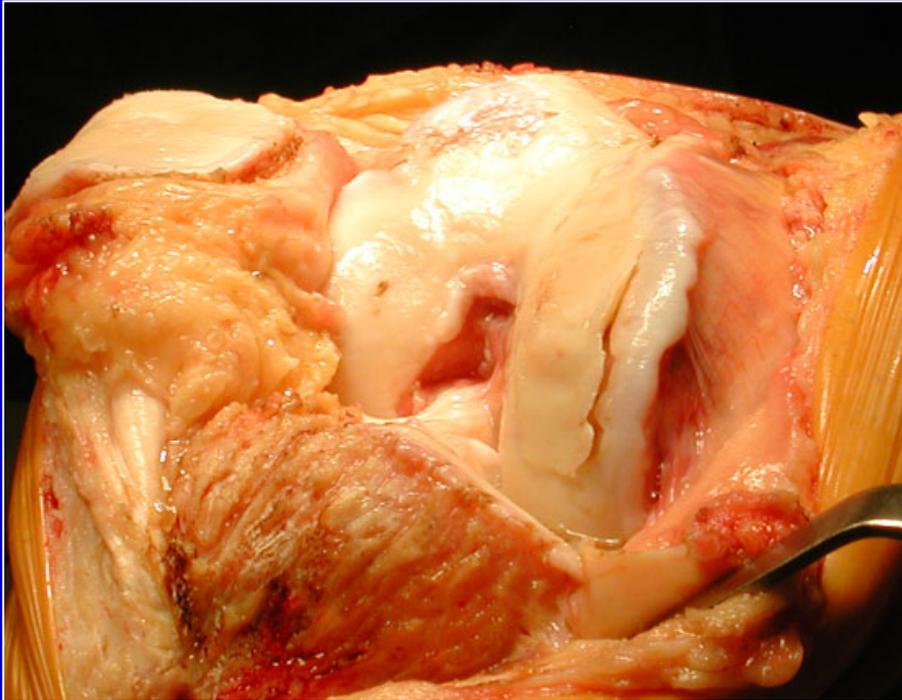
Necrosi del condilo femorale



Trapianto + Protesi







Necrosi del piatto tibiale esterno

