Isolated meniscus injuries in skeletally immature children and adolescents: state of the art

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ABSTRACT

The prevalence of isolated meniscal injuries in children and adolescents is low; however, we see an increase mainly due to intensified sports-related activities at an early age. A meniscal repair should be attempted whenever possible as children present with increased meniscal healing potential. The diagnosis and management of meniscal tears involve both patient factors and tear characteristics: size, anatomical location and associated injuries. Special attention should be given to the feature of discoid menisci and related tears as they require a specific management plan. This state-of-the-art review highlights the most recent studies on clinical evaluation, surgical techniques, tips and tricks, pitfalls, outcomes, return-to-sports, geographical differences and future perspectives related to meniscal injuries in children and adolescents.

INTRODUCTION

Meniscal injuries are less prevalent in children and adolescents than in adults. However, the increase in sports participation by the skeletally immature athlete has furthermore increased the incidence of meniscal injuries in this population. Those involve meniscal tears and symptomatic discoid menisci.

The meniscus plays a fundamental role in shock absorption, load distribution, knee stability, joint lubrication and knee congruity. Meniscal deficiency is known to compromise the future of the knee, leading to premature, progressive osteoarthritis (OA).1 2 Surgical meniscectomy can lead to the development of early degenerative changes of the knee, ligamentous laxity and pain over time, especially when the procedure is performed at a young age.3–5

Numerous studies have stressed the importance of “meniscus retain, repair or replace” through a meniscal scaffold or meniscal allograft transplantation (MAT) to maintain knee joint homeostasis.6–9 Whenever feasible, meniscus retention or repair is indicated to avoid the well-known deleterious effects of partial, subtotal, or total meniscectomy on the knee. Discoid lateral meniscus (DLM) is an abnormal congenital morphological anomaly of the knee characterised by a wide and thick meniscus that typically covers a larger area of the tibial plateau, and is easily prone to damage as a result.10–12 A symptomatic DLM is usually linked to a meniscal tear or an unstable discoid meniscus, and can be treated with partial meniscectomy, ‘normal reshaping’ of the discoid meniscus with meniscoplasty/saucerisation, removing the central part of the meniscus to restore its standard crescent shape and retaining up to 8 mm of peripheral rim, with or without meniscal repair.13–15

This state-of-the-art review aimed to provide an overview of the most important available evidence on meniscal injuries in children (below the age of puberty) and adolescents (the period from puberty to adulthood).

EPIDEMIOLOGY

The true prevalence of isolated meniscal injuries among skeletally immature children and adolescents is still unknown. Initially, meniscal injuries in children were thought to be extremely rare, especially under 10 years of age, unless associated with a discoid meniscus.16 Some authors suggest that the occurrence of an isolated meniscal injury is greater than previously thought, mainly due to increased sports participation at a younger age.12 13 A study on 1082 meniscal injuries in high school athletes reported an overall meniscal injury rate of 5.1 per 100 000 athletes and a 40.7 per 100 000 incidence in boys’ football and 23.2 per 100 000 in girls’ soccer.17 Stanitski et al.18 reported in their study that 70% of the 47 meniscal injuries in adolescents and children involved the medial meniscus. According to Mitchell et al.19 study of 1082 meniscal injuries in high school athletes, anterior cruciate ligament (ACL) injury is highly associated with meniscal injuries in 36.9% of the cases.20 The prevalence of meniscal tears in 124 skeletally immature patients who underwent ACL reconstructions was 69%, with the lateral meniscus being involved in the majority of cases.21 However, the prevalence of ACL-associated ramp lesions in children and adolescents is similar to that in adult populations (15%–24%).22

Discoid lateral meniscus has a prevalence that ranges from 0.4% to 20%, with higher prevalence in Asian children.9–14 21 22 The presence of a medial discoid meniscus is very rare: 0.07%–0.3% when compared with 1.2%–5.2% for the lateral discoid meniscus.14 23 Even more rare is to have ipsilateral lateral and medial discoid meniscus (figure 1). The prevalence of bilateral DLM is unknown due to its asymptomatic nature.24 The longitudinal type of tears accounts for 50%–90% of meniscal injuries in the young, while bucket-handle meniscal tears represent approximately 14% of all meniscal tears, mostly affecting the medial meniscus.24 25 According to Shieh et al.26 a retrospective study of 293 children and adolescents with meniscal tears who underwent arthroscopic surgery showed that patients with discoid tears had a lower mean age (12.7) than those with non-discoid tears (15.7).

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To cite: Vinagre G, Cruz F, Alkhelaifi K, et al. J ISAKOS Epub ahead of print: [please include Day Month Year]. doi:10.1136/jisakos-2020-000496

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EMBRYOLOGY AND ANATOMY

The menisci arise from mesenchymal tissue within the limb bud and are formed in the knee joint between the 8th and 10th week of embryonic life, being evident by week 8 and having a normal appearance by week 14 of embryological development. Blood supply arises from the periphery through the perimeniscal capillary plexus, being fully vascularised at birth, two-thirds peripheral by 9 months and then gradually decreases. Adult morphology is reached by the age of 10 years. Commonly, the peripheral rim is known as the ‘red–red’ (R-R) zone and the inner one-third as the ‘white–white’ zone. By adulthood, only the peripheral 10%–30% will receive blood supply. The inner two-thirds of the mature menisci receive nutrition by diffusion from the synovial fluid. Medial meniscus has a C-shape and covers approximately 50% of the medial tibial plateau while the lateral meniscus is more circular and covers approximately 70% of the lateral tibial plateau. The inner structure of the meniscus consists of mostly type I collagen fibres arranged in a circumferential pattern parallel to its long axis. Radial, oblique and vertically oriented fibres help the circumferential fibres to reduce the (hoop) stresses.

A discoid meniscus is an abnormal congenital morphological anomaly: it is thicker, has less vascularity, has a ‘disc’ shape instead of a normal ‘semilunar’ shape and covers more tibial plateau. The histology and ultrastructure of the discoid meniscus are different from those of a normal meniscus. In the discoid meniscus, there are decreased collagen fibres and the presence of irregularly oriented collagen fibres. Intrameniscal mucoid degeneration is common, and mucoid material has been found. The precise aetiology of a discoid meniscus is unknown, although some authors suggested that it is congenital, with a genetic or familiar predisposition for the development of discoid menisci. According to Aydın Kabakçı et al on human fetal cadavers, a fetal lateral meniscus classification was described, leading to a better understanding of the morphological development of fetal meniscal development.

The Watanabe classification describes three types of DLM based on their shape and tibial attachments.

MECHANISM OF INJURY

Traumatic meniscus tears in children and adolescents have a clinical presentation similar to those in adults but are highly associated with ACL injuries. Most of non-discoid meniscal injuries (80%–90%) occur during sports events. The mechanism of injury is a sudden twist of flexed knee with the foot planted during cutting and pivoting sports activities such as soccer, American football, basketball, skiing or wrestling. We did not find any report describing a specific mechanism of injury for discoid meniscal tears, as the true natural history of discoid menisci is still thought to be unknown.

RISK FACTORS AND ASSOCIATED CONDITIONS

Box 1 presents known risk factors and associated conditions related to meniscal injuries in children and adolescents.

DIAGNOSIS

Clinical assessment and physical examination

Young patient population with a meniscal injury present with activity-related pain, especially with twisting movements, as the predominant complaint. Additional symptoms, such as snapping, intermittent catching, locking or instability (‘giving way’ feeling) may be present and depend on the type of tear and injury characteristics. Further signs can be observed: quadriceps atrophy, flexed stance, swelling or haemarthrosis.

Although traumatic meniscal tears in children and adolescents present in a similar manner as in adults, they are more commonly associated with ACL tears, whether the ACL injury is acute or chronic. If there is suspicion of an ACL injury, meniscal injuries should be ruled out.

Findings on the physical examination of the patient include joint line tenderness, swelling, effusion and positive
meniscus-specific tests, such as McMurray, Apley or Thessaly tests. Examining a child's knee could be more challenging due to less cooperation and the patient's pain and anxiety.

The clinical presentation of discoid menisci varies, depending on the age, stability and presence or absence of meniscal tears. Discoid menisci can be asymptomatic if stable (type 1, complete, and type 2, incomplete) and become symptomatic if a tear occurs. Symptoms of a torn or unstable discoid meniscus (type 3) include pain, instability (type 3), popping and snapping ('snapping knee syndrome'—heard and felt), lack of terminal extension (inability to achieve full knee extension) and positive McMurray test, frequently with a loud click or snap that is heard and felt. These symptoms and signs are generally intermittent and frequently occur spontaneously. A lateral joint line bulge with full flexion may be present in an unstable subluxated lateral discoid meniscus (type 3).

It is important to perform a detailed physical exam of the affected and unaffected knee and to obtain appropriate imaging studies. Alternative conditions should be considered as part of the differential diagnosis, such as ACL tear, osteochondritis dissecans, patellar dislocation or subluxation, pathological plica, loose bodies, and osteochondral or physeal fractures.

### Imaging studies

Initial radiographic evaluation is indicated in skeletally immature patients with suspected meniscus injuries to rule out the aforementioned conditions. Radiographs are often normal in patients with a discoid meniscus; however, they may reveal indirect radiological signs, such as widening of the joint space up to 11 mm (figure 4A), flattening of the femoral condyle and presence of other related conditions as described in box 1.

MRI is useful in detecting the presence of a meniscal tear (figure 5) or is performed as part of preoperative evaluation. MRI has a lower sensitivity and specificity for detecting of meniscal injuries in the young population. A child's meniscus has high meniscal vascularity, causing signs of intrameniscal enhancement on MRI, and can consequently present as a meniscal tear leading to false positives. Furthermore, according to Bouju et al, MRI overestimates medial and underestimates lateral meniscal lesions when compared with diagnostic arthroscopy (figure 6). Discoid meniscus can be diagnosed by MRI when three or more consecutive sagittal sections (5 mm-thick slices) demonstrate a continuity of the meniscus between the anterior and posterior horns (bow-tie sign) (figure 4B). MRI can also be used to evaluate meniscal integrity, stability, residual healing and anatomy after discoid meniscal surgery. Furthermore, discoid meniscal instability signs include meniscal shift, meniscal megahorn, 'pseudo-bucket-handle tear', 'too much meniscus' sign, 'crimped meniscus' sign (thickened, displaced, unstable lateral discoid meniscus on the sagittal view) (figure 5A) and parameniscal oedema.

### General Treatment Concepts

The treatment of meniscal tear injuries in children and adolescents usually follows the same principles as the one in the adult population, with a specific focus on meniscal repair. There are four different treatment options according to the ‘4 Rs’ proposal: "retain" (conservative), "resect" (meniscectomy), "repair" or "remove" (meniscal detaching and excision). The success of conservative treatment is often more difficult to determine in children, as the symptoms are often not as evident as in adults. The main reason for meniscal repair is to maintain the normal anatomy and function of the knee joint. However, the risk of meniscal repair is higher in children due to the growth plate and the surrounding cartilage. Therefore, it is important to weigh the benefits and risks of meniscal repair carefully before proceeding with the procedure. If the meniscal repair fails, the next option is to perform a meniscectomy. Meniscectomy is a surgical procedure that involves the removal of a meniscus from the knee joint. This procedure is usually performed when the meniscus is severely damaged and cannot be repaired. Meniscectomy is a relatively simple procedure that can be performed using a variety of techniques. The most common technique is the arthroscopic meniscectomy, which involves the use of a small camera and instruments to perform the procedure. The arthroscopic meniscectomy is usually performed on an outpatient basis and can be performed on both partial and total meniscectomy.
"replace" (meniscal scaffold or MAT). These four treatment indications are explained in Table 1.

In paediatric patients, the majority of meniscal tears are large and symptomatic, usually requiring surgical treatment. In case of conservative treatment, pivoting sports activities should be avoided for 12 weeks. We do not recommend treatment of asymptomatic incidental meniscus tears/discoid meniscus or to do ‘prophylactic’ saucerisation before the onset of symptoms. However, observation of those findings is highly recommended, especially in this type of population.

TYpes of tears, treatment and outcomes

The pattern of meniscal tears in children tends to present as a longitudinal peripheral or bucket handle in the R- meniscal zone.

The reported outcome of total or subtotal meniscectomy in the paediatric population is poor and leads to early arthrosis at a faster pace compared with adults.

Manzione et al. analysed the long-term results of 20 children and adolescents treated with partial or total meniscectomy, with an average 5.5-year follow-up. They found that 75% of patients were still symptomatic; 80% had radiographic changes consistent with early OA; and 60% were dissatisfied with the postsurgical outcome.

Box 2 Essential typical features of diagnostic evaluation and surgical procedures

- Radiological indirect signs of discoid meniscus are widening of the joint space and flattening of the femoral condyle.
- MRI discoid meniscus signs diagnostic signs are: continuity of the meniscus between the anterior and posterior horns (bow-tie sign); meniscal shift; meniscal megahorn; ‘pseudo-bucket-handle tear’; ‘too much meniscus’ sign; ‘crimped meniscus’ sign (Figure 5A) and parameniscal oedema.
- Saucerisation can be challenging due to a limited visualization from a small knee and thickened discoid meniscus. Surgical tips can include a low-profile straight basket to start a path through the central portion of the discoid meniscus. For the midbody, a side-basket can be helpful for trimming. For the anterior horn, a back basket or meniscal knife can be useful. The oscillating shaver should be then applied to gently smooth the remaining shape of the inner meniscus rim.
- After saucerisation, a probe should be used and meniscal instability should be treated with meniscal repair to the capsule.

Table 1 Treatment options and indications for meniscal injuries

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<th>Surgical procedure</th>
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| Meniscus retention (conservative treatment) | - Asymptomatic meniscal tears and asymptomatic discoid meniscus.  
- Non-displaced stable peripheral tears measuring 10 mm or less in length that involve the outer 10%–30% of the meniscus (vascular region) and are manually displaceable by less than 3 mm.  
- Small radial tears measuring 3 mm or less. |
| Meniscus resection (meniscectomy)       | - Chronic tears.  
- Avascular zone involvement (inner third of the meniscus, W-W zone).  
- Complex tears.  
- Symptomatic discoid meniscus tears: saucerisation, meniscus repair.  
- Symptomatic unstable discoid meniscus: saucerisation and meniscus repair. |
| Meniscus repair                         | - Acute tears (better before 8 weeks).  
- Peripheral vascularised zone (middle and outer third of the meniscus, R-R and W-W zones).  
- Non-damaged bucket-handle tears.  
- Stable knee.  
- Better outcomes: acute, young age; peripheral tear; longitudinal vertical tear; lateral meniscus; associated with ACL reconstruction.  
- Inside-out: posterior horn and meniscal body (mid-horn); bucket-handle tears  
- Outside-in: anterior horn and meniscal body (mid-horn).  
- All-inside: posterior horn of lateral meniscus and meniscal body (mid-horn). |
| Meniscus replacement (meniscal scaffold and meniscal allograft transplantation) | - Symptomatic meniscal-deficiency knee.  
- Postmeniscectomy syndrome.  
- Neutral alignment.  
- Stable knee. |


There is a consensus among published studies that meniscal tears have greater healing potential in children and adolescents. Attempts at studying long-term outcomes of meniscal repair should be strongly considered in this age group to help us define the importance of healing potential.

Mintzer et al reported a 100% clinical healing rate of 29 meniscal repairs in 26 patients younger than 17 years of age seen for follow-up at an average of 5 years. Noyes and Barber-Westin reported a meniscal repair healing success rate of 75% in patients under the age of 20 years, with a higher rate of meniscal healing in the ACL reconstruction group.

Krych et al reported an overall clinical healing rate in patients 18 years and younger of 84% for simple tears, 59% for displaced bucket-handle tears and 57% for complex tears (74% overall). They found that complex tears (tear in more than one plane) have a higher healing rate if repaired at the same time with ACL reconstruction (57%) versus if repaired in isolation (13%). Eggli et al found an overall healing rate of 88% for the repair of isolated meniscal tears in patients under the age of 30 years and 67% in patients over the age of 30 years. A more recent study conducted by Yang et al details a meniscus repair healing rate ranging from 33% to 100% with less than 40% reoperation rate.

All types of tears can be seen in a discoid meniscus. Although symptomatic discoid menisci are usually related to a tear (types 1 and 2) or unstable discoid menisci (type 3), the presence of a horizontal cleavage tear, especially in a child younger than 10 years old, should raise suspicion of a discoid meniscus. Symptomatic discoid menisci tears can be debrided with adequate PRF or scaffold and stem cell injections.
saucerisation, but if the tear extends into the peripheral vascular zone, a repair attempt is indicated (figure 6).

In general, although the optimal surgical intervention for symptomatic discoid meniscus tears is not fully known, most surgeons prefer arthroscopic ‘normalisation’ of the discoid meniscus (meniscectomy/saucerisation) with partial meniscectomy and/or repair rather than total meniscectomy due to poor reported long-term results.

The goal of arthroscopic treatment for symptomatic discoid meniscus is to relieve symptoms and to prevent further meniscal degeneration through rim preservation and stabilisation after saucerisation. Peripheral stabilisation of the meniscal rim should be added in case of an unstable discoid meniscus (type 3). The contralateral knee should be examined as it can be bilateral.

The long-term results of postsurgical treatment for discoid meniscal lesions are unknown and necessary to further refine the optimal treatment algorithm, but mid-term overall outcomes are satisfactory. According to Ahn et al.’s study, 23 patients (28 knees) with a mean age at operation of 9 years underwent saucerisation and peripheral rim repair with a minimum follow-up of 2 years. They were able to return to their previous life activities with little or no limitation, and no reoperation was required after an average of 51 months.

Root avulsions of the medial meniscus in skeletally immature patients are rare and should be recognised and surgically repaired to avoid evolution towards early joint degeneration. In this population, the presence of an open physes must be taken into consideration for the choice of the surgical technique to avoid potential iatrogenic growth disturbances.

The need for MAT in children is rare. Middleton et al. studied prospectively 23 patients aged 18 years or younger that had undergone MAT. They found an improvement of function and a decrease in postoperative pain. Therefore, MAT is a viable option in the paediatric population with symptomatic meniscal knee injuries and postmeniscectomy syndrome and can offer beneficial outcomes.
risk of failure. Complex and bucket-handle tears have a higher incidence of discoid meniscus in Asian countries than in Western countries. In a study done in South Korea, Bae et al reported a high prevalence of bilateral DLM (79%), while the incidence of discoid menisci in the Greek population is quoted to be as low as 1.8%. However, other studies from Japan reported an incidence of 13%; in Korea, Kim et al observed an incidence of 10.6%; in India, Rao et al noted an incidence of 5.8%; and in the USA, Jordan described an incidence of 3%-5%.

These data support the fact that discoid menisci can be a congenital anomaly and with a genetic or familiar predisposition for its development.

FUTURE PERSPECTIVES
Menisci is a complex structure that plays a critical role in knee biomechanics, and proper treatments of meniscus injuries could improve clinical outcomes and avoid progression to early OA. According to the current literature, it is crucial to early understand the clinical history and associated factors and to appropriately manage the most updated treatments for each specific meniscal injury. However, further understanding of the
pathogenesis and biology of meniscal injuries in children and adolescents is needed to allow for an evidence-based patient selection of treatment options.

Future large-scale epidemiological studies are required to determine the real prevalence of meniscal tears and discoid meniscus, as well as its geographical differences between different regions around the world.

We believe that future improvements in meniscal devices will allow for more stable and complex meniscal repair configurations. In parallel, imaging advances in hardware and software will allow a more precise diagnosis and understanding of the 3D meniscus anatomy and vascularisation.

Biological augmentation (hyaluronic acid, platelet-rich plasma, bone marrow aspirate concentrate, fibrin clots, stem cells and biological augmentation membranes) will potentially enhance meniscal healing potential and promote tissue regrowth, especially in avascular zone. These treatments can also play a role in conservative approaches. Furthermore, future replacement devices (scaffolds and meniscus artificial implants) and better surgical techniques will be also a reality.

Prospective randomised control trials are needed to determine the safety and clinical efficacy of these treatments in a clinical setting, in order to provide the best care for our young patients.

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Contributors All the authors (GV, FC, KA and PDH) have made the following contributions: substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; drafting the work or revising it critically for important intellectual content; final approval of the version to be published; and agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patent consent for publication Not required.

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