

# Tactoset<sup>®</sup> Case Report

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A 63-year-old engineer with a history of medical meniscectomy in 2013 presented for a second opinion consultation for left knee pain. The patient is active in bicycle-riding and golf. Since that procedure, he has had continued pain and multiple cortisone injections. His pain level is routinely 2/10 in nature with 10 being the worst. During golf and other activities of daily living (ADL), his pain can consistently reach 7/10. He had been treated by another orthopaedic surgeon who is recommending total knee replacement.

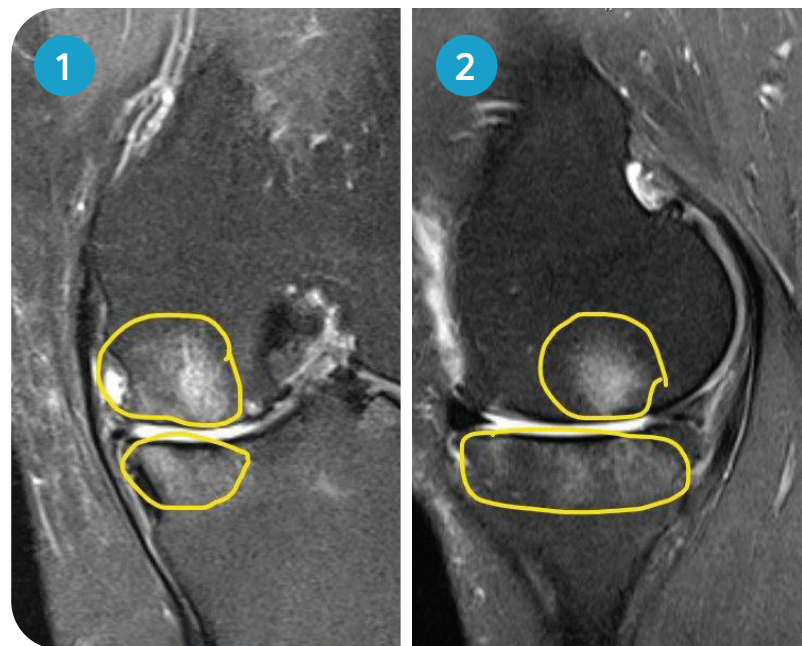
## Pre-operative Exam

The patient's knee showed a moderate effusion, positive Steinman maneuver, and medial joint tenderness with palpable osteophytes. An MRI indicated a chronic ACL tear and degeneration of the medial compartment. He had large insufficiency fractures of the medial femoral condyle and tibial plateau.

Conservative treatment options of weight loss, icing, NSAIDs, as well as physical therapy were discussed. The patient relayed he had done all of these without pain relief. Other treatment options discussed were:

1. Repeat cortisone
2. Hyaluronic acid injections
3. Unloader brace with physical therapy
4. Arthroscopy with meniscectomy and debridement
5. Uni compartment replacement
6. Total knee arthroplasty

The patient decided on open reduction and internal fixation surgery (ORIF) of the insufficient fractures.



*Pre-operative MRI showing insufficiency fractures of the medial femoral condyle and medial tibial plateau.*

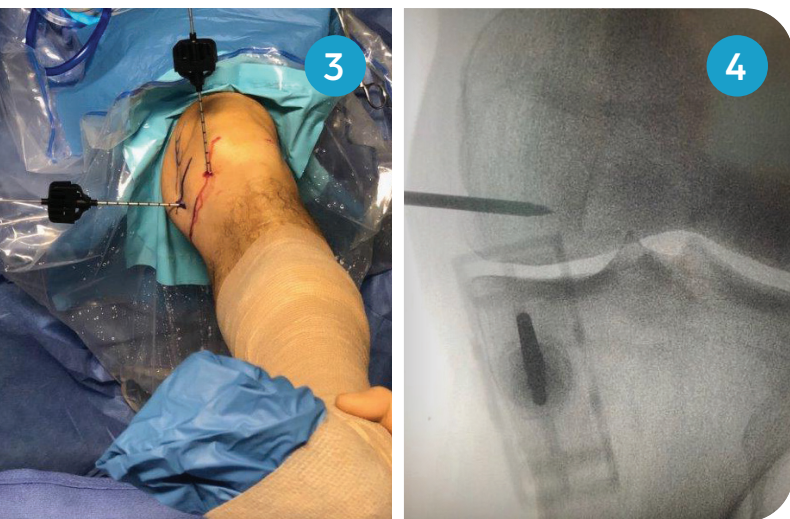
## Intra-operative Experience

The patient was taken to surgery in August of 2019 where he underwent knee arthroscopy. Findings included a residual medial meniscal tear and grade 3-4 chondromalacia of the medial femoral condyle and tibial plateau. Chondroplasty and partial meniscectomy were performed.

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Fluoroscopically assisted injection trocars were placed in the central area of the insufficiency fractures and 2 cc's of Tactoset were injected into each of the fractures. The tibial cannula was placed ant/posterior to be able to inject to the outer rim of the tibial plateau through the side injection portal. Femoral trocar was placed from the side and circumferential injection was performed through the side injection portal.



*Intra-operative images showing cannula placement. Note the AP placement of the tibial cannula which facilitates injection the peripheral tibial rim.*

Intraosseous injection was confirmed fluoroscopically and arthroscopically. The Tactoset was prepped on the back table after the femoral trocar was placed. Waiting time was about 8 minutes before injection. After the last injection, the tourniquet was deflated and the Tactoset allowed to cure over 10 minutes.

## Post-operative follow up

At the first post-op visit at 8 days, the patient was doing well and showed a normal post-op visit. He described his pain as 0/10, was full weight bearing, and off all pain medications. He had a slight effusion and had started physical therapy.

At the patient's 7-week post-op visit, he related that his preoperative pain was completely gone. His physical exam showed normal range of motion (ROM) and minimal effusion.

At 11 weeks post-op, the patient continued to have no pain and had returned to work and all activities of daily living (ADL) were pain free.

A telephonic follow up at 17 weeks found that the patient continues to be pain free 0/10 with all ADL's, and he was completely satisfied with the procedure.

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