

The process begins in the patient's room with marking the leg to be operated on and in particular the exact point on the knee where the patient feels the pain. Then, following a description of the operation offered the risks, benefits and alternatives a formal consent for the surgery and type of anaesthesia is obtained.

Once the patient is blissfully snoring away a temporary tourniquet is placed at the top of the thigh. The skin is covered with an antiseptic solution and the rest of the patient draped so that only the knee is exposed. This is to reduce the risks of postoperative infection. Two small holes are made either side of the fat pad and a narrow telescope with the latest high definition HD camera is placed through one portal and even smaller instruments placed through the other. Pictures are taken and a video is made for the patient of the state of the knee before the procedure, during the procedure and after removal of the fibrosed synovial tag has been achieved.

The patient is woken and returned to theatre recovery for a chat with the recovery nurse. They then return to their room and have lunch, get up and walk around. Before being taken home the dressing from theatre is changed and the physiotherapist on the team checks the patient is self caring, can mobilise and walk up and down stairs.

Your surgeon should see you after surgery to discuss the findings and confirm what you can and cannot do following the treatment.

WHAT ELSE SHOULD I KNOW?

Patients are reviewed back at the hospital 2 weeks after surgery to remove sutures, check the wound, show them the pictures of the fibrosed synovial tag and its removal and advise on whether further physiotherapy is necessary. Usually it is not. You are then seen six weeks after surgery to assess your progress.

After you go home you should continue exercising to strengthen and improve the range of motion of your knee. Although you should be able to get back to light work (such as a desk job) in about a week, it may take longer (2 to 3 weeks) to start doing more active work..

Don't engage in strenuous activities like jogging, running, or active sports until your surgeon says so. Avoid twisting your knee - if you have to turn while standing, do so by stepping with your feet and not simply by turning at the waist.



Hoffa's Posterior
Fat Pad
Syndrome
(Liposynovitis
Prepatellaris)

Further copies of this brochure can be found at:

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HOFFA'S POSTERIOR FAT PAD SYNDROME

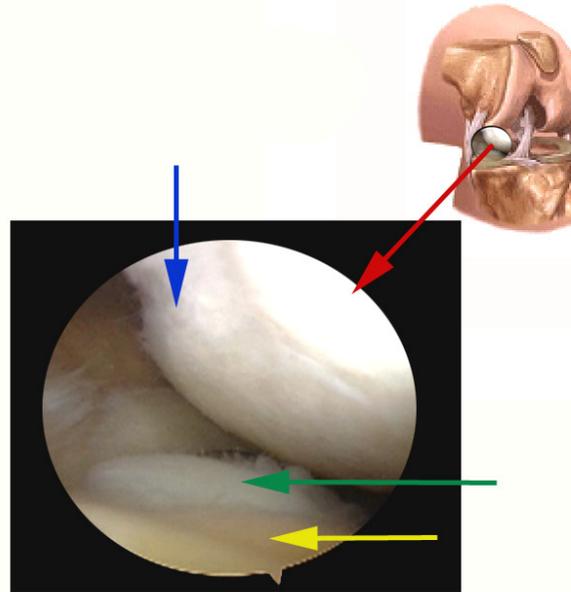
INTRODUCTION

The knee joint is formed by the lower end of the thigh bone (femur) and the upper end of the shin bone (tibia). The knee cap (patella) sits in the tendon of the quadriceps muscle which is connected to the tibia by the patella tendon. The fat pad of Hoffa lies behind the patella tendon suspended by the infrapatella ligament. A medial and a lateral extension of fat lay either side of the base of the anterior cruciate ligament ([Gallagher J et al. 2005](#)). The condition goes frequently unrecognised by many doctors. It is called variously Hoffa's Posterior Fat Pad Syndrome (HPFPS), Hoffa's Syndrome or Liposynovitis Prepatellaris. It is one of the causes of the umbrella diagnosis "anterior knee pain".

WHAT CAUSES IT?

The condition is caused by chronic impingement of the one of the extensions of fat pad either side of the base of the anterior cruciate ligament in the knee (yellow arrow). After a time the fat becomes scarred by this pinching (green arrow) leading to high pressure between the viscoelastic hyaline cartilage that covers the joint surfaces of the bone. The analogy is a stone in the shoe causing a pain then a blister then an ulcer as the patient walks on with the stone under the heel. Once the scarred fat flips into the joint the patient experiences a sharp catch in the front of the knee. Patients are good at pin pointing the place where this happens. This causes slow degenerate changes to the hyaline cartilage of the tibia and

femur (blue arrow) leading to a localised osteoarthritis in the knee.



The Consultant in Orthopaedics and Trauma with experience in arthroscopic surgery of the knee should have taken a history, examined you, performed investigations like MRI and helped you come to a decision on the best treatment for you under the circumstances of your current medical condition. MRI helps determine the presence of a tear of the ligamentum mucosum ([Saddik D et al 2004](#)), oedema or fibrosis in the fat pad and the presence or absence of chondromalacia or osteoarthritis ([Magi M et al. 1991](#)).

The purpose of this leaflet is to explain the conservative treatments and surgical options to relieve your symptoms. The treatment aim is to get the fibrosed synovial tag out of the articulating surfaces of the joint to relieve the pain and prevent the degenerative change.

CONSERVATIVE TREATMENT

If your condition is acute (six weeks) with no evidence of cartilage damage (chondromalacia) then a course of pain killers physical therapy, patella taping and orthotics should be considered. The patella taping works by either changing the forces induced by the muscles ([Cowan SM et al. 2002](#)), by off loading the extension of the fat pad or by another mechanism yet unknown. Patella taping once taught will be repeatable if the patient takes a digital photograph of the pattern of taping that has worked in their case. [Taping](#) paradoxically works in different directions for different people.

SURGICAL TREATMENT

If at least six weeks of conservative treatment has failed to cause improvement then surgery should be considered. This is Day Case key hole surgery.

"My advice to patients is that they should not accept an operation from a surgeon who has not been through this extensive process of assessment and consent of the individual".

PREASSESSMENT

Depending on other underlying conditions you may require other types of tests before surgery such as an ECG (electrocardiogram), blood tests and tests to exclude MRSA

THE OPERATION

The operation is arthroscopy of the knee (keyhole surgery) and partial excision of the fat pad (removing only the scarred bit) with or without chondroplasty (repairing or removing any loose flaps of cartilage).