RESEARCH ARTICLE

Practice Trends in Primary Total Knee Arthroplasty among Members of the Iranian Society of Knee Surgery, Arthroscopy, and Sports Traumatology

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Abstract

Objectives: The survey conducted at the 2024 biennial meeting of the Iranian Society of Knee Surgery, Arthroscopy, and Sports Traumatology (ISKAST) aimed to assess practice trends among ISKAST members in primary total knee arthroplasty (TKA), thereby providing a benchmark for future studies.

Methods: The session moderator presented multiple-choice questions via an audience response system to 94 registered ISKAST members. Responses were collected centrally and subsequently displayed to the audience after a brief interval.

Results: The survey revealed that most ISKAST surgeons, reflecting their high level of expertise, work in diverse settings, with more than half performing over 100 TKAs annually. Regarding perioperative management, the majority of respondents utilize spinal anesthesia and tranexamic acid, with a significant number applying tourniquets during surgery. The median parapatellar approach and posterior cruciate-substituting designs are commonly preferred for routine TKA procedures. Additionally, pain management is primarily achieved through patient-controlled analgesia, while low-molecular-weight heparin, combined with mechanical measures, is the most common method for venous thromboembolism prophylaxis. Although follow-up practices vary, the majority of surgeons schedule annual postoperative visits.

Conclusion: The survey results provide valuable insights into the approaches of knee surgeons in Iran toward TKA, highlighting both common practices and variations in treatment methods. While these findings reflect current practices, they may not represent the most optimal techniques. This underscores the need for further research to validate these results and explore their applicability to a broader patient population.

Level of evidence: V

Keywords: Biennial meeting; Current practice patterns; Iranian Society of Knee Surgery, Arthroscopy, and Sports Traumatology (ISKAST); Total knee arthroplasty

Introduction

edical and surgical practices evolve in response to various factors.¹ A survey conducted during the 2024 biennial meeting of the Iranian Society of Knee Surgery, Arthroscopy, and Sports Traumatology (ISKAST) represents a significant step toward understanding the current practices of ISKAST members in primary total knee arthroplasty (TKA). Compared with future surveys, this data will provide valuable insights into the evolving

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landscape of TKA practice patterns.

Materials and Methods

The moderator conducted a poll using individual slides, each featuring a multiple-choice question based on the studies by Abdel et al.¹⁻³ and Berry *et al.*⁴ presented to the attendees of the ISKAST meeting [Appendix A]. Participants were encouraged to engage through an audience response

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system, a handheld device that allows each individual to select one answer from the available multiple-choice options. Responses were collected centrally, and the aggregated results were displayed to the audience after approximately ten seconds. Percentages of 0.5 or greater were rounded to the nearest whole number, which may result in a total rate slightly exceeding 100% for specific questions. The audience primarily consisted of ISKAST members, with a few guests who may have been present and participated. Ninety-four ISKAST members registered for the event. The audience response system transponders were widely distributed across the auditorium. Initially, the audience was asked questions related to TKA.⁴

Results

On average, each question received 76.5 responses. Details regarding the wording of each question, the number and percentage of responses for each multiplechoice option, and the participant count for each question were provided [Appendix A].

More than half of the surgeons (54.1%) work in diverse settings, including private and government or university hospitals. Approximately 25.7% work exclusively in private hospitals, 10.8% in university hospitals, and 9.5% in non-academic government hospitals. This diversity in practice settings reflects the multifaceted nature of modern medical practice.

About 62% of surgeons perform more than 100 TKAs annually, reflecting a high level of expertise and experience. The remaining surgeons perform between 20 and 50 TKAs, 50 and 100 TKAs, or fewer than 20 TKAs, accounting for 12.5% of the total. This high volume of procedures reinforces the audience's confidence in the surgeons' proficiency in knee surgery.

Perioperative Management of primary TKA patients

About 58% of respondents use the three-joint alignment view in preoperative planning, 39.1% use it in selected cases, and 2.3% never use it. Regarding Rosenberg's view, 44.9% never use it, 40.4% use it in selected cases, and 14.6% always use it for patients.

In TKA, 65.4% of respondents favor spinal anesthesia in most cases. In comparison, 17.3% prefer general anesthesia, 11.1% opt for epidural anesthesia, and 6.1% choose a combination of a lumbosacral plexus peripheral nerve block with spinal or epidural anesthesia.

Before surgery, 56.8% of respondents routinely reserve blood for patients, while the remaining do not. Fifty-one percent of respondents do not require a blood transfusion, 35.7% need between 1% and 9%, 8.3% require between 10% and 24%, 3.6% require between 25% and 50%, and 1.1% require more than 50%.

More than 90% of respondents use tranexamic acid in patients undergoing TKA. Half use it intravenously and intraarticularly, 16% use it intra-articularly only, and 32% use it intravenously, with none administering it orally.

Among surgeons, 62.1% use tourniquets, 29.9% use them except in vascular cases, 3.4% use them only during exposure and cementation, and 4.6% do not use tourniquets in TKA.

When using tourniquets, 81.9% apply a pressure of 300 to 400 mmHg, 13.3% apply a pressure of 200 to 300 mmHg, and

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4.8% apply a pressure of more than 400 mmHg. Of the surgeons who use tourniquets, 54.2% do not routinely release them for hemostasis at the end of the procedure.

Primary TKA Preferences

About 65% of respondents perform the procedure in fewer than 1% of their knee arthroplasty patients. Meanwhile, 25.3% perform it for 1% to 9% of their patients, 4.6% for 10% to 24%, 3.4% for 25% to 50%, and 1.1% for more than 50% of patients.

Thirty-one percent of respondents perform bilateral TKA in 1% to 9% of their knee arthroplasty cases, 12.9% in 10% to 25%, and another 12.9% in more than 25% of cases. Meanwhile, 42.4% have never performed bilateral TKA.

The median parapatellar approach is the most frequently employed method for routine primary TKA, accounting for 78.8% of cases, followed by the mid-vascular approach at 11.8% and the sub-vascular approach at 9.4%.

Seventy-five percent of respondents consistently use a posterior cruciate-substituting TKA design with a post. In contrast, 13.3% regularly use a posterior cruciate ligament-retaining design, 7.2% use an ultra-congruent design, and 4.8% use a medial-stabilized design. Additionally, 76.5% of respondents employ a posterior cruciate-substituting design for complex deformity cases.

In primary TKA, 80% of respondents aim for neutral mechanical alignment, while 20% aim for kinematic alignment.

Sixty percent of respondents prefer to determine femoral implant rotation using anatomical landmarks, while 40% opt for 'gap balancing' methods.

Among respondents, 93% favor a modular fixed-bearing metal-backed tibial component in most cases, 5.8% typically use a mobile-bearing tibial component, and 1.2% commonly use a monoblock tibial component. Notably, 50% of respondents utilize mobile-bearing tibial components, while the remaining 50% do not.

In TKA for patients with a body mass index (BMI) over 35, 77.9% of respondents opt for a short supplemental stem on the tibial component, compared to 22.1% who employ the standard tibial design component.

In complicated TKA, 57.5% of surgeons never use patientspecific implantation, while 42.5% do. Fifty-five percent of respondents use antibiotic-impregnated cement during TKA, whereas 31.8% use it only for high-risk patients, and 12.9% never use it.

Regarding polyethylene (PE) usage, 48.2% use crosslinked PE in more than 50% of cases, 21.2% consistently use conventional PE, 5.9% apply crosslinked PE in 1% to 49% of cases, and 24.7% express no preference.

Forty-two and a half percent of respondents never perform patellar resurfacing on patients. Meanwhile, 40.2% resurface the patella in 1% to 9% of cases, 9.2% in 10% to 89% of cases, 3% in 90% to 99%, and only 5.7% consistently resurface the patella in TKA patients.

Among respondents who do not resurface the patella, 51.2% remove osteophytes and de-nerve, 23.3% de-nerve with lateral facetectomy, 16.3% remove osteophytes, 8.1%

perform lateral facetectomy, and 1.2% de-nerve the patella. Half of the respondents (49.5%) do not use irrigation, 34.8% use dilute betadine or other antimicrobial irrigants for all patients, and 15.7% use it selectively for high-risk patients. Additionally, 74.4% of respondents do not use antibiotic powder (vancomycin) in the wound at the end of the procedure (subcutaneously or on the implant).

Twenty-five percent of respondents use continuous passive motion. In line with this trend, only 35% of respondents in the current poll reported using drains routinely after primary TKA. Furthermore, continuous passive motion and drains have become less common in primary TKA procedures. However, half of the surgeons (49.4%) use knee immobilizers after primary TKAs, while the other half do not.

About 50.6% of respondents favored patient-controlled analgesia via a pain pump in managing pain after TKA. Meanwhile, 40% opted for a periarticular injection alone, and 7% utilized a motor-sparing nerve block in combination with a periarticular injection. Only 1.2% of respondents chose femoral nerve blocks. Consequently, adductor canal blocks are rarely used compared to pain pumps or periarticular injections (1.2%).

The three primary types of venous thromboembolism (VTE) prophylaxis include low-molecular-weight heparin combined with mechanical measures (50%), oral factor Xa inhibitors with mechanical measures (30%), and aspirin with mechanical measures (19%). In VTE prophylaxis, most respondents (54.1%) opted for 81 mg twice daily, while 8% took 81 mg daily. Additionally, 15.3% used 325 mg once daily, and 11.8% administered 325 mg twice daily.

Seventy-four percent of surgical professionals restrict patients from activities with substantial impact (running, jumping) after TKA, while 18.2% had no activity restrictions. Regarding high-impact activities, 82.8% recommend avoiding them, while 17.2% do not recommend any limitations.

For postoperative visit intervals, 64% of respondents see patients annually, 23.3% only see them if a clinical problem arises, 11.6% visit every two years, and 1.2% visit every five years.

Practices Trends in Primary TKA

About 41% of participants set the BMI threshold at 40, 20.5% at 35, 5.7% at 45, and 33% had no BMI cut-off, provided sufficient indication was present.

Regarding smoking, 55.7% of respondents indicated they would avoid performing arthroplasty on patients who continued smoking without prior cotinine testing. Meanwhile, 38.9% did not impose any strict limitations, and 5.7% had firm restrictions but did not conduct testing.

When evaluating perioperative IV antibiotics, 58.8% of respondents opted to include a second antibiotic (such as cefazolin or an aminoglycoside) if the patient had received vancomycin or clindamycin before the incision, aiming to enhance Gram-negative coverage. Conversely, 41.2% chose not to add another antibiotic.

Following surgery, 41.7% of participants were prescribed oral antibiotics for 24 hours, 28.6% for less than 24 hours,

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21.4% for one week, and 7.1% for two weeks. Additionally, 63.1% extended antibiotic prophylaxis for high-risk patients for seven days or more. Among patients labeled as 'high-risk,' 63.1% of surgeons prescribed 7 days of oral antibiotic prophylaxis, while 36.9% did not use any additional prophylaxis.

Forty percent of surgeons advised lifelong antibiotic use before dental procedures for all patients. At the same time, 60% recommended antibiotic prophylaxis for one to two years after arthroplasty surgery in both standard-risk and high-risk patients.

When managing preoperative urinary tract infections, 61.4% of surgeons conduct screenings, and if a positive result is found, they cancel the procedure until the infection is fully treated. In contrast, 25% no longer perform routine screenings, while 13.6% screen for infections, treat them if positive, and proceed with surgery regardless of delay.

Discussion

The findings from this survey reflect data collected from knee surgeons at a specific point in time and, therefore, provide valuable insights into current practices in Iran. While the most commonly observed practices may not necessarily represent the optimal procedures, they offer a snapshot of prevailing trends.

This data has several advantages, including a large sample size, collection at a single time point, and an anonymous data collection method. However, its weaknesses and limitations include unvalidated questions and the format used to assess intra-responder consistency. Additionally, there is uncertainty regarding whether the respondents' answers accurately reflect their actual practices. Furthermore, the multiple-choice format of some questions may have overly simplified certain practices.

Notably, most respondents are knee arthroplasty surgeons who manage demanding clinical workloads. However, the relevance of these responses to less active or non-arthroplasty specialists remains unclear.^{1,2,4}

Conclusion

The survey provides valuable insights into the practices of knee surgeons in Iran, highlighting common trends and variations in TKA management. While the data reflects the current practices of many experienced surgeons, it may not fully align with optimal clinical guidelines. Continuous evaluation is crucial to ensure that surgical practices meet evolving standards of care. Further studies are needed to validate these results and assess their applicability to larger surgical populations, aiming to improve patient outcomes and the overall quality of care in primary TKA.

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Appendix

App	Appendix A. 2024 Membership Poll Results						
N	Poll Question	Response Options	Count	Results	Total Votes		
1		1. University hospital	8	10.8%	74		
1	What type of practice do you have?	2. Government hospital, non-academic	7	9.5%			
		3. Private hospital	19	25.7%			
		4. Both Private and government or university hospital	40	54.1%			
2	П	1.>100	50	62.5%	80		
	How many IKA do you do per year?	2. 50-100	10	12.5%			
		3.20-51	10	12.5%			
		4.<20	10	12.5%			
2		1.Spinal	53	65.4%			
3	what type of anestnesia do you prefer?	2.General	14	17.3%			
		3.Epidural	9	11.1%	81		
		4.Spinal + Nerve Block	4	4.9%			
		5.Epidural+ Nerve Block	1	1.2%			
	Do you routinely reserve blood for	1.Yes	46	56.8%			
4	Planned TKA Patients?	2.No	35	43.2%	81		
		1.<1%	43	51.2%			
5	What percentage of your TKA patients	2.1-9%	30	35.7%			
		3.10-24%	7	8.3%	84		
		4.25-50%	3	3.6%			
		5.>50%	1	1.1%			
	Do you routinely use Tranexamic acid	1.Yes	78	90.7%			
6	in TKA Patients?	2.No	8	9.3%	86		
		1.Intra-articular	14	16.9%	83		
7	If you use tranexamic acid, what route of	2.Intravenous	27	32.5%			
	auministration do you preier:	3.IV and IA	42	50.6%	. 05		
		4.0ral	0	0%			
		1. No one. I give it to all primaries	28	32.9%			
8	Tranexamic acid exclusion?	2.Patients with arterial vascular disease	12	14.1%	QE		
		3.patients with high VTE risk	13	15.3%	. 05		
		4.Patients with arterial disease or VTE(2 and 3)	32	37.6%%			
	What percentage of knees in your	1.Zero%	57	65.5%			
9		2.1-9%	22	25.3%			
	practice getting of A:	3.10-24%	4	4.6%	87		
		4.25-50%	3	3.4%			
		5.>50%	1	1.1%			
	How often do you perform	1.Never	36	42.4%			
10		2.1-9%	27	31.8%	85		
	bilderal simulateous man	3.10-25%	11	12.9%			
		4.>25%	11	12.9%			
		1.Always	54	62.1%			
11	How often do you use tourniquet in TKA?	2.Always except in vascular cases	26	29.9%	87		
		3.Only during exposure/cementation	3	3.4%	07		
		4.Not at all	4	4.6%			
		1.>400 mmHg	4	4.8%			
12	What level of tourniquet pressure	2.300-400 mmHg	68	81.9%	83		
		3.200-300 mmHg	11	13.3%			

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In rest of your TKA patients?I.1.03II.1I.3.3% C.2.5%II.1II.2.6%II.1II.2.6%II.1II.2.6%II.1II.2.6%II.1II.2.6%II.1II.2.6%II.1II.1II.2.6%II.1II.1II.2.6%II.1II.1II.1II.1II.1II.1II.1II.1II.1II.1II.1II.1II.1II.1II.1II.1II.1II.1IIII.1III.1III.1IIII.1 <t< td=""><td></td><td>,</td><td>3.Subvastus</td><td>8</td><td>9.4%</td><td></td></t<>		,	3.Subvastus	8	9.4%			
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10 in patient with complex detormities, with ge of constrain doy ou prefer? 2.45 with post 6.5 7.65 %. 11 Constrain doy ou prefer? 3.00 %. 9.4%. 12 For most primary TKA, you ain? 2.85 mest of Kinematk Alignment 1.88 20.0%. 0.66 13 What is you prefer? 2.85 mest of Kinematk Alignment 1.88 20.0%. 0.67 13 What is you prefer? 1.10 web for mathem K Alignment 1.88 20.0%. 0.90.0% 14 What is you prefer? 1.10 web for mathem K Alignment 1.88 20.0%. 0.90.0% 14 What is you prefer? 1.10 web for mathem K Alignment 1.80 0.90.0% 0.90.0% 15 5.0%. 1.10 web for mathem K Alignment 1.8 0.00%. 0.90.0% 16 1.75 5.0%. 1.0% 0.00%. 0.00% 17 1.60 web web methods for implant Alignment 1.9 1.2%. 0.00%. 0.00%. 18 0.90 web web methods for implant Alignment 1.8 1.0%. 0.00%. 0.00%. 10 1.7% web web web web methods for implant Alignment 1.9 0.00%. 0.00%. 19 0.20% web web web methods for implant Alignment 1.9 0.00%. 0.00%.			1.CR	5	5.9%			
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4.Crosslinked>50% 41. 48.2% 5.Don't care 21 24.7% 1.Always resurface 5 5.7% 1.Always resurface 90-99% 2 2.3% 3.Resurface 10-89% 8 9.2% 4.Resurface 1-9% 35 40.2% 5.Never Resurface 37 42.5%			3.Crosslinked PE, 25-49%	2	2.4%	85		
In what percentage of you TKA patients you resurface the patella? 5.Don't care 21 24.7% 29 In what percentage of you TKA patients you resurface the patella? 1.Always resurface 0.99% 5 5.7% 3.Resurface 10-89% 2 2.3% 8 9.2% 87 4.Resurface 1-9% 35 40.2% 5.Never Resurface 37 42.5%			4.Crosslinked>50%	41.	48.2%			
29 In what percentage of you TKA patients you resurface the patella? 1.Always resurface 5 5.7% 29 In what percentage of you TKA patients you resurface the patella? 2.Resurface 90-99% 2 2.3% 3.Resurface 10-89% 8 9.2% 87 4.Resurface 1-9% 35 40.2% 5.Never Resurface 37 42.5%			5.Don't care	21	24.7%			
29 In what percentage of you TKA patients you resurface the patella? 2.Resurface 90-99% 2 2.3% 3.Resurface 10-89% 8 9.2% 87 4.Resurface 1-9% 35 40.2% 5.Never Resurface 37 42.5%		In what percentage of you TKA patients	1.Always resurface	5	5.7%			
3.Resurface 10-89% 8 9.2% 87 4.Resurface 1-9% 35 40.2% 5.Never Resurface 37 42.5%	29		2.Resurface 90-99%	2	2.3%	1		
4.Resurface 1-9% 35 40.2% 5.Never Resurface 37 42.5%		you resurrace the patena?	3.Resurface 10-89%	8	9.2%	87		
5.Never Resurface 37 42.5%			4.Resurface 1-9%	35	40.2%			
			5.Never Resurface	37	42.5%			

PRACTICE TRENDS IN TKA AT MEMBERS OF ISKAST

Арр	Appendix A. Continued							
20		1.Just remove osteophytes	14	16.3%				
30	If you don't resurface Patella:	2.De-nervate	1	1.2%				
		3.Remove osteophyte and De-nervate	44	51.2%	86			
		4.Perform lateral facetectomy	7	8.1%				
		5.De-nervate plus lateral facetectomy	20	23.3%				
		1.In selected complex cases	37	42.5%				
31	Do you use PSI in complicated TKA?	2.Never	50	57.5%	87			
		1.Using Dilute betadine or some other	31	34.8%				
32	Irrigation primary TKA	antimicrobial irrigant on all			89			
		2.Use selectively for high risk	14	15.7%	07			
		3.Don't use at all	44	49.4%				
		1.35	18	20.5%				
33	What is your BMI cut-off for primary TKA?	2.40	36	40.9%	88			
		3.45	5	5.7%				
		4.No cut-off if sufficient indications	29	33.0%				
		1.Hard stop and I test with Cotinine	5	5.7%				
34	Do you have a hard stop for smoking?	2.Hard stop but I do not test	49	55.7%	88			
		3.No Hard stop	34	38.6%	00			
		1.I don't routinely screen any more	22	25.0%				
35	Preop UTI screening	2.I screen, treat if positive but go ahead without delay	12	13.6%	88			
		3.I screen, and if positive cancel until fully treated	54	61.4%	00			
	Do you routinely order CPM machine for	1.Yes	22	25.0%				
36	postoperative rehabilitation?	2.No	66	75.0%	88			
37	Do vou routinely use drain in TKA patient?	1.Yes	32	35.6%				
	5 5 1	2.No	58	64.4%	90			
38	Do you use knee immobilizer in primary TKA?	1.Yes	44	49.4%				
		2.No	45	50.6%	89			
		1.Always	51	58.6%				
39	Do you use an alignment view in primary TKA?	2.Selected Cases	34	39.1%	87			
		3.Never	2	2.3%				
		1.Always	13	14.6%				
40	Do you use Rosenberg view in primary TKA?	2.Selected Cases	36	40.4%	89			
		3.Never	40	44.9%				
		1.24h	13	14.6%				
41	When do you change the patient dressing?	2.48h	35	39.3%	80			
		3.5 days	19	21.3%	07			
		4.7days	22	24.7%				
		1.Femoral nerve block	1	1.2%				
42	Your modality of choice:	2.Adductor canal block	1	1.2%				
		3.Periarticular injection	34	40.0%	85			
		4.Nerve block + Periarticular injection	6	7.1%				
		5.PCA(pain pump)	43	50.6%				
		1.Mechanical alone	0	0.0%				
43	What is your DVT prophylaxis protocol for	2.Aspirin + mechanical	17	19.3%				
	fourne TKA patients:	3.LMWH+ Mechanical	44	50.0%	88			
		4.Warfarin + Mechanical	0	0.0%				
		5.0ral Factor Xa inhibitors+ Mechanical	27	30.7%				
		1.81 mg qd	16	18.8%				
44	Aspirin	2.81 mg bd	46	54.1%	85			
		3.325 mg qd	13	15.3%	00			
		4.325 mg bd	10	11.8%				

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PRACTICE TRENDS IN TKA AT MEMBERS OF ISKAST

Арр	Appendix A. Continued					
45	How long do you keep patient in hospital?	1.1 night	36	40.9%		
		2.2 nights	47	53.4%	88	
		3.3 nights	4	4.5%		
		4.> 3 nights	1	1.1%		
46	When your patients get home after TKA, do you have them work with PT?	1.Yes	57	64.0%	00	
		2.No	32	36.0%	89	
47	What kind of activity restriction do you prescribed for your TKA patients?	1.No activity Restriction	16	18.2%	88	
		2. Avoid high impact activities (running, jumping)	65	73.9%		
		3.Doing only	7	8.0%		
48	What would you recommend for post op impact activities (Running, Jumping)?	1.Recommend avoiding impact activities	72	82.8%	07	
		2.Do not recommend any limitations	15	17.2%	8/	
49	How often do you visit your primary TKA patient?	1.Annually	55	64.0%		
		2.Every 2 years	10	11.6%	86	
		3.Every 5 years	1	1.2%		
		4.Never unless clinical problem	20	23.3%		

TKA, total knee arthroplasty; IV, intravenously; IA, intra-articular; VTE, venous thromboembolism; CR, cruciate retaining; PS, posterior stabilized; PE, polyethylene; PSI, patient specific instrumentation; BMI, body mass index; UTI, urinary tract infection; CPM, continuous passive motion; PCA, Patient-controlled analgesia