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Introduction

e ankle can be a di cult joint to evaluate completely because of its restrictive bony and ligamentous architecture. Due to the joint's restrictive anatomy, early ankle arthroscopy was limited to addressing anterior pathology. Smaller cameras and operator-friendly distractor devices are now available that allow for complete arthroscopic evaluation of the ankle joint from a perspective unobtainable with open exposures of the ankle [1]. Current therapeutic indications for ankle arthroscopy include evaluation and treatment of anterior ankle impingement due to synovitis and/ or degenerative osteophytes of the distal tibia and talar neck. Traumatic osteochondral injuries and associated loose bodies are amenable to debridement and removal through arthroscopy. Arthroscopic tibiotalar fusions can be performed in selected patients with degenerative arthritis and minimal deformity. Synovitis of rheumatoid arthritis and other in ammatory arthritis can also be addressed with ankle arthroscopy. e wrist is another joint that relies on distraction techniques for optimal arthroscopic evaluation, and wrist arthroscopy is felt to be the gold standard for diagnosis of intra-articular wrist pathology. Indications for therapeutic wrist arthroscopy include triangular brocartilage complex tears, adjuncts to reduction and xation of intra-articular fractures and ligament disruptions, loose body removal, debridement of chondral defects, synovectomy, degenerative arthritis, and septic arthritis. e elbow is surrounded by multiple nerves and vascular structures [2]. e arthroscopic understanding of anatomy and the establishment of safe entry portals along with development of smaller instruments have allowed elbow arthroscopy to become an alternative to open procedures for the evaluation and treatment of certain disorders. erapeutic indications include removal of osteochondral loose bodies, synovectomy, temporizing arthritis debridement, radial head excision for radial head fractures, and septic arthritis. As with the other joints, elbow arthroscopy is an excellent diagnostic tool, providing a magni ed view of the joint that cannot be achieved by standard open exposures. Endoscopic techniques have also been developed and used for other orthopaedic-related disorders such as carpal tunnel syndrome and plantar fasciitis. Although most of these techniques have not shown a clear therapeutic advantage over open techniques, they do o er further options for the treatment of these disorders. Two hundred eleven arthroscopic procedures were performed at Ochsner in 1999. e knee was the most common joint treated and meniscal tears and degenerative joint disease were the most common diagnoses addressed by arthroscopy [3]. e majority of arthroscopies were performed by joint reconstruction specialists who treat a relatively older population of patients with arthritis problems. In the summer of 2000, the addition of an orthopedic sports medicine specialist to the Ochsner orthopedic sta is expected to bring an increase in the number of arthroscopic procedures for more activity-related injuries. Arthroscopy, one of the greatest advances in orthopaedic surgery in the 20th century, o ers a minimally invasive alternative to standard open surgical techniques, which o en require extended incisions for adequate joint exposure. Decreased comorbidity, shorter rehabilitation, and the resulting socio-economic bene ts are proven advantages. Arthroscopic surgery has improved the understanding of joint pathology and expanded therapeutic options for previously unknown or less understood joint disorders and continues to develop into a tool vital to future advances in orthopedic surgery. Prior to the widespread clinical use of arthroscopy and its specialized instrumentation, joint surgery required extended incisions and arthrotomies for exposure and treatment of joint pathology. Arthroscopy o ers several advantages over such extended open arthrotomies. Compared with minimally invasive arthroscopic procedures, the extended exposure of joints prolongs recovery and increases pain and risk of complications, such as infection and arthro brosis [4]. Minimally invasive surgeries, in general, result in less pain and postoperative swelling than open techniques. As a result, arthroscopically treated patients tend to heal faster and begin rehabilitation earlier and, subsequently, return to normal activity and work sooner. As techniques and indications for treatment have expanded,injuries, particularly those in athletes that at one time would have been career ending, can now be addressed with arthroscopy allowing patients to return to full function. Examples include anterior cruciate knee ligament injuries in running athletes and intra-articular shoulder pathology in throwing athletes. Some arthroscopists even have the facilities to perform procedures in an o ce setting, further reducing costs [5]. Arthroscopy can be performed under many options of anesthesia ranging from local to general. Choice of anesthesia varies depending on the nature of the procedure and preferences of the patient and physician.As with any invasive procedure, complications can occur with arthroscopy, now the most commonly performed

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orthopedic procedure. A 1983 national survey of 118,590 procedures reported 930 complications—an incidence of 0.8%. In this survey, equipment failure accounted for 17% of complications reported while vascular injuries accounted for 1%. Arthroscopy is a technical procedure requiring a wide range of equipment (camera and monitor, surgical equipment, pump, tourniquet, etc.) that can malfunction or break during a procedure. e surgeon should be familiar with the equipment and use it only for its intended purposes. Anesthesia problems can also occur, but this is not unique to arthroscopic surgery. When arthroscopic surgery is performed in an o ce setting, the surgeon must be prepared for any potential anesthesia problems that might arise. Other complications include hemarthrosis, thrombophlebitis, arterial injury, nerve injury, compartment syndrome, and infection and metabolic complications in patients with metabolic diseases (diabetes, gout) or those using steroids [6]. While arthroscopy has resulted in an overall decrease in morbidity compared with open techniques, it is still an invasive procedure and inherently involves risks. ese problems can be addressed with extended open techniques, the comorbidity associated with open procedures o en prevents such patients from returning to their pre-injury functional status. For professional athletes, these types of injuries more o en led to the end of their paying careers. e knee was the model joint for the development of arthroscopy, and the evolution of the arthroscope from diagnostic tool to therapeutic tool is common to its application to other joints [7]. e arthroscope was initially used to clearly identify speci c intra-articular pathology, thereby assisting treatment management. If treatment required surgery to address pathology such as meniscal tears, open arthrotomies were necessary. As equipment and techniques improved, arthroscopy became a surgical tool in its own right, reducing the comorbidity of joint surgery [8]. e menisci of the knee, the semi-lunar shock absorbing cartilage between the femur and tibia, were the focus of most early knee arthroscopists. Prior to arthroscopy, total menisectomy was advocated for meniscal tears, and it was felt that a new meniscus would regenerate similar to the original. Subsequently, the use of arthroscopy has shown that partial meniscectomies for amenable tears provide better short- and long-term functional results and less arthritic changes than total meniscectomies. Currently, meniscal surgery of the knee is the most commonly performed arthroscopic procedure. Peripheral tears of the menisci may be amenable to repair and today can be performed completely arthroscopically by experienced orthopedic surgeons. With the popularity of athletics, the advent of arthroscopy has brought the treatment of the anterior cruciate ligament (ACL) of the knee to the forefront of modern orthopedics. At one time, an ACL injury could be career ending for a professional athlete [9]. Today both the ACL and the posterior cruciate ligament can be reconstructed through an arthroscope. Such procedures now allow all athletes, from professionals to weekend warriors, to return to pre-injury levels of activity with appropriate rehabilitation. e indications for knee arthroscopy are numerous and continue to expand. Arthroscopy has proven to be a bene cial, temporizing, and therapeutic procedure for the treatment of osteoarthritis. Knee arthroscopy for osteoarthritis o ers an alternative pain relief option for patients who are not ready or are unwilling to undergo a major surgical procedure such as knee replacement surgery. Arthroscopic synovectomy of the knees in patients with rheumatoid arthritis and other hypertrophic synovial-producing syndromes has signi cantly reduced complications and improved outcomes compared with open synovectomies of the knee. Osteochondral injuries and osteochondritis dessicans lesions of the knee can be repaired and drilled to stimulate bro-cartilaginous healing, and dissociated loose bodies can easily be removed by arthroscopy. Knee arthroscopy can also be used as an adjunct in assessing the intra-articular reduction of tibial plateau fractures and intra- articular distal femur fractures. Knee arthroscopy o ers an e ective means of draining septic knee e usions, as well as traumatic hemarthroses, while at the same time o ering an excellent diagnostic examination of the intra-articular structures of the knee. More recently, exciting advances such as osteochondral and meniscal transplants have continued, and as these techniques develop will continue to use arthroscopy as a primary portal of entry. e shoulder is the second most common joint evaluated and treated by arthroscopy. As with the knee, early arthroscopy of the shoulder focused on diagnosing and understanding intra-articular joint pathology. O