EFFECTIVENESS OF INTRASOSSEOUS INFILTRATION OF AUTOLOGOUS PLATELET-RICH PLASMA IN THE AREA OF THE BONE MARROW EDEMA IN OSTEOARTHRITIS OF THE KNEE JOINT

Lyachkin AV, Garkavi AV, Islaieh OI, Katuryan PI, Bobrov DS, Yavlleva RH, Tielisheva EYu

I.M. Sechenov First Moscow State Medical University, Moscow, Russia

Osteoarthritis (OA) affects both elderly people, for whom it is one of the main causes of disability, and people of active working age and is an urgent clinical and social problem of resistance of pain syndrome to therapy. The disease is characterized by both destruction of intra-articular and paraarticular structures, such as subchondral bone. While OA is an important sign of pathological changes believe the bone marrow edema (BME). This work examines the effect of BME on development osteoarthritis, and therapeutic approaches to the management of patients with OA. The aim of the study was to develop a method of treatment of BME in OA of the knee joint by locally intrasosseous injection of autologous thrombotic-rich plasma (PRP) into the edema zone. In this study 17 patients with the diagnosis: Osteoarthritis II-IV Grade. According to the classification of Kellgren-Lawrence, in which areas of local inflammation in the form of BME were detected on MRI in the subchondral zone in accordance with the international classification of WORMS (Whole Organ Magnetic Resonance Imaging Score). The mean age of patients was 41.7 ± 14.3 years, 10 of them were women and 7 men. Patients were treated with autologous platelet-rich plasma under x-ray control injected from extra-articular intrasosseous access in the area of BME. Evaluation of effectiveness of treatment performed by VAS, WOMAC and KOOS scales, before the introduction of autoplasma, after 1 and 3 months after the start of treatment. Three months after the manipulation, there was a statistically significant decrease in the intensity of inflammatory syndrome: for WOMAC by 17.5%, for KOOS by 19.4% and for VAS by 33.1% (p < 0.01). Thus, the efficiency of intrasosseous infiltration of autologous platelet-rich plasma in the treatment of patients with OA, accompanied by edema of the bone marrow in the subchondral zone, was proved.

Keywords: bone marrow edema, osteoarthritis, autologous platelet-rich plasma, intrasosseous Infiltation, quality of life

Author contribution: Lyachkin AV and Islaieh OI — research planning, literature collection and analysis, data interpretation, draft preparation; Garkavi AV — research planning, data interpretation; Katuryan PI — research planning, draft preparation; Bobrov DS, Yavlleva RH and Tielisheva EYu — research planning.

Compliance with ethical standards: the study was approved by the local ethics committee of the Sechenov University (protocol № 06–18 dated June 06, 2018). All patients agreed to participate in the study in writing.

Correspondence should be addressed: Osama I. Islaieh
Bolshoi Tishinsky Pereulok 26/15, Moscow, 123557; osaibso@yahoo.com

Received: 12.07.2019 Accepted: 26.07.2019 Published online: 20.08.2019

DOI: 10.24075/vrgmu.2019.053

ЭФФЕКТИВНОСТЬ ВНУТРИКОСТНОГО ВВЕДЕНИЯ АУТОЛОГИЧНОЙ ОБОГАЩЕННОЙ ТРОМБОЦИТАМИ ПЛАЗМЫ В ЗОНЕ ОТЕКА КОСТНОГО МОЗГА ПРИ ОСТЕОАРТРОЗЕ КОЛЕННОГО СУСТАВА

А. В. Лычагин, А. В. Гаркавий, О. И. Ислейих, П. И. Катунян, Д. С. Бобров, Р. Х. Явлева, Е. Ю. Целищева
Первый Московский государственный медицинский университет имени И. М. Сеченова (Сеченовский Университет), Москва, Россия

Остеоартроз (OA) поражает как пожилых людей, для которых он одна из основных причин инвалидности, так и лиц трудоспособного возраста и является актуальной клинической и социальной проблемой. В структуре OA одним из основных проявлений является отек костного мозга (ОКМ). В работе рассмотрены вопросы влияния ОКМ на развитие гонартроза, а также терапевтические подходы к ведению пациентов с OA. Целью исследования была разработка методики лечения ОКМ при OA коленного сустава путем локального внутрикостного введения в зону отека аутологичной обогащенной тромбоцитами плазмы (PRP). Исследовали 17 пациентов с диагнозом «Остеоартроз II-IV ст.» по классификации Kellgren-Lawrence, у которых на МРТ в субхондральной зоне выявлены области локального воспаления в виде ОКМ в соответствии с международной классификацией WORMS. Средний возраст пациентов составил 41.7 ± 14.3 лет. Пациентам внутрикостно из внесуставного доступа в зону ОКМ вводили аутоплазму под рентгеноскопическим контролем. Оценку эффективности лечения проводили по шкалам ВАШ, WOMAC и KOOS до введения аутоплазмы, через 1 и 3 месяца после начала лечения. Через 3 месяца после манипуляции отмечалось статистически значимое снижение показателей интенсивности воспалительного синдрома: по WOMAC на 17.5%, KOOS на 19.4% и по ВАШ на 33.1% (p < 0.01). Таким образом, доказана эффективность внутрикостного введения аутологичной обогащенной тромбоцитами плазмы в лечении пациентов с OA, сопровождающихся ОКМ в субхондральной зоне.

Ключевые слова: отек костного мозга, остеоартроз, аутологичная обогащенная тромбоцитами плазма, внутрикостное введение, качество жизни

Information о вкладе авторов: A. V. Lyachkin and O. I. Islaieh — planning the study, literature collection and analysis, data interpretation, draft preparation; A. V. Garkavi — research planning, data interpretation; P. I. Katunyan — research planning, preparation; D. S. Bobrov, R. H. Yavliva and E. Yu. Tseliacheva — planning the study.

Соблюдение этических стандартов: исследование одобрено локальным комитетом по этике ИММУ им. И. М. Сеченова (протокол No 6–18 от 06 июня 2018 г.). Все пациенты подписали добровольное информированное согласие.

Для корреспонденции: Osama I. Islaieh
ул. Большой Тишинский переулок, д. 26/15, г. Москва, 123557; osaibso@yahoo.com


DOI: 10.24075/vrgmu.2019.053

According to the WHO, 11 to 13% of the world’s population suffer from osteoarthritis (OA). OA affects both the elderly, for whom it is one of the main causes of disability, and the working age people [1–4]. Peculiar to the disease are chronic pain, destruction and loss of articular cartilage, remodeling of subchondral bone, formation of osteophytes, inflammation of the synovial membrane of varying degree, involvement of both intraarticular and paraarticular structures in the pathological process [5]. For a long time, it was the articular cartilage that was believed to be the driver of OA development. However, in the last decade the role of the subchondral bone (SB) has been attracting attention both from the point of view of etiopathogenesis and...
that of its clinical significance in the processes [6]. It was proved that SC remodeling plays an important part in OA pathogenesis [7]. The changes therein can come first and trigger OA of which can be a consequence of the developing degenerative dystrophic processes [8–10].

An important sign of pathological changes in SC with OA in the background is the MRI-detected bone marrow edema (BME). This term was first registered in 1988; it is increasingly used to describe an MR signal alerting of an OA-associated pathology [11, 12]. BME is usually found in the subchondral sclerosis zone, aggravated by the increased share of the bone tissue volume and trabecular layer compaction [13]. As OA advances, BME can also be a sign of osteonecrosis, which causes pain at rest [20, 21].

Despite the increasing attention paid to the BME’s influence on OA lately, a consensus has not yet been reached. Treating subchondral bone pathology is one of the most-discussed topics. When the nature of articular cartilage and subchondral bone interrelation was understood, the importance of changes in this bone became more apparent. The interrelation was called the osteochondral (functional) unit. It was shown that BME is closely associated with the progression of intraarticular structures degeneration and joint pains intensification. Thus, the likelihood of arthroplasty as the subsequent progressive destruction of articular structures tends to grow, which is considered an important risk factor in the progression of OA. At the same time, some researchers believe that BME can also be a sign of osteonecrosis, which causes pain at rest [14, 18].

Exclusion criteria: bilateral arthrosis of the knee joints with bone marrow edema in the subchondral zone; body mass index 20–33; opportunity for observation during the entire study period; mental adequacy, ability and willingness to cooperate and implement the doctor’s recommendations. Exclusion criteria: bilateral arthrosis of the knee joints with synovitis; body mass index > 33; polyarthritides; severe limb deformation — varus curvature of the diaphysis more than 4 °C and valgus — more than 16 °C; arthroscopy less than 6 months before inclusion in the study; patient refusal from further participation in the study; identification of objective contraindications to surgery; lack of the possibility of dynamic monitoring and control during the established period.

METHODS

The study involved 17 patients (41.7 ± 14.3 years), 15 of them with grade II–IV knee OA (Kellgren–Lawrence classification) with concomitant with MRI-detected BME primarily located in the medial (inner) parts of the knee joint [30]. Inclusion criteria: patients of both sexes in age from 40 to 80 years; predominance of the knee joint arthritis, joint pain score more than 3 points on VAS; radiological 2 and 4 degrees of the disease severity according to I. Kellgren and I. Lawrence classifications with bone marrow edema in the subchondral zone; body mass index 20–33; opportunity for observation during the entire study period; mental adequacy, ability and willingness to cooperate and implement the doctor’s recommendations. Exclusion criteria: bilateral arthrosis of the knee joints with synovitis; body mass index > 33; polyarthritides; severe limb deformation — varus curvature of the diaphysis more than 4 °C and valgus — more than 16 °C; arthroscopy less than 6 months before inclusion in the study; patient refusal from further participation in the study; identification of objective contraindications to surgery; lack of the possibility of dynamic monitoring and control during the established period.

The duration of the disease ranged from 1 to 9 years (5.2 ± 4.5). The patients were diagnosed with OA based on their complaints, history and clinical-radiological examination. All patients had their knee joints x-rayed in two projections, anteroposterior and lateral, with tibia flexed at 30 (Table1). MRI provided the data needed to evaluate the condition of the subchondral zone and BME in all patients. We used WORMS (Whole Organ Magnetic Resonance Imaging Score) to describe the bone marrow edema. The Score is designed to assess signal intensity on T2-weighted images [2]. The lesions were evaluated in points; we measured the maximum diameter of the edemas using RadiAnt DICOM Viewer 4.6.9 (64-bit) software (Medixant; France). Table 2 contains the diagnosis criteria. Figures 1 and 2 are tomograms depicting severe BME in some of the patients participating in the study.

Upon admission, all patients had their pain level evaluated with the help of VAS and filled the WOMAC and KOOS questionnaires [31–33]. The values of the same indicators were registered further on, in 1 and 3 months after the studied procedure.

PRP preparation and method description

We used a Regenlab PRP kit (REGEN ACR technology, 2011, Switzerland) to prepare PRP injections. The kit allows making a preparation that persists for a specific period of time after intraosseous administration. We distributed 30 ml of...
autologous venous blood into three tubes: two REGEN BCT tubes to prepare autologous platelet-rich plasma and one REGEN ATS tube to obtain autologous thrombin serum used to activate the preparation (step 1). All tubes were centrifuged for 5 minutes at 3100 rpm (step 2). Then, under sterile conditions, we mixed PRP from REGEN BCT and autologous thrombin serum from REGEN ATS in a syringe at 10:1 ratio (step 3) (Fig. 2). The PRP was injected into the BME zone as identified on the T2-weighted images, i.e. in the medial or lateral condyle of femur or tibia. For the manipulation, the patients were put on to the operating table, supine, under the influence of intravenous anesthesia (step 4) (Fig. 2).

The preparation was administered through a stylet with a 13 gauge mandrin (Stryker, USA); the process was monitored with the help of an electron-optical converter (EOC). The lesion received 5 ml of the preparation through the needle that reached it (Fig. 3).

For the days following the procedure, the patients were recommended to apply cold locally, limit loads for up to 1 week, restrain from increased loads for up to 2 weeks, take 4 g of paracetamol a day (orally) if in pain. No selective non-steroidal anti-inflammatory drugs were used.

Statistica 13.3 software (StatSoft; USA) enabled statistical analysis of the data.

### Table 1. The patients

<table>
<thead>
<tr>
<th>Gender (number of patients)</th>
<th>Female</th>
<th>10 (58.8%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>7 (41.2%)</td>
</tr>
<tr>
<td>Average age (years)</td>
<td></td>
<td>41.7 ± 14.3</td>
</tr>
<tr>
<td>Knee joint disease duration (years)</td>
<td>5.2 ± 4.5</td>
<td></td>
</tr>
<tr>
<td>Average time under medical supervision (months)</td>
<td>5.5 ± 2.5</td>
<td></td>
</tr>
<tr>
<td>Affected joint (amount)</td>
<td>One side</td>
<td>17 (100%)</td>
</tr>
<tr>
<td>Kellgren–Lawrence grade based on x-ray</td>
<td>I</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>5 (29.4%)</td>
</tr>
<tr>
<td></td>
<td>III</td>
<td>10 (58.8%)</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>2 (11.8%)</td>
</tr>
</tbody>
</table>

### Table 2. WORMS diagnosis criteria

<table>
<thead>
<tr>
<th>BME degree</th>
<th>Lesion diameter (mm)</th>
<th>WORMS score</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Minimal</td>
<td>&lt; 5</td>
<td>1</td>
</tr>
<tr>
<td>Moderate</td>
<td>5–20</td>
<td>2</td>
</tr>
<tr>
<td>Severe</td>
<td>&gt; 20</td>
<td>3</td>
</tr>
</tbody>
</table>

**RESULTS**

According to MRI, 2 patients had minimal BME, in 7 patients the edema was moderate and in 8 it was qualified as severe (Fig. 4).

After PRP administration, the pain, as measured with VAS, subsided significantly over time. Before the treatment, it was identified as “severe” (51.4 ± 6.9 points); 1 month after, the score decreased by 36.4 points, which corresponds to “minor” (15.0 ± 8.3, p < 0.01), and 3 months later the value was 18.3 ± 11.6 points, (p < 0.01), which is also within the “minor” range (Fig. 5).

WOMAC figures also reflect significant improvement of the indicators. The average score (summed) at admission was 57.38 ± 12.85 points, 1 month after drug administration — 76.45 ± 5.91 points (p < 0.01), and after 3 months it reached 75.33 ± 8.41 (p < 0.01) (Fig. 5).

KOOS figures followed the same pattern: the average score at admission was 52.78 ± 13.38 points, a month after PRP injection — 72.00 ± 7.35 points (p < 0.01), and 3 months later it reached 72.13 ± 8.50 points (p < 0.01) (Fig. 5).

Since KOOS includes 5 subscales that consider various aspects of the knee joint condition, it is of interest to evaluate them individually (Table 3). Relative to the beginning of the
treatment, all indicators have shown significant positive dynamics. It should be noted that the most pronounced improvement in the average values was recorded in the Sport and Recreation Function (from 25.83 ± 21 to 53.33 ± 28.86) and the Quality of Life (from 24.08 18.39 to 54.18 21.48) subscales by the third month. The pain subsided by the first month and then increased slightly by the third months but still remained significantly less intense.

It is important to note that the majority of KOOS subscales, as well as VAS and WOMAC, revealed that the improvement peaks 1 month after administration of the preparation, and by the third month the average values deteriorate slightly, although the change was not always significant.

**DISCUSSION**

The intraosseous subchondral PRP injection technique we developed is a minimally invasive and affordable modality to treat gonarthrosis with BME. The PRP preparation made with the Regenlab PRP kit offers a prolonged therapeutic effect. Previously, it was shown that BME is a zone of high bone metabolism and accumulation of cytokines and angiogenic factors, which is essentially translates into local inflammation [24, 25]. The improvement of the patients’ condition after administration of PRP supports the theory that such plasma produces a pronounced anti-inflammatory effect when applied topically. Despite the fact that PRP contains angiogenic and

---

**Fig. 2.** Preparation of PRP. 1: Blood collection. 2: Centrifugation. 3: Mixing (10 : 1 ratio). 4: Injection

**Fig. 3.** EOC-controlled administration of PRP into the BME zone, medial condyle of the femur. EOC image: needle in the femur’s medial condyle

**Fig. 4.** Patients by BME severity, WORMS
Fig. 5. Dynamics of the average values, VAS, WOMAC and KOOS. 17 knee OA patients were injected PRP in the BME zone. Their condition was assessed before injection and 1 and 3 months after treatment.

Table 3. Functional scale, KOOS subscales

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>1 month after treatment</th>
<th>3 months after treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>62.85 ± 10.28</td>
<td>74.28 ± 10.53*</td>
<td>71.43 ± 6.18*</td>
</tr>
<tr>
<td>Pain</td>
<td>53.70 ± 7.18</td>
<td>74.40 ± 11.87*</td>
<td>70.36 ± 12.52*</td>
</tr>
<tr>
<td>Activities of Daily Living</td>
<td>53.36 ± 15.41</td>
<td>73.04 ± 10.21</td>
<td>74.51 ± 4.24*</td>
</tr>
<tr>
<td>Sports and Recreation</td>
<td>25.83 ± 21</td>
<td>58.33 ± 19.66 *</td>
<td>53.33 ± 28.86 *</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>24.08 ± 18.39</td>
<td>40.62 ± 23.30 *</td>
<td>54.18 ± 21.48*</td>
</tr>
<tr>
<td>Final index</td>
<td>52.78 ± 13.38</td>
<td>72.00 ± 7.35*</td>
<td>72.13 ± 8.50 *</td>
</tr>
</tbody>
</table>

Note: * — statistically significant change of the value compared to the initial measurements, \( p < 0.01 \).

profibrotic growth factors, there was not reported a single case of aggravation.

The data we obtained in the context of this research effort are largely consistent with those of other authors who injected PRP intraosseously to treat gonarthrosis [27–29]. One of the papers describes treating 14 gonarthrosis patients (severe condition) with three intraarticular injections of 8 ml of PRP in combination with subchondral intraosseous injections of 5 ml of PRP (delivered to the medial tibial condyle and the medial condyle of the femur); after 6 months, all patients reported less pain and improved KOOS scores, which echo our results [29]. In our case, the drug was administered intraosseously, once, and the clinical improvement was recorded 3 months earlier.

Nevertheless, it must be recognized that by the third month the achieved effect fades, although clinical tests still show that the improvement is significant.

The most pronounced improvements, which were recorded in the Sport and Recreation Function and the Quality of Life subscales, probably result from the emotional state of the patients who felt the positive effect of the treatment; thus, it should be monitored individually and with other measurement techniques.

CONCLUSIONS

II–IV grade OA, as defined by the Kellgren–Lawrence system, is aggravated by an MRI-detectable subchondral BME lesions, which are part of the disease pathogenesis contributing to its further progression and causing pain. Autologous platelet-rich plasma injected into the BME lesion produces a pronounced and persistent positive effect, alleviating pain and improving function of the affected joint; the effect lasts for at least 3 months.

Further investigation of the gonarthrosis-associated BME treatment method that implies use of PRP is an important task for modern orthopedics with considerable promise in the view of improvements registered in patients and the data on the role played by the osteochondral functional unit in the pathological process.

References

6. Alekseeva IJ, Zajceva EM. Rol’ subhondral’noj kosti pri osteartroze.
5

3.

2.

1.

19.

17.

13.

12.

10.

9.

8.

7.


et al. Subchondral bone marrow lesions are highly associated with and predict subchondral bone attrition longitudinally. The MOST study Osteoarthritis and Cartilage. 2010; (18): 47–53.


