

University of Groningen

Compression with the Juxta Reduction Kit ® (medi) in patients undergoing a total knee arthroplasty

Hendrickx, Ad A.; Krijnen, Wim P.; Damstra, Robert J.; Bimmel, Richard; van der Schans, Cees P.

Published in:
Veins and Lymphatics

DOI:
[10.4081/vl.2017.6622](https://doi.org/10.4081/vl.2017.6622)

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2017

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):

Hendrickx, A. A., Krijnen, W. P., Damstra, R. J., Bimmel, R., & van der Schans, C. P. (2017). Compression with the Juxta Reduction Kit ® (medi) in patients undergoing a total knee arthroplasty. *Veins and Lymphatics*, 6(6622). <https://doi.org/10.4081/vl.2017.6622>

Copyright

Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

Take-down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): <http://www.rug.nl/research/portal>. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.

Compression with the *Juxta Reduction Kit*® (*medi*) in patients undergoing a total knee arthroplasty

Ad A. Hendrickx,^{1,2} Wim P. Krijnen,¹ Robert J. Damstra,² Richard Bimmel,³ Cees P. van der Schans^{2,4}

¹Expert Centre of Lympho-Vascular Medicine, Nij Smellinghe Hospital, Drachten; ²Research and Innovation Group in Health Care and Nursing, Hanze University of Applied Sciences, Groningen; ³Department of Orthopaedics and Traumatology, Nij Smellinghe Hospital, Drachten; ⁴Department of Rehabilitation Medicine, University of Groningen, University Medical Center Groningen, The Netherlands

Introduction

Total knee replacement (TKA) is a successful operation in the treatment of osteoarthritis. Enhanced recovery programs, with emphasis on early mobilization and optimal analgesics have reduced hospital stay and peri-operative morbidity.^{1,2}

Patients undergoing a knee arthroplasty can experience pain, swelling, a decrease in knee-extension strength, loss of range of motion (ROM), causing a decline in functional performance.³⁻⁶ Problems with the activation of the quadriceps, in the early postoperative phase can be related to either the surgical procedure or arthrogenic reflex inhibition of the muscle related to pain and swelling.⁷

Post-operative swelling is mainly caused by intra-articular bleeding and inflammation of peri articular tissues.⁸

Impaired functional performance can delay rehabilitation and affect length of stay and patient-reported outcomes.⁸

Thereby, excessive swelling is associated with increased rates of wound dehiscence and infection in surgical wounds.⁹

Compression therapy is a frequently used modality in the postoperative treatment to reduce swelling. The literature is not consistent about the effects of compression therapy. This is due to the use of various materials, the time frame of application and the different outcome measurements used.^{8,10,11} Our experiences with compression in the treatment of venous ulcers and lymphedema create possibilities to introduce compression technologies in other fields of medicine, such as orthopaedic sur-

gery.

Regarding the type of bandage, inelastic compression bandages show a low, tolerable resting pressure and a more effective activation of the deep venous system and calf muscle pump with ambulation (working pressure) compared to elastic materials.^{12,13}

The *Juxta Reduction Kit*® (JRK) is a non-elastic compression device, suitable for self-management, which can be tailored to the circumference of the leg. The device allows full ROM, so ambulation and exercise will not be impaired.

It is hypothesized that immediate post-operative compression and prolonging the period of use until 6 weeks postoperatively will prevent excessive swelling and initiate an earlier reduction. Reduced swelling improves range of motion, knee extension strength, reduces pain, supporting the rehabilitation process.

The research questions concern feasibility and effectiveness of the treatment on volume, pain, wound aspects and functional recovery. In this article we will focus on study design and feasibility aspects.

Materials and Methods

In Nij Smellinghe hospital the *fast-track principles* have been implemented in joint replacement surgery.

Ambulation and exercise of the patient start 4 hours postoperative and patients are discharged when they are functional independent.

Table 1 shows the compression and exercise protocols for the control and treatment group.

Patients are instructed about the use of the JRK prior to the operation and during clinical stay. They are instructed to apply a firm, but tolerable dose of compression.

After having signed the inform consent patients are randomly assigned to either the control or the treatment group.

Inclusion criteria: i) 18 years of age or older; ii) patients undergoing a primary elective total knee arthroplasty; iii) the patient is able to understand the study and is willing to give written Informed Consent.

Exclusion criteria: i) allergy against one of the used materials; ii) severe systemic diseases causing peripheral edema; iii) acute superficial or deep vein thrombosis; iv) arterial occlusive disease (stadium II, III or IV) ABPI<0.8; v) local infection in the therapy area; vi) auto-immunological disorders or vasculitis; vii) use of systemic corticosteroids; viii) inability to don, doff and

Correspondence: Ad A. Hendrickx, Nij Smellinghe Hospital, Department of Physical Therapy, Compagnonsplein 1, 9202 NN Drachten, The Netherlands.
E-mail: a.hendrickx@nijsmellinghe.nl

This work is licensed under a Creative Commons Attribution 4.0 License (by-nc 4.0).

©Copyright A.A. Hendrickx et al., 2017
Licensee PAGEPress, Italy
Veins and Lymphatics 2017; 6:6622
doi:10.4081/vl.2017.6622

adjust the device.

The local Medical Ethical Committee approved the study. The study was registered under ClinicalTrials.gov, NCT02375945.

Measurements and data collection

Feasibility data are collected about the number of patients recruited and dropped out, time required for the whole process (measurements, preparation of the JRK, instruction of the patient and administration), pain in action (PA) and in rest (PR), the ability to exercise and sort and number of complications.

Data collection was pre-operative, day 1 and day 2 during hospital stay and at day 14, 42 and 84 after discharge.

Statistical analyses

All data are analyzed with the programming language R version 3.3.0 for statistical computing. A P-value smaller than or equal to 0.05 is considered to be statistically significant.

Results

In total 68 patients were included (32 patients in the control group and 36 patients in the treatment group). 19 patients in the control group (13 drop outs) and 20 patients in the treatment group (16 drop outs) completed the study.

Measurements, preparation of the JRK, instruction and administration demanded 6 hours per patient.

Pain scores in rest and action are shown in Figure 1. Figures 2 and 3 show the *inter-action data plots*.

The ability to exercise was successful in the first phase of recovery. When the ROM comes closer to the 90 degrees of flexion the material strips up at the back of the knee and restricts the possibility to flex the knee. No complications did occur.

Conclusions

The VAS scores for pain in rest and in action showed no significant differences between the two groups. Regarding feasibility

ity this is considered positive, because more pain was expected by adding compression in the first phase of recovery. A limitation of this study is that no data were collected about the use of pain-medication. The analgesic influence of compression on the pain

cannot be stated.

This pilot study demonstrates a feasible concept. Regarding outcome on volume the preliminary results show a positive effect in favor of the treatment group, supporting the need for further research.

Table 1. Compression and exercise protocol.

Control group	Treatment group
<ul style="list-style-type: none"> Immediately postoperative until 24 hours postoperative compression with elastic bandages for the knee region with Elastomuhl Haft® (Jobst) From 24h until 6 weeks postoperative an anti-thrombosis stocking, Comprinet stocking® (BSN Medical) 	<ul style="list-style-type: none"> Immediately postoperative until 6 weeks postoperative, 24/7 compression with the JRK®+ Struva®, class 2 anti-thrombosis stocking (medi)
<ul style="list-style-type: none"> Ambulation and exercise program according to the <i>fast-track principles</i> 	<ul style="list-style-type: none"> Ambulation and exercise program according to the <i>fast-track principles</i>

	Results Control group		Results Treatment group		P-value. Time effects	P value. Group by time interaction effects
	Mean	SD	Mean	SD		
	Pain Rest (VAS 0-10)		Pain Rest (VAS 0-10)			
T0	2.8	2.7	3.9	2.9		
T1	4.3	2.6	5.9	1.9	0.039	0.663
T2	2.0	2	3.8	1.7	0.296	0.823
T14	2.6	2.1	3.8	2.4	0.637	0.972
T42	2.1	2.3	1.9	1.7	0.198	0.205
T84	0.7	1.1	0.8	1.7	0.001	0.265
	Pain Action (VAS 0-10)		Pain Action (VAS 0-10)			
T0	5.8	2.8	5.9	2.4		
T1	5.8	3.1	6.6	1.9	0.888	0.580
T2	4.3	3.2	4.9	1.7	0.098	0.597
T14	3.4	2.9	3.8	2.3	0.002	0.828
T42	2.7	2.5	2.7	2.3	<0,001	0.972
T84	1.5	1.7	1.7	2.3	<0,001	0.863

Figure 1. Pain scores in rest and action.

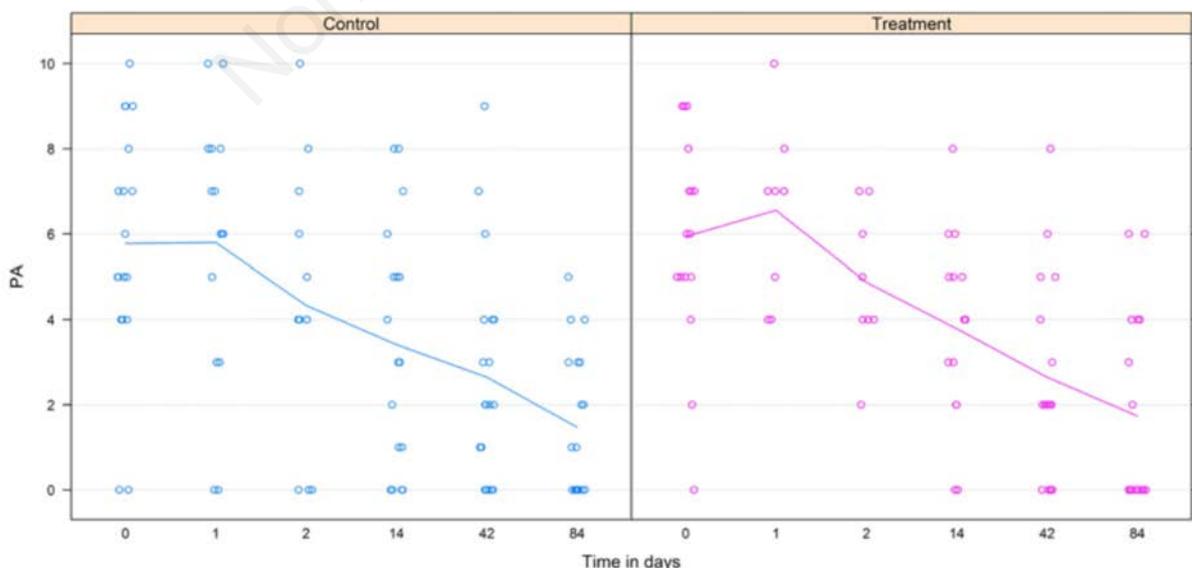


Figure 2. Interaction plot pain in action (PA).

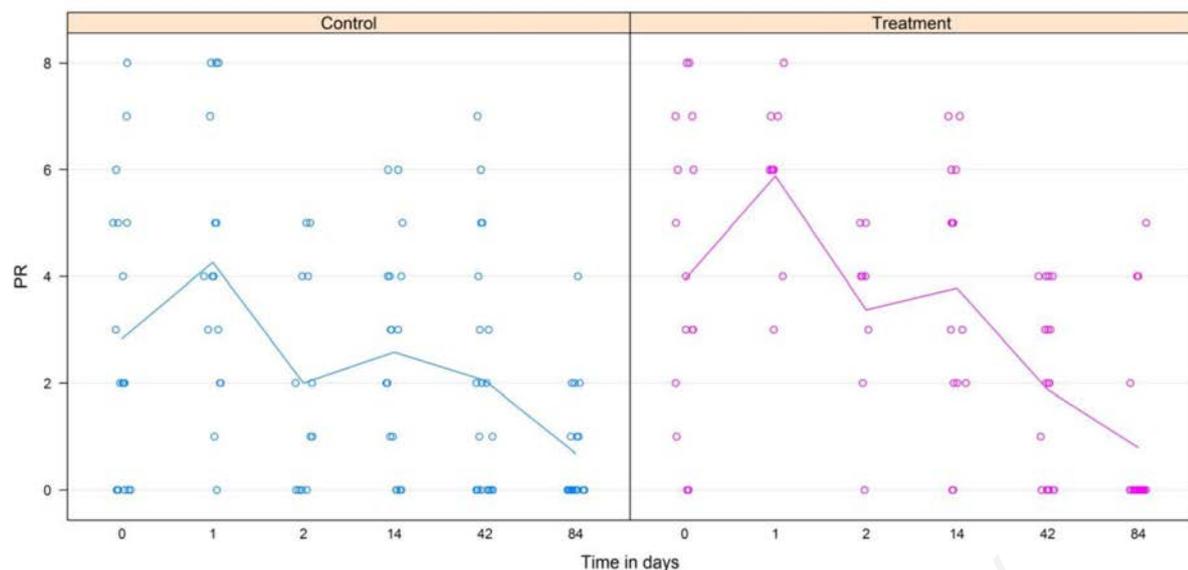


Figure 3. Interaction plot pain in rest (PR).

References

1. Khan SK, Malviya A, Muller SD, et al. Reduced short-term complications and mortality following enhanced recovery primary hip and knee arthroplasty: results from 6,000 consecutive procedures. *Acta Orthop* 2014;85:26-31.
2. Berend KR, Lombardi Jr AV, Mallory TH. Rapid recovery protocol for perioperative care of total hip and total knee arthroplasty patients. *Surg Technol Int* 2004;13:239-47.
3. Mizner RL, Petterson SC, Snyder-Mackler L. Quadriceps strength and the time course of functional recovery after total knee arthroplasty. *J Orthop Sports Phys Ther* 2005;35:424-36.
4. Mizner RL, Petterson SC, Stevens JE, et al. Early quadriceps strength loss after total knee arthroplasty. The contributions of muscle atrophy and failure of voluntary muscle activation. *J Bone Joint Surg Am* 2005;87:1047-53.
5. Mizner RL, Snyder-Mackler L. Altered loading during walking and sit-to-stand is affected by quadriceps weakness after total knee arthroplasty. *J Orthop Res* 2005;23:1083-90.
6. Stevens JE, Mizner RL, Snyder-Mackler L. Quadriceps strength and volitional activation before and after total knee arthroplasty for osteoarthritis. *J Orthop Res* 2003;21:775-9.
7. Holm B, Kristensen MT, Bencke J, et al. Loss of knee-extension strength is related to knee swelling after total knee arthroplasty. *Arch Phys Med Rehabil* 2010;91:1770-6.
8. Brock TM, Sprowson AP, Muller S, Reed MR. Short-stretch inelastic compression bandage in knee swelling following total knee arthroplasty study (STICKS): Study protocol for a randomised controlled feasibility study. *Trials* 2015;16:87.
9. Yu GV, Schubert EK, Khoury WE. The Jones compression bandage. Review and clinical applications. *J Am Podiatr Med Assoc* 2002;92:221-31.
10. Munk S, Jensen NJ, Andersen I, et al. Effect of compression therapy on knee swelling and pain after total knee arthroplasty. *Knee Surg Sports Traumatol Arthrosc* 2013;21:388-92.
11. Andersen LO, Husted H, Otte KS, et al. A compression bandage improves local infiltration analgesia in total knee arthroplasty. *Acta Orthop* 2008;79:806.
12. Partsch H, Menzinger G, Mostbeck A. Inelastic leg compression is more effective to reduce deep venous refluxes than elastic bandages. *Dermatol Surg* 1999;25:695-700.
13. Spence RK, Cahall E. Inelastic versus elastic leg compression in chronic venous insufficiency: a comparison of limb size and venous hemodynamics. *J Vasc Surg* 1996;24:783-7.