

EDITOR'S LETTER | 8 MAY 2026

Dear reader,

I am incredibly proud to introduce the first edition of our newsletter.

This edition focuses on revision surgery and the risks and challenges surrounding it, an area of growing importance across modern medical practice.

As we move further into an increasingly digital age, with AI becoming part of our daily professional lives, we wanted to embrace innovation in a thoughtful and responsible way. We have introduced James and Pri, our two AI educators, to help present and introduce our factual articles, all of which are written by experienced professionals and published unedited for our audience and clients.

As always, our commitment remains the same, to continue providing the highest levels of service, support, and protection to our customers as the healthcare landscape continues to evolve.

I hope you enjoy reading this first edition as much as we enjoyed creating and publishing it.

Best Wishes,




CEO, First Medical Indemnity Limited


Lifestyle

 THE **FMI News** THE VOICE OF HEALTHCARE PROFESSIONALS. STORIES THAT MATTER.

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REVISION KNEE SURGERY IN UK PRIVATE PRACTICE: ARTHROPLASTY AND ACL RECONSTRUCTION IN AN ERA OF RISING COMPLEXITY.

Written by Professor Sanjiv Jari

Revision knee surgery: whether following total knee arthroplasty (TKA) or anterior cruciate ligament reconstruction (ACLR) represents two of the most technically demanding areas of orthopaedic practice. Within the UK independent sector, both are increasing in volume, complexity, and patient expectation. Though mechanistically distinct, they share a common narrative: the challenge of managing a failed primary procedure in a patient who often arrives with high demands and imperfect anatomy.

A Growing Burden Across Both Disciplines

Annual revision knee replacement procedures in the UK increased from 2,743 in 2006 to 6,819 in 2019 which a 149% rise with incidence climbing from 6.3 to 14 per 100,000 adults over the same period.¹ In ACLR, the trajectory is similar. Failure rates in primary ACL reconstruction reach up to 15%, and as the total number of primary reconstructions rises, so too does the volume of revision procedures, with re-failure rates following revision surgery reported as high as 25%.⁴ The COVID-19 pandemic compounded both problems: the NHS accounted for only 70% of pre-pandemic primary knee replacement numbers post-COVID, while independent sector activity rose substantially,² and the time from ACL injury to reconstruction surgery doubled over the pandemic period.⁸ These delays concentrated a more complex, physiologically compromised cohort into private practice pipelines.

Understanding Failure: A Prerequisite for Revision

In both settings, understanding why the primary procedure failed is the essential first step. ACL reconstruction failure is primarily driven by technical errors, particularly tunnel malposition, accounting for 60–70% of cases, followed by traumatic mechanisms and biological failure, with timing of failure offering important diagnostic clues.¹² For revision TKA, the procedure is technically demanding and associated with high complication rates, requiring not only an expert surgeon but a full multidisciplinary team including allied surgical specialties, infection specialists, and physiotherapists.⁵ In both contexts, the surgeon in private practice must often reconstruct a failure mechanism from incomplete records which is a clinical skill in itself.

Surgical Evolution: Technology and Technique

Both revision arthroplasty and rACLR are being reshaped by technological and procedural advances. In knee replacement, robotic-assisted platforms are increasingly applied to complex revision scenarios. Robotic navigation enables accurate implant placement in revision TKA, addressing bone defects, joint line challenges, and component orientation including in periprosthetic joint infection cases managed via 1.5-stage exchange.⁶ In revision ACLR, lateral extra-articular augmentation has become a central strategic consideration.

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THE PATIENT EXPECTATION PROBLEM

Written by Professor Sanjiv Jari

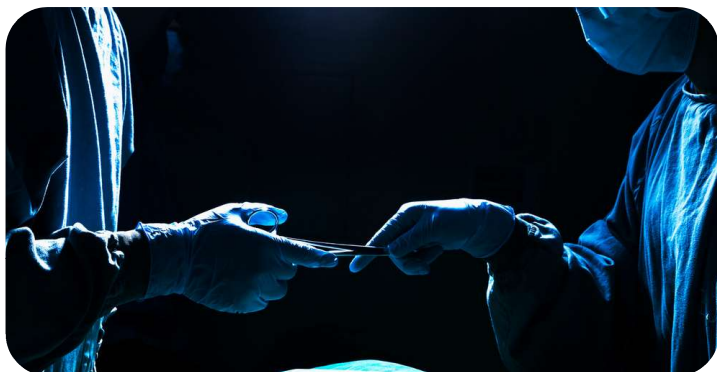
Reported use of lateral extra-articular procedures in both primary and revision ACLR increased significantly between 2016 and 2023, with surgeons incorporating lateral augmentation more frequently over time.⁷ For cases with elevated posterior tibial slope, slope-reducing osteotomy is increasingly recommended to correct bony malalignment that, if untreated, contributes directly to graft failure.¹²

The Patient Expectation Problem

Managing patient expectations is perhaps the defining challenge of revision knee surgery in the private sector. Nearly 20% of patients are dissatisfied following well-performed primary TKA, with unfulfilled expectations identified as a principal source of dissatisfaction, patients typically anticipating pain relief, improved function, and return to sport, yet often being overly optimistic.⁹ In rACL, the psychology is equally formidable. Athletes undergoing revision ACL surgery demonstrate ACL-RSI scores 14.2 points lower than those following primary reconstruction, a clinically relevant deficit reflecting significantly reduced psychological readiness to return to sport.¹⁰ Meanwhile, patients undergoing revision ACLR have lower but still demanding expectations, with younger, highly active individuals reporting the highest.¹¹ In both populations, private patients are frequently well-informed, financially invested, and emotionally primed which is a combination that heightens the stakes of every consultation.

Conclusion

Revision knee surgery, whether arthroplasty or ligament reconstruction, is evolving rapidly within UK private practice. Technical advances, from robotic implantation to lateral augmentation strategies, are improving the surgeon's armamentarium. But the evidence consistently shows that operative excellence alone is insufficient. Structured pre-operative counselling, systematic failure analysis, psychological readiness assessment, and honest outcome framing are as important as any surgical technique. For the private orthopaedic surgeon, excellence in revision knee surgery demands equal investment in the consultation room and the operating theatre.



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