The Knee 23 (2016) 342

Contents lists available at ScienceDirect

The Knee

Corrigendum

Corrigendum to "The magnetic resonance aspect of a polyurethane meniscal scaffold is worse in advanced cartilage defects without deterioration of clinical outcomes after a minimum two-years follow-up" [Knee (2015) 389–394]

Pablo Eduardo Gelber [a,b,*], Alexandru Mihai Petrica [a], Anna Isart [b], Raquel Mari-Molina [c], Juan Carlos Monllau [b,c]

[a] Department of Orthopaedic Surgery, Hospital de la Santa Creu i Sant Pau, Universitat Autònoma de Barcelona, Sant Quintí 89, 08041 Barcelona, Spain
[b] ICATME-Hospital Universitari Quirón Dexeus, Universitat Autònoma de Barcelona, Sabino de Arana 5-19, 08028 Barcelona, Spain
[c] Department of Orthopaedic Surgery, Parc de Salut Mar, Universitat Autònoma de Barcelona, Barcelona, Spain

The authors regret that they made a mistake when writing the figure legends of Figs. 3 and 4. Both magnetic resonance images were showing the lateral instead of the medial compartment of the knee.

The authors would like to apologise for any inconvenience caused.

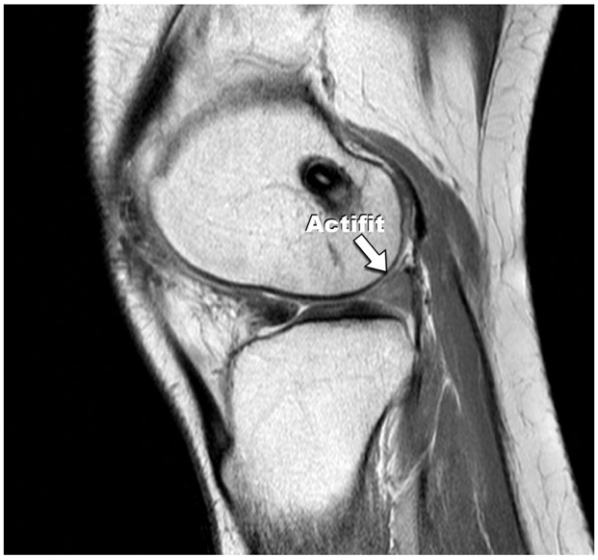

Fig. 3. MRI examination of a lateral compartment of the knee without chondral injury (ICRS grade 0) in 24 months after a medial Actifit® implantation. The sagittal spin-echo intermediate-weighted images showed that the Actifit® implant (white arrow) size was in this case identical to that of the normal meniscus (type 3) and that the signal intensity was slightly hyperintense (type 2). The interface between the prosthetic meniscus and the native meniscal tissue can no longer be observed.

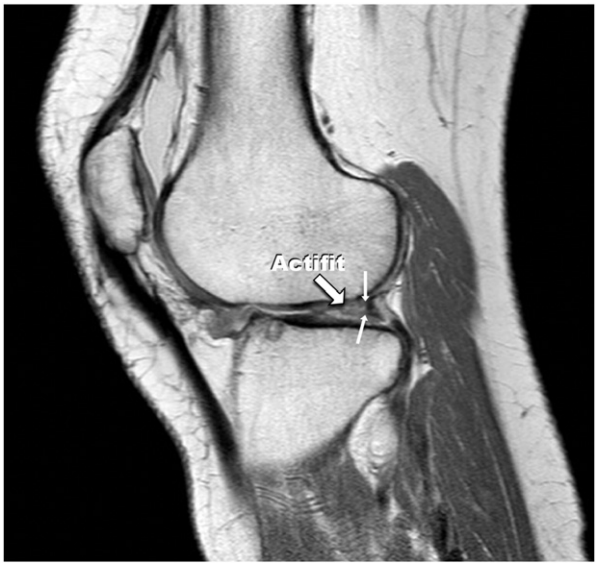

Fig. 4. MRI examination of a lateral compartment of the knee with a grade 4 ICRS chondral injury in 24 months after a medial meniscal polyurethane scaffold implantation. In this knee, a concomitant high tibial valgus osteotomy and a microfracture technique were concomitantly performed at the time of the index surgery. The sagittal images obtained with spin-echo intermediate-weighted showed the Actifit® with reduced size and irregular morphology (type 2). The signal intensity was slightly hyperintense (type 2) and the interface between the implant/meniscal tissue is clearly distinguishable (small white arrows).

DOI of original article: http://dx.doi.org/10.1016/j.knee.2015.01.008.
* Corresponding author at: Department of Orthopaedic Surgery, Hospital de la Santa Creu i Sant Pau, Universitat Autònoma de Barcelona, Sant Quintí, 89, 08041 Barcelona, Spain. Tel.: +34 93 553 70 31; fax: +34 93 553 70 33.
E-mail address: pablogelber@gmail.com (P.E. Gelber).

http://dx.doi.org/10.1016/j.knee.2016.01.002