Purpose: The goal of the classification we have developed proved to be very useful in the planning of the correct corresponding surgical treatment. As reported in the literature, early detection and treatment facilitates better outcome. This is not only confirmed by our study, but we have found that talus lesion starting from II degree is very often associated to a minor tibial plafond lesion, often underestimated, secondary to microinstability or to axial malalignment that in our experience has required an associated high tibial osteotomy. Conclusions: The rationale of this classification consists in giving each lesion a precise identification of position subdividing in A tibia, B talus as main lesions, 1-2-3 medial third, medial, lateral third, "a" tibia and "b" talus as secondary lesions (were present) We felt that it was important to maintain the classification of Berndt and harty with regards to the depth and the anatomo-pathological lesions found. For the staging of the lesions with the new classification the following will be used: es. grade A2bIII to define a lesion that has main localization the tibia, the medial position, secondary localization in the talus dome and grading of the lesion III.

P349
A NEW ANKLE CONDRAL LESIONS CLASSIFICATION
E. Di Cave, F.V. Sciarretta, P. Versari, A. Basilé
Jewish Hospital, Rome, Italy

Purpose: Aim of this study has been the identification of a treatment algorithm based on the proposal a new ankle chondral lesion classification, that took in consideration the need to better localize, understand and commonly relate the different chondral lesions patterns, diagnosed on MRI and confirmed and treated by ankle arthroscopy, both in the distal tibia and in the talar dome. Last ten years dilemma in such lesions treatment has focused on talus lesions staging, that, in our opinion represents just the 2/3 of the problem, neglecting the thorough examination of the distal tibia articular surface lesions.

Methods: Initially we needed to create a classification of cartilage ankle lesions in order to identify a common language both for the diagnosis then the planning and treatment of the lesions. One of the main problems to solve was that of evaluating, beyond the talus lesions, until now considered alone, the distal tibia extremity lesions which until now have been in impingement classification. We therefore searched for the most adequate and homogeneous classification to answer the needs of foot and ankle surgeons in daily practice, searching for common parameters between MRI -CT- RDX - Arthroscopic findings

Results: The results of this classification consists in giving each lesion a precise identification of position subdividing in A tibia, B talus as main lesions, 1-2-3 medial third, medial, lateral third, “a” tibia and “b” talus as secondary lesions (were present). The rationale of this classification consists in giving each lesion a precise identification of position subdividing in A tibia, B talus as main lesions, 1-2-3 medial third, medial, lateral third, “a” tibia and “b” talus as secondary lesions (were present). We felt that it was important to maintain the classification of Berndt and Hartle with regards to the depth and the anatomopathological lesions found. For the staging of the lesions with the new classification the following will be used:

P345
WHOLE BODY VIBRATION EXERCISE FOR PATIENTS WITH KNEE OSTEOARTHRITIS (OA): A COMPARISON OF TWO DEVICES AND A CONTROL GROUP
H. Lund, T. Trans, J. Aaboee, M. Henriksen, R. Christensen, B. Danneklej-Samsee, H. Bliddal
The Parker Institute, Frederiksberg, Denmark

Purpose: Whole body vibration (WBV) has been proposed as an effective exercise intervention because of its potential for increasing force generating capacity in the lower limbs, and a training effect on the neuromuscular system. Knee OA is associated with decreased muscular strength and neuromuscular function in the lower extremities. The aim of this study was to evaluate whether WBV would be able to improve muscle function of the lower extremities and balance and to improve the patients pain and physical signs of knee OA. In addition two different WBV devices were compared: one with vibration alone (VibMax) and one with vibration combined with the demand of keeping the body equilibrium during WBV (VibrosFär).

Methods: 52 female patients with knee OA, fulfilling the ACR-criteria, volunteered to participate in this study. Their mean age was 60.5 years (SD 9.9) and their mean Body Mass Index was 28.8 kg/m2 (SD 4.5). Patients with other chronic diseases or artificial knee or hip joint were excluded from the study. Before randomization, the proprioception (measured as knee joint position sense, JPS and threshold to detection of a passive movement, TDPM), ability to climb up and downstairs on time, walking on time, standing balance on a force plate and isometric muscle strength was measured. In addition the patients filled in the SF-36 and WOMAC questionnaires. Patients randomized to either VibrosFär (balance plate with laterally vibration, 24 - 30 Hz, 1-2 mm amplitude, VibrosFär, ProMedVi, Sweden) or VibMax (stable plate with both laterally and vertical vibration, 25-30 Hz, 1/2-4 mm amplitude, Vibmax, Xendor, Sweden) exercised two times per week for eight weeks. The exercise progression was standardized and equal for both exercise groups. A third group acted as control group.

Results: Baseline values of proprioception showed a total mean for all three groups of JPS: 5.5° (SD 2.6°) and for TDPM: 2.6° (SD 1.1°); total mean for all three groups for climbing six steps