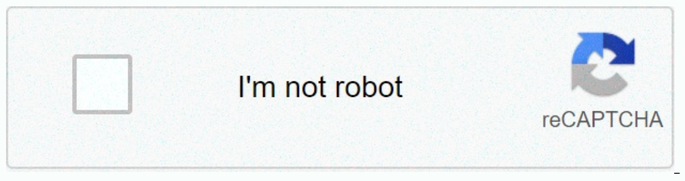

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Posterior meniscofemoral ligament of wrisberg

Meniscofemoral ligaments are straight collagen bands that attach to the posterior horn of the lateral meniscus and lateral part of the medial femoral condyle. While some consider them a link to two zones others regard them as two different links. These ligaments are named based on their position in relation to the posterior cross-link. The anterior meniscus ligament, also known as the Humphrey ligament, is anterior to PCL and the posterior meniscus mamory ligament or ligament of Wrisberg is posterior to the posterior cross ligament.in about 70% of the knees, there is either Humphrey's anterior meniscus ligament or posterior meniscus myric ligament present. At 6% of the knees, both ligaments will be present. Poirier and Charpy were first described in 1892 as the third cruciate ligament. Origin and IntroductionAustic: Musculoskeletal KeyAnterior menosynthetic ligament or HumphreyShorroratic fissal ligament extends between the posterior part of the posterior horn of the lateral meniscus and the femur. Anterior meniscus ligament or Humphrey ligament is thinner [<1/3 the diameter of PCL]. It arises from the posterior horn of the lateral meniscus, runs anteriorly towards the posterior cruciate ligament and inserts into the peripheral edge of the femur pcl attachment. This link may be confused for PCL during arthroscopy. Rear meniscus ligament or Wrisberg connectorIt is usually larger than humphrey's ligament (up to half the PCL diameter). It extends from the posterior horn of the lateral meniscus to the medial femur condyle and is located behind PCLAT the femur, inserts into the medial part of the interfacelar notch near the insertion of the posteriormedial belt of the posterior cruciate ligament. This is why the fibers of the posterior lumbar ligament and posterior cruciform ligaments are sometimes mixed. Meniscal insertion of the meniskophemic ligament can mimic the appearance of a tear. Functions of meniscopherthic ligamentsSensiosymological ligaments play an important role as stabilizers and protectors for the exferic femur. They increase the connection between the movable lateral meniscus and the lateral fillary concollegia during knee movement. They also carry a protective role for the posterior horn of the lateral meniscus. The MFL has a completely different function during knee extension and bending due to different applied tension to the anterior and posterior meniscophric ligament. The ligament's anterior meniscus is stretched during bending and loose during expansion, while the ligament's posterior meniscus is stretched during expansion and loose during bending. The anterior link has a complementary role in the anterior zone of the posterior cruciate ligament, while the posterior menescafemic ligament complements the the posterior belt of the posterior cruciate ligament. Meniscofemoral ligament could act as a splint during injuries to the posterior cruciate ligament. Clinical SignificanceMeniscofemoral ligaments usually cause a pseudothet of the posterior horn of the lateral meniscus in imaging. Wrisberg rips are longitudinal vertical menisk tears. They appear at the intersection of Wrisberg's ligament and the posterior horn of the lateral meniscus, and are usually associated with anterior cruciate ligament tears. ReferenceNami, C.M. Gopte, A.M. J. Bull, and A. Edwards, Anatomy of the Posterior Cruciate Ligament and Ligament Meninges, Knee Surgery, Sports Trauma, Arthroscopy, vol. 14, No.M.M , vol. 84, no. 6, p. 846-851, 2002.M. Gopte, A. Smith, N. Jamieson, A.M. J. Bull, R. D. Thomas, and A. A. Amis, Meniscofemoral Links-Structural and Material Properties, Journal of Industrial, vol. 35, No. 12, p. 1623-1629, 2002.Coulier, Marking of the unusual demarcation of Humphrey's anterior male ligament during the knee arthro-CT-CT, Surgical and Radiological Anatomy, vol. 31, No.M D. McDermott, A. A. Amis, and A.M. J. Bull, An industrial study of menissocological ligaments and their contribution to reducing contact pressure in the knee, Knee Surgery, Sports Oropology, Arthroscopy, vol. 16 , No. 11, p. 1004-1008, 2008.Erbagci, H. Yild , N. Kizilkan, and E. Gümüsburun, An MRI study of meniscus and transverse knee ligaments, Surgery and Radiological Anatomy, vol. 24, no. 2, p. 120-124, 2002.Arun Pal Singh is an orthopedic and trauma surgeon, founder and editor-in-chief of this website. Working at Kanwar Bone and Pine Clinic, Dasuya, Hoshiarpur, Punjab.This website is an effort to educate and support people and medical staff on orthopedic issues and musculoskeletal health. You can follow him on Facebook, Linkedin and Twitter Posterior Meniscus linkAntiside MeniscusTofumligamemonum meniscofemorale posteriusTA98A03.6.08.08.. 004TA218887FMA76855Anatomic terminology[editing in Wikidata] The posterior meniscus ligament (also known as the Wrisberg ligament) is a small fibrous zone of the knee joint. It connects to the posterior area of the lateral meniscus and crosses upper and medially behind the posterior cruciate ligament to attach to the medial condyle of the femur. It is formed with articulio meniscolateralis anterior joint mesicofemoralis which is the upper floor of the genus articulio. Bends and expands functionally as tinglymus with frontal axis. Rear ligament in MRI, coronary posterior meniscus ligament for MRI, nodular posterior meniscus ligament (Wrisberg) behind the posterior horn of the lateral meniscus near its insertion. Sometimes incorrectly interpreted as a menesque tear. This link related to the article is a stub. You can help Wikipedia by extending it.vte Recovered from Although meniscopymic links are distinct anatomical units, their anatomy and function are controversial from an anatomical and radiological point of view. Five hundred MR knee tests were studied retrospectively in an effort to demonstrate frequency and variations in gender and age distribution, as well as the anatomy of the meniskophemic ligament in magnetic resonance imaging. The patients were mainly male, three hundred and twelve, as opposed to the women who were fewer, one hundred and eighty-eight patients. The average age of patients included in this study was 46 years. More than half of them were between 20 and 40 years old. one hundred and thirty-three patients between 20 to 30 years of age and one hundred and one patient between 31 and 40 years of age, a total of two hundred and thirty-four patients.1. An imaging discovery had led us to pay more attention to small anatomical structures, such as meniscus-like ligaments. Meniscus connectors are straight collagen bands associated with the posterior horn of the lateral meniscus and the lateral part of the medial faria consyl [1]. For some authors, the meniscus ligament is a link to two distinct zones, while for others it is two distinct links. The anterior meniscus ligament (aMFL) that leans anteriorly towards the posterior cruciate ligament (PCL) is also known as the Humphrey ligament, and the posterior meniscus ligament (pMFL) leans posteriorly to PCL known as the Wrisberg connector [1-6]. The incidence of the aMFL and pMFL regions in the literature, although most of the studies are anatomical studies [2–7]. There are not many references in the literature regarding the examination of magnetic resonance imaging of the respective ligaments. The purpose of this study is to clarify the incidence of links on the distribution between men and women and between patients of different ages.2. Materials and Methods Six hundred and three knee MRI examinations carried out in our hospital during the period 2010-2011. Exclusion criteria include patients with a restriction on diagnosis due to motion artifacts and pcl imaging conclusions of PCL pathology and lateral meniscus (LM). The remaining five hundred MRI scans on the knee were included in this retrospective study. The age of the patients ranged from 29 to 73 years (average age 46 years). Patients were admitted for an MRI scan for either chronic knee pain or after trauma. All patients MRI tests were performed on 1 Tesla scanner (Siemens Expert Plus) using a gradual series of knee coils. Each patient was placed supine with the knee in a bending 10° and 15° external rotation. The examination protocol included coronary and nodular turbospin echo PD-WI and T2-WI, T2*-WI axial sequences and STIR MR coronary sequences, all with a slice thickness of 4 mm. No intravenous media contrast was administered. For the interpretation of MRI, we paid particular attention to the coronary and nodose PD-WI sequence and the nodose T2-WI sequence. The two ligaments, Humphrey and Wrisberg, were observed as a thin, linear band, with a low MR signal intensity in coronary anterior or posterior images in PCL, respectively. In the sagittal images AMFL had a low MR signal, dot-like appearance located anteriorly in PCL and pMFL with the same appearance leaning posterior to PCL. Frequency of occurrence, different proportions in men and women, mr symbol and appearance were recorded. Moral approval for this study was not obtained due to the fact that it was a retrospective study and was not necessary.3. Results from 603 MR knee tests, 103 excluded. The incidence of MFL was evaluated in the remaining 500 knee MRIS. The pMFL or Wrisberg link was present at a very high rate, 322 patients (64.4%), (Figure 1). and not in sections (150/322/47%). Although the incidence of the Wrisberg ligament was high, it was usually thin and associated with PCL making the interpretation difficult. (a) for two b) for b) for two b) for b) 1 In contrast, aMFL was present in a smaller number of patients, 59 patients (11.8%) (Figure 2). In this case the incidence in men was disproportionately higher, 40 patients (67.8%), than in women, 19 patients (32.2%). than in coronary (15/59/25.4%). (a) for two (b) for (b) 1 (a) for two (b) for (b) 1 Both anterior and posterior meniscophine ligaments were present in 81 patients (37%) (Figure 3). Both links were also observed more frequently in men, 44 patients (54.3%), compared to women 37 (45.6%). The results are summarized in Table 1. Meniscus ligaments were absent in 38 patients (7.6%). over 60 years of age. The first group consisted of 174 (34.8%) patients 98 (56.3%) men and 76 (43.6%) women, the second group 101 (20.2%) patients, 46 (45.5%) men (Figure 4) and 41 (44.5%) (44,5%) third group 111 (22.2%) patients, 69 (62.1%) men and 42 (37.8%) women, 59 patients between 50 and 60 years of age 35 (71.1%) men and 24 (40.6%) Women. Finally, the last group consisted of patients, 55 (11%) men and 20 (21%) females (Figure 5), respectively. Table 2 summarizes the incidence of one or both ligaments and the number of patients without an age-related link. amMFLpMFLaMFL + pMFLMale4024044Female198237Agage groupageMFLFMFL + pMFLAbsent20–30 y1713224131–40 y135729241 –50 y16 7716251–60 y833810>60 y523423(a) (b) (b) (b) (b) (b) (b) (b) (b) The Wrisberg link was thicker than the Humphrey link. It is clearly depicted in the coronary sections. On the other hand, the Humphrey link was thinner and better envisioned in the nodds. 4. DiscussionAnatomy, function, and imaging of MFLs is an important issue among anatomy, orthopedics, and radiologists. The meniscus-farrae ligaments connect the posterior horn of the lateral meniscus to the lateral part of the medial fillary condyle [1]. There are collagen bands that consistently attach the posterior part of the lateral meniscus during knee bending [5, 8]. Poirier and Charpy first described it in 1892 [3]. The name of the third cruciform ligament was used incorrectly [9]. The name of the ligament is also not used correctly because the meniscomic ligament does not extend from one bone to another bone, but from a fibrostate anatomical structure is the meniscus to a bone [9]. Embryological studies on human and animal knees have suggested that MFL starts from the posterior lateral meniscus horn as a single zone. The appearance of one or double MFL is due to the location of the PCL. On this basis, a different hypothesis was made about variants that could present a meneskomic link [8]. Anatomically numerous variations of the design have been described, proximal or peripheral introductions of ligaments [6, 8, 10]. Anterior meniscus ligament passes anteriorly to the posterior cross ligament and there are described anatomical variants of the corresponding ligament. In the less frequent variant, the ligament consists of two or even three different bands with a different origin from the posterior horn of the lateral meniscus and different introductions to the femur condyle. Most of the time variations are according to the size of the ligament, which could be small or large [8]. On the other posterior, meniscus ligament, which passes posterior to the posterior cruciate ligament, also displays anatomical variations. The PMFL has described that it could consist of two different zones that have or are not shaped like beautiful glass. Although it is a thin link another anatomical variant describes a thick ligament, thicker than PCL. Of course, all these are anatomically proven and may be difficult to observe in knee MRI examinations [8]. Anterior Fronts degree of ligaments between the posterior part of the posterior horn of the lateral meniscus and the femur, in position 10 o'clock in the left knee, next to the articular cartilage. Rear meniscofiric ligament that also leans between the anterior part of the posterior horn in the lateral meniscus but in the femur inserts into the medial part of the interconnectionlar notch near the insertion of the posteriormedial zone of the posterior cruciform ligament. This is why the fibers of pMFL and PCL are sometimes mixed [2, 8-11]. Meniscal introduction of MFLs is possible to mimic the appearance of a tear. In our study, anatomical variants of MFL were not evaluated. We are trying to describe specific details of MFL, because as far as you are concerned, there have been very few MRI studies in the corresponding issue. The function of the AMFL and pMFL is not clearly understood. We know that MFL plays an important role as stabilisers and protectors for ex-ifterotibic compartment. They try during knee movement to increase the connection between the mobile lateral meniscus and lateral faria condyle. They also play a protective role for the posterior horn of the lateral meniscus. The MFL has a completely different function during knee extension and flexion due to tension, which is applied to PMFL and AMFL, which is completely different. They have a reciprocal and non-isometric tension pattern. The AMFL is taught during bending and relaxed during expansion which is unlike the function of pMFL. It is stretched during expansion and relaxed during bending. The aMFL has a complementary role in the anterior zone of the posterior cross ligament as opposed to the pMFL complementing the function of the posterior zone of the PCL [2–4, 10, 12–15]. Studies have shown that MFL has a major role in the internal rotation of the tibia with a fixed leg [10]. There are authors who have insued that MFLs have functional similarities to the posterior zone of the posterior cruciate ligament. For these reasons, most of the studies negotiated the competitive role of MFL after partial or total rupture of the posterior cross-link [4]. MFLs could act as a splint during PCL injuries giving the appropriate time to the ligament for conservative healing. It is important to know the presence, anatomy and specific difficulties and variations in MFL. The visualization adds important information about the incidence. Several authors have shown, most through anatomical studies, the high prevalence of one or both MFL. Anatomical studies, such as by kusayama et al. and Amadi et al., show a very incidence of 100%, so other studies, such as Amis et al., have a smaller incidence of 93% [2, 9, 15]. There is no radiological study with as high incidence as shown in the study of Amis et al. [2]. In recent radiological radiological carried out by hassine et al., Gopte et al., Choi et al., Erbagci et al., and Lee et al., the effects range from 87% to 78% for the presence of at least one MFL [4-6, 14, 16]. In our study, the incidence of at least one MFL was almost 65%, which is consistent with other studies. The different incidence between anatomical and radiological studies is due either to a partial effect on average volume or to a slight difficulty in evaluating Humphrey's ligament. Each mensonic link was evaluated separately. The incidence of pMFL was higher than the incidence of aMFL in all studies. Cho et al. visualized the link of Wrisberg in 84% of cases, Lee et al. 80%, and the least impact was from Erbagci et al. 42% [5, 14, 16]. In our study, pMFL was present in 322 patients (64.4%). Cho et al., visualized humphrey's link in 15.8% of cases, Lee et al. 4%, and in the study of Erbagci et al. 12%. In our study, AMFL was present in 59 patients (11.8%) [5, 14, 16]. The results in our research are smaller than in other studies perhaps due to the large number of knee MRI tests that were studied retrospectively. We further separated the corresponding cohort on the sex of the patients. PMFL was present in 240 men, (74.6%) but fewer women, 82 patients (25.4%). Although Erbagci et al., visualized pMFL in a significantly smaller cohort of 100 magnetic knee tests in 22 (52%) male patients and 20 (48%) women, the incidence rate is almost in line [15]. The aMFL was present in 40 men (67.8%), a figure disproportionately higher than that of 19 female patients (32.2%). Amadi et al. visualized aMFL at 4 (33%) male patients and 8 (67%) women, which is in disagreement with our study [15]. Perhaps it is also due to the large number of knee mr images being studied retrospectively. Both MFL were present in Moran et al. 28% and Lee et al. 1% [5, 13]. Erbagiet al. did not disclose any numbers [16]. In our study both MFL were present in 81 patients (37%). and 37 (45.6%) Women. In the Erbagci study, MFL was present in 13 (46.4%) male patients and 15 (53.6%) women, which is in disagreement with our study [16]. Once again there is also a difference in findings in this group, but it is relative to smaller ones. We noticed that the Wrisberg link was thicker than the Humphrey link. It is clearly depicted in the coronary sections. On the other hand, the Humphrey link was thinner and better envisioned in

the nodds. Lee et al. came to the same conclusion [5]. In this study, the and the appearance of the meniskovic ligaments has been presented for different age groups. Gopte et al. and Cho et al. have suggested that the incidence is higher in younger patients, which is in full accordance with our order [3, [3, 14]. This study has limitations. The retrospective nature in the design of the study does not allow any arthroscopic or surgical association. 5. Conclusions The purpose of this study was to provide an overview of the radiological perspectives of AMFL and pMFL. Degenerative cause may be able to explain the higher incidence in younger patients. The relatively large cohort of patients can contribute to better knowledge of the radiological anatomy of the meniscophemal ligament and prevent misdiagnosis of aMFL and pMFL as loose bodies or PCL pathology. Refers.