Americans are living and staying active longer, participating in sports and other vigorous activities well into their middle and later years. When they begin to encounter pain and stiffness, they may also begin to avoid physical activity because they have—or because they fear—increasing pain. Golf clubs are relegated to the closet, gardening tools to the shed, evening walks are curtailed—and thus quality of life diminished.

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But when his patients cannot or no longer respond to nonsurgical treatment, Dr. Robinson makes sure they understand every aspect of their procedure before he performs it—including both risk and benefit. “These are highly technical and complicated surgeries,” he explains, “so I want to be sure my patients understand exactly what they can expect when their knee or shoulder needs surgery.”

If these patients have no other options, joint replacement can be entirely appropriate, Dr. Robinson says. Today’s joint replacements can last 20 years or longer, and in the right patient, the procedure rarely has to be redone.

“Subchondroplasty isn’t a substitute for knee replacement,” Dr. Robinson says. “The biggest advantage—of the many—is that it preserves the strength of bone, and is gradually replaced with natural bone over 12 to 24 months. ‘It’s a new and very exciting option for these patients, “ he says. “But, ‘today I’m seeing active 40 to 55-year olds who want to stay active, patients who are developing micro-cracks in the subchondral bone, similar to stress fractures, secondary to osteoarthritis. They’re in significant pain, but they’re not ready for a knee replacement,’ he practically or emotionally. Similarly, Dr. Robinson sees 65-year olds who would be candidates for knee replacement, but other medical conditions put them at increased risk for surgery.

Professional orthopedic had little to offer these “in-between” patients who presented with significant pain, but for whom joint replacement wasn’t an option.

For Dr. Robinson’s knee patients, that changed in 2014, when he perfected a new, minimally invasive procedure called subchondroplasty, which involves standard arthroscopy to debride intra-articular pathology, as well as fluoroscopically guided insertion of a bone substitute made of calcium phosphate, which sets in 10 minutes, mimics the strength of bone, and is gradually replaced with natural bone over 12 to 24 months. “It’s the safest and least option for these patients,” he says. “The biggest advantage—of the many—is that it preserves the patient’s natural joint and allows a quick recovery time.”

His patients report significant pain relief within a few weeks. “Subchondroplasty isn’t a substitute for knee replacement,” Dr. Robinson cautions, “and it’s not curing the arthritis. But it has been shown to relieve pain and increase function for as much as five years; and importantly, it doesn’t limit the patient’s future treatment options, whether partial or total knee replacement.”

Just as with his knee patients, Dr. Robinson often treats shoulder pain successfully without surgery: with injections, therapy or medications, as appropriate. When surgery is required, he can frequently preserve the shoulder joint by making many repairs arthroscopically. When the joint can no longer be preserved, a standard shoulder replacement is done; or in cases of severe damage to the joint and rotator cuff, he performs the innovative reverse total shoulder replacement, which reverses the ball and socket function within the shoulder.

Dr. Robinson helped pioneer the routine use of regional anesthesia for shoulder surgery patients in Hampton Roads, a tremendous benefit for patients both during and after their procedure. Because regional anesthesia provides excellent pain relief, less anesthesia is required during surgery and less medication required following the procedure. This eliminates or reduces the complications associated with anesthesia and post-operative pain medications and helps with recovery.

Understanding the Goal Drives the Treatment.

“When I was treating professional athletes, I understood their goals,” Dr. Robinson says. “They wanted to be back playing the sport they loved. It’s the same with today’s patients: they may not be elite athletes, but their pain is no less real, and their desire to return to what they love is no less intense.”

Today, Dr. Robinson incorporates the concepts and techniques he learned taking care of professional athletes and applies them to everyday orthopedic problems, as well as more complex presentations.