INTRODUCTION

The meniscus gradually assumes its definitive configuration during fetal life starting from a completely discoid form. The occasional persistence of this stage, due to non absorbance of the central portion is responsible for the discoid form found in knees of some adults.

Accordingly discoid menisci are three types : primitive, intermediate and infantile ***(Smillie, 1948)***.

In ***1957, Kaplan et al.*** noticed the frequent absence of attachment of the posterior horn of meniscus to the tibial plateau in discoid lateral menisci, concluded that the malformation developed after birth following anomalous mechanical stress caused by hypermobile meniscus. But this theory does not explain the rare cases of discoid medial meniscus.

Watanabe et al. (1979) stated a morphological classification of discoid meniscus : complete, incomplete or fissured, and wrisberg type in which the meniscus is liable to anterior dislocation due to deformed posterior menisco-tibial attachment.

Albertsson and Gillquist (1998) consider both ***Smillie's and Kaplan's*** theories to be correct. Thus the three types of discoid meniscus in ***Watanabe's*** classification have different pathogenesis : the first two are the result of arrest in development, whereas the wrisberg type is caused by mechanical factors linked to congenital meniscal instability.

Dickaut (1992) recommends a total meniscectomy in wrisberg type to avoid the risk of leaving a hypermobile meniscal residue.

Rosenberg and others advice arthroscopic suture of a discoid lateral meniscus of wrisberg type.

Arthroscopic removal of only the central portion of the discoid meniscus, leaving a stable residual part, followed by regularization of the residual free edge and any lesions is by far the most recent beneficial treatment that also reduces the incidence of degenerative changes occur in knees after total meniscectomy.