ARC JOINT

A guide from ARC

The questions to ask before you agree to a knee replacement

A short, plain guide for anyone who has just been told a knee replacement is the next step — and would like to understand the whole ladder before climbing to the top of it.

What is inside

01 What you are actually deciding

02 Whether this applies to you

03 Who it is not for

04 Fifteen questions for your appointment

Section 01

What you are actually deciding

The choice is almost never “live with it” or “replace it”. Between those two ends sits a ladder, and most people are only ever shown the bottom rung and the top one.

Conservative care sits at the bottom: physical therapy, activity changes, anti-inflammatory medication, injections. Joint replacement sits at the top: the damaged joint is removed and a prosthetic is installed. Both are real, proven treatments. What is missing from most conversations is everything in between.

Phase one — preserve

Preserve is where nearly everyone starts, and where a good many people can stay. Therapy, load management, medication and targeted injections address inflammation and mechanical stress without changing the joint's structure. When they work, nothing else is needed.

The failure of this phase is not that it does not work. It is that it gets repeated. When pain persists through consistent conservative care, running the same programme a fourth time is not a plan.

Phase two — modulate

This is the rung most treatment paths skip. Peripheral nerve stimulation does not treat the joint at all; it targets the nerves carrying the pain signal away from it. The joint is left where it is, and the procedure is reversible — if it does not help, the hardware comes out and you still hold every option you held before.

Modulation is a candidate when conservative care has not been enough but the joint still has structure worth preserving. It does not reverse arthritis and it is not a cure. It is an attempt to quiet a pain pathway while keeping your anatomy intact.

Phase three — replace

Replacement is the right answer for joints that have deteriorated past what preservation or modulation can reach: bone-on-bone arthritis, significant deformity, mechanical failure. Nothing in this guide argues against it. Replacement is a powerful operation and this is an argument about sequence, not about whether it works.

Why the order matters more than the options

Replacement is permanent. Once the joint is gone it cannot be restored, and if the prosthetic wears or a complication arrives, revision surgery is the only road forward. Modulation is not permanent. That asymmetry is the whole argument: if the reversible step gives you enough relief, you have avoided an irreversible one; if it does not, replacement is still sitting exactly where it was.

What you spend to find out is time. What you risk by not asking is finding out afterwards that a rung existed and nobody mentioned it.

Section 02

Whether this applies to you

Peripheral nerve stimulation is built for a specific situation, not for everyone with a sore knee. Here is the shape of the person it is built for.

The usual profile

- Chronic knee pain — persistent, most days, for months or years rather than weeks.
- Conservative care has been tried honestly and has not held: therapy, medication, injections, or some combination.
- The pain limits ordinary activity — stairs, standing, sleep, walking any real distance.
- The joint still has functional structure. PNS works on the signal, so there has to be something left worth preserving.

- Replacement has been raised as the next step, and you would like to understand what sits below it first.

It is also relevant to people who are not ideal surgical candidates — because of age, because of other health conditions, or simply because they do not want an operation. Because it is minimally invasive and reversible, the risk profile is a different conversation from the one you have about surgery.

The mismatch worth naming out loud

Imaging and pain do not always agree. People with dramatic films sometimes function well; people with unremarkable films are sometimes in serious daily pain. If your scan and your experience have never quite matched, that is a real thing and it is worth saying in the room — it is often the clue that a nerve-driven component is carrying more of the load than the picture suggests.

What a first consultation looks like

A physician reviews your history and imaging, examines the knee, and asks what you are actually trying to get back — the stairs, the dog, a shift at work. If PNS is appropriate they will explain the procedure, what it is meant to do, and what it is not meant to do. The usual pathway puts a period of trial stimulation before any longer-term implant, so that the longer-term step is offered only to people who have already responded. Your physician sets the length of that trial and the criteria for reading it.

Section 03

Who it is not for

Being straight about who this does not help is the part most treatment pages leave out. If any of the following describes you, PNS is probably the wrong next step, and knowing that early is worth more than a hopeful appointment.

Severe structural damage

PNS does not repair, regenerate or replace joint tissue. Where a knee has reached bone-on-bone arthritis with significant deformity or mechanical failure, the problem is structural and nerve modulation is unlikely to be enough on its own. Replacement may simply be the more appropriate operation. PNS can still have a role afterwards — pain that persists after a replacement is one of the situations it is used for — but it is a poor primary treatment for a joint that has already failed.

Active infection, or unstable systemic conditions

Placing leads near an active infection is contraindicated. A joint infection, a skin infection near the target, or a systemic infection has to be resolved first. Uncontrolled diabetes, unmanaged autoimmune disease and clotting disorders also affect candidacy. None of these are necessarily permanent disqualifiers; once they are stabilised, candidacy can be looked at again.

Other implanted electronic devices

A pacemaker, an implantable defibrillator or any other active implanted electronic device does not automatically rule PNS out, but it does require specialist review and coordination with the physician who manages that device. Raise it at the first appointment rather than the last.

Pain whose main driver is not physiological

PNS is a physical intervention for physiological pain. It is not a substitute for psychological pain management or for treatment of a pain condition with a primary psychological component. Chronic pain and mental health are genuinely entangled, and relief often improves mood as a consequence — but where psychological factors are prominent, PNS belongs inside a broader care plan rather than instead of one.

Expectations it cannot meet

PNS is not a cure and it does not undo arthritis. Anyone expecting the complete disappearance of pain, or the knee they had at thirty, is likely to be disappointed no matter how technically well the procedure goes. A meaningful reduction in pain and a meaningful improvement in what you can do in a day is the honest goal. A physician who will not have that conversation before proceeding is telling you something.

Section 04

Fifteen questions for your appointment

Print this section, or keep it on your phone. Take it in with you. Ask the ones that apply, write the answers in the margin, and do not agree to a date in the same appointment in which you first hear the word.

About my knee

- ☐ What does my imaging actually show, and how much of my pain does it explain?
- ☐ How much of this do you think is the joint structure, and how much is the nerve carrying the signal?
- ☐ Am I bone-on-bone, or is there still joint surface worth preserving?
- ☐ If I change nothing for six months, what do you expect to be different?

About the options below surgery

- [ ] What have I not tried yet?
- [ ] Is peripheral nerve stimulation something you offer, or something you would refer for?
- [ ] If nerve stimulation does not help me, what has it cost me — in time, in options, in anything about a future operation?
- [ ] Is anything in my history a reason not to do it? Infection, an implanted electronic device, blood thinners, diabetes control.
- [ ] What would you need to see before you would call me a candidate?

About the replacement itself

- [ ] Why now, rather than in a year?
- [ ] What does recovery genuinely look like for someone my age, in my condition, living where I live?
- [ ] What happens if I still have pain afterwards — who treats that, and how?
- [ ] How long is this implant expected to last for someone like me, and what does a revision involve?

About money and afterwards

- [ ] Who checks what my plan covers, and at what point will I know a number?
- [ ] Who do I call at two o'clock in the morning in week two, if something feels wrong?

There is no wrong question on that list. A surgeon who is confident in the recommendation will answer all fifteen without minding.

Before you go

What ARC is, and what it is not

ARC Joint connects people with knee pain to independent Arizona practices that offer peripheral nerve stimulation. It publishes what the options are and, if you ask it to, passes your answers to a practice near you. It is not a healthcare provider: it does not employ those physicians, does not own those practices, does not schedule your appointment and does not send you a bill.

That is also why this guide names no manufacturer and no device. ARC does not choose the system used in any of those locations, and a guide that named one would be describing somebody else's product as though it were the category.

What your insurance covers

Whether your plan covers the procedure is a question for your plan and for the location, and it is worth asking both. Plans that cover peripheral nerve stimulation do so against their own criteria, and those criteria differ from plan to plan. ARC does not bill, does not verify benefits, and cannot promise what a plan will pay.

If you would like to know whether this is worth a conversation

The assessment at arcjoint.com/knee asks three questions about your knee and takes about a minute. It is not a diagnosis and it does not book anything. It tells you whether peripheral nerve stimulation is worth raising with a specialist, and if it is, which Arizona location is nearest to you.