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Review Article

The use of artificial intelligence in treating knee osteoarthritis: a review

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Abstract - This review aims to explore the current applications of artificial intelligence (AI) in the diagnosis, treatment, rehabilitation, and management of knee osteoarthritis (OA), as well as to identify the potential benefits and ongoing challenges. A literature review was performed using Scopus, PubMed, Google Scholar, and IEE databases for articles published in peer-reviewed journals. Knee OA is a prevalent and debilitating musculoskeletal condition, characterized by structural changes to the articular cartilage and subchondral bone. The prevalence of knee OA has been steadily on the rise for the past few decades. This can be attributed to obesity, age, gender, and other risk factors, as well as independent causes. Knee OA presents significant obstacles in diagnosing, treating, rehabilitation, and managing the condition. Healthcare could become much more interactive, personalized, predictive, and preventive with the use of AI. Current research suggests that AI has the potential to improve diagnostic accuracy, optimize treatment strategies, and enhance patient outcomes in the context of knee OA. With AI emerging as a formidable tool with the potential to revolutionize knee OA diagnosis, treatment, rehabilitation, and management, it is reasonable that the technology will follow its current trajectory and eventually develop into an efficient tool for the healthcare sector. While AI can bring fundamental changes in the management of knee OA, it is also crucial to address its limits and fully explore its potential for future study, as it can increase diagnostic accuracy, optimize treatment strategies, and improve patient outcomes.

Keywords: artificial intelligence, deep learning, diagnosis, knee osteoarthritis, machine learning

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1. INTRODUCTION

Osteoarthritis (OA) is a prevalent and persistent ailment that causes discomfort, exhaustion, functional restrictions, greater healthcare consumption, and substantial economic burdens on society[1]. It affects the entire joint, including the surrounding tissue. Approximately 528 million individuals across the globe suffered from OA in 2019; this represents a 113% rise from 1990 [2]. The knee is the most affected joint, accounting for 365 million cases, followed by the hip and hand [3]. Knee OA accounts for roughly four-fifths of all OA cases worldwide as people age and gain weight [4]. As the population ages, it can be expected that the number of persons suffering from knee OA will double (Figure 1).

Figure 1 shows the global cases projection of site-specific knee OA, with a decomposition analysis of the relative contribution of changes in prevalence rate, population growth, and population aging to the total percent change in age-restricted case number by region for 2020–2050 [5]. The global burden of OA has significantly increased, particularly affecting the knee joint, with prevalence driven by aging and obesity. Given the substantial rise in OA cases and the expected doubling of knee OA incidence, there is an urgent need for targeted public health interventions to address and mitigate the impact of this debilitating condition.

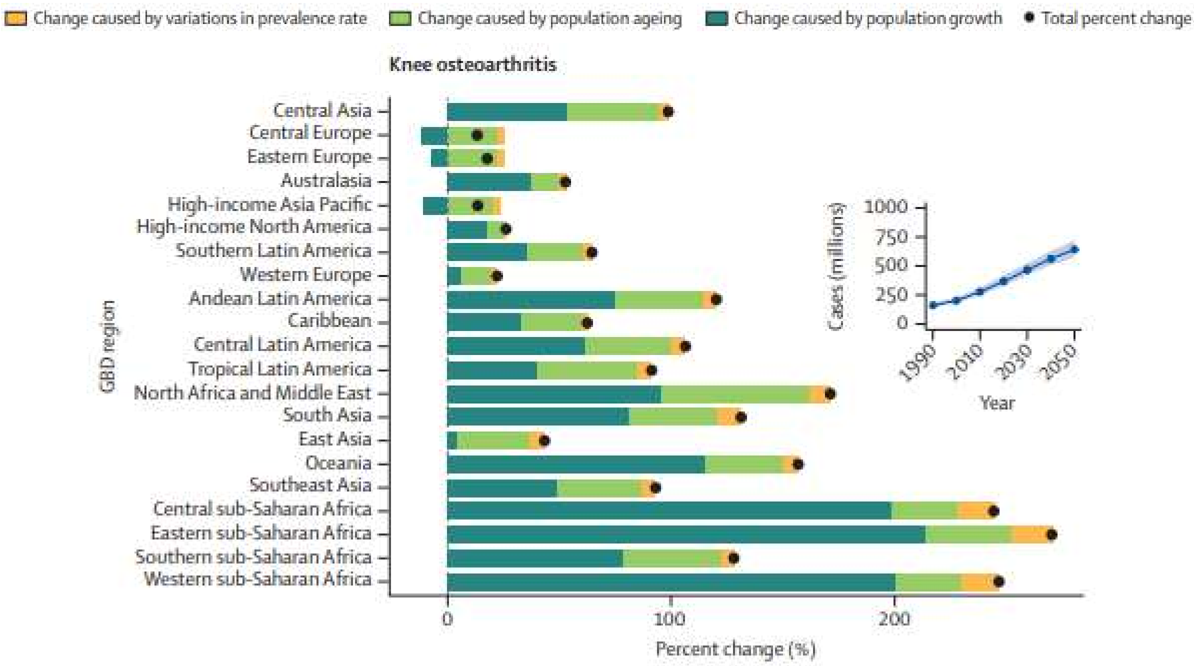

Figure 1: Global Cases Projection of Site-Specific Knee Osteoarthritis (OA), With a Decomposition Analysis of the Relative Contribution of Changes in Prevalence Rate, Population Growth, and Population Aging to the Total Percent Change in Age-Restricted Case Number by Region for 2020–2050.

Risk factors and epidemiology

Advanced age, obesity status, female sex, high physical occupational demands, and prior joint injury are among the established risk factors that contribute to the development of knee OA [6] [7][8]. According to Hame and Alexander (2013), women are more affected by knee OA compared to men, which can lead to functional limitations and a decrease in health-related quality of life, as stated by Jeong and Lee [9]. An equally significant aspect mentioned by Kamsan et al. (2021) is the prevalence of knee OA across diverse geographical regions [10], with rates documented to range from 13 to 20% in the United States [11], 9 to 17% in Europe [12], 22 to 25% in the Middle East [13], and 10 to 38%

in specific Asian populations [14]. These variations suggest potential influences beyond the established risk factors. However, early intervention through diagnosis and suitable treatment can help prevent the progression of knee OA and its associated symptoms.

Knee OA is influenced by multiple risk factors and this condition disproportionately affects women and varies widely across different geographical regions, indicating the potential influence of additional, region-specific factors. Early diagnosis and appropriate treatment are critical and mitigating its impact on quality of life.

Diagnosis of knee OA

Knee OA can be diagnosed in both clinical and radiological terms. It is a clinical condition characterized by objective physical examination findings of knee stiffness, deformity, crepitations, subjective feelings of joint discomfort on loading and bone enlargement, and additional radiological findings [15]. With a focus on creating a radiographic classification scheme for OA, Kellgren and Lawrence (1957) successfully introduced their first organized efforts in 1957 [16]. The Kellgren-Lawrence (KL) grading scale classification system based on plain radiographic X-ray images has been the gold standard and an acceptable quantification tool to assess knee OA severity [15].

Anterior-posterior (AP) knee radiographs are used to describe the KL grading scale classification system by assigning each radiograph a grade from 0 to 4 (Table 1). It is crucial to have an early and accurate diagnosis for effective treatment. Traditional methods rely on X-ray images and physical evaluations, but they may not always be successful in identifying early knee OA or distinguishing it from other conditions. Knee OA diagnosis relies on both clinical and radiological evaluations, with the KL grading scale serving as the gold standard for assessing severity. However, early and accurate diagnosis is crucial for effective treatment, and traditional methods may fall short in identifying early knee OA or differentiating it from other conditions.

AI in knee OA management

With recent advancements in technology, AI may provide better support by safely filtering patient data, analyzing medical imaging, making diagnosis recommendations, and even serving as a virtual assistant for patients and doctors [17]. Even now, in its early stages, the application of AI in knee OA management appears to be potentially remarkable. The improvement of patient quality of life through personalized and efficient knee OA management strategies necessitates further research, a collaborative environment between AI researchers and medical practitioners, and adherence to ethical principles concerning patient data and model development.

The recent inventions of technologies suggest that AI can increase knee-OA tenfold by screening patient data, processing in any way the image of medical, providing diagnostic recommendations even assisting as a virtual assistant. While in its early stages, AI holds the promise to enhance patient quality of life, through personalized and effective management strategies. It also calls for more analysis, combining AI researchers with medical professionals, and respecting basic principles of patient data and model development ethics.

Hence, this review explores the present condition of AI applications in knee OA by assessing the potential advantages that AI could offer in managing this condition and recognizing the ongoing challenges that need to be addressed for its successful application. By examining recent advancements and identifying key challenges, this paper seeks to highlight the potential of AI to enhance the management of knee osteoarthritis and offer insights into future research directions.

Table 1: Variations of the Kellgren-Lawrence (KL) Grading Scale Classification System which was adapted from Kellgren and Lawrence (1957) and Kohn et al. (2016). The abbreviations used in Table 1: osteoarthritis (OA) and joint space narrowing (JSN).

Grade	Figure	Description
Grade 0 (None)		A definite absence of changes in the X-ray image of knee OA
Grade 1 (Doubtful)		A doubtful (JSN) and with a possibility of osteophytic lipping
Grade 2 (Minimal)		A definite number of osteophytes with a possibility of JSN
Grade 3 (Moderate)		A moderate amount of multiple osteophytes with definite (JSN), some sclerosis, and a deformity of bone ends
Grade 4 (Severe)		The presence of large osteophytes marked the JSN with severe sclerosis and definite deformity of bone ends

3. METHODOLOGY

Literature Search Strategy

The literature search for this review was conducted using several electronic databases, such as Scopus, PubMed, Google Scholar, and IEEE Xplore. The search strategy focused on identifying peer-reviewed articles published between January 2017 and December 2023. The following keywords and phrases were used in various combinations:

- "Knee Osteoarthritis"
- "Artificial Intelligence"
- "Machine Learning"
- "Deep Learning"
- "Diagnosis"
- "Treatment"
- "Total knee arthroplasty"
- "Rehabilitation"

Besides, Boolean operators (AND, OR) were used to refine the search results. References from selected articles were also reviewed to identify any additional relevant studies.

Inclusion and Exclusion Criteria

Inclusion criteria:

1. Peer-reviewed articles published in English.
2. Studies focusing on the application of AI techniques in the diagnosis, treatment, rehabilitation, or management of knee OA.
3. Articles that discuss the performance, benefits, and limitations of AI models in knee OA.
4. Research involving machine learning, deep learning, or other AI methods applied to knee OA data (clinical, imaging, or other relevant data).

Exclusion criteria:

1. Articles not published in English.
2. Studies that do not specifically address knee OA or do not involve AI techniques.
3. Conference abstracts, editorials, and opinion pieces without original research data.

4. APPLICATION OF ARTIFICIAL INTELLIGENCE (AI) IN KNEE OSTEOARTHRITIS (OA)

Overview of Traditional Knee* Osteoarthritis *(OA) Diagnosis Methods

Plain X-rays and Patient-Reported Outcome Measures (PROMs) are frequently used to diagnose knee OA and assess the health status of a patient in a specific timeframe. On top of that, it is also possible for joint aspiration, arthroscopic evaluation, physical examination, and advanced imaging systems to serve as alternative techniques for diagnosing knee OA. From PROMs, a comprehensive history such as age, activity level, previous injuries, and the characteristics of pain, stiffness, and swelling can be obtained from the patients [18]. As described by Maricar et al. (2016), assessing the joint range of motion, tenderness, crepitus, and joint effusions through a physical examination will provide valuable insight into the joint function and its outcomes [19] . The limitations of patient history and physical examination are based on subjective information that varies depending on the pain tolerance of a patient and the evaluation of the physician. Subtle changes may occur in the early stages of knee OA, which leads to findings that may overlap with other knee pathologies [20]. By referring to the view of Kellgren and Lawrence (2002), potential delays in diagnosis and treatment are possible as traditional methods struggle to identify the early stage of knee OA where changes might be subtle.

According to Kijowski et al. (2019), the use of X-rays is widespread for its cost-effectiveness and excellence in visualizing joint space narrowing (JSN), hallmarks of OA, and bone changes such as osteophytes, also known as bone spurs [21]. Although there are limitations with soft tissue problems or synovitis [22], it is beneficial to use X-rays in directly visualizing cartilage and the main tissue affected in OA [23]. While X-rays are widely accepted as the standard imaging tool for diagnosing OA in the knee, their sensitivity to short-term OA changes is lower and their imaging features are restricted to changes in the bone. Advanced imaging techniques, such as Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scan, medicine bone scan, and ultrasonography, are not routinely used in clinical practice. Researchers have advocated employing MRI to analyze radiomic aspects of OA that are concealed in soft tissue and bony structures, but they are frequently faced with restrictions in its implementation, particularly in complex situations, due to the high cost and its limited availability.

Besides PROMs, physical examinations, and X-rays, laboratory tests are also crucial in the diagnosis of knee OA. Laboratory tests contribute a supporting role in the diagnostic work-up for knee OA. On top of that, certain laboratory tests are also significant in the exclusion of other inflammatory arthritis such as rheumatoid arthritis. This differential diagnosis is critically important as it makes for a better treatment strategy [24]. Despite their usefulness in differential diagnosis, laboratory testing has limitations in the context of knee OA as it provides little insight into the severity of the condition and cannot conclusively diagnose knee OA [25]. This shortcoming highlights the inadequacy of blood testing to determine the extent of joint injury or forecast disease development.

While the diagnosis of knee OA is still based on traditional diagnostic methods, primarily based on radiographic assessment, are often subjective and prone to inter-observer variability therefore these limitations emphasize the need for more sensitive and objective tools. In light of this, the developments in AI and other fields of technology provide optimism for future advancements in knee OA diagnosis and treatment.

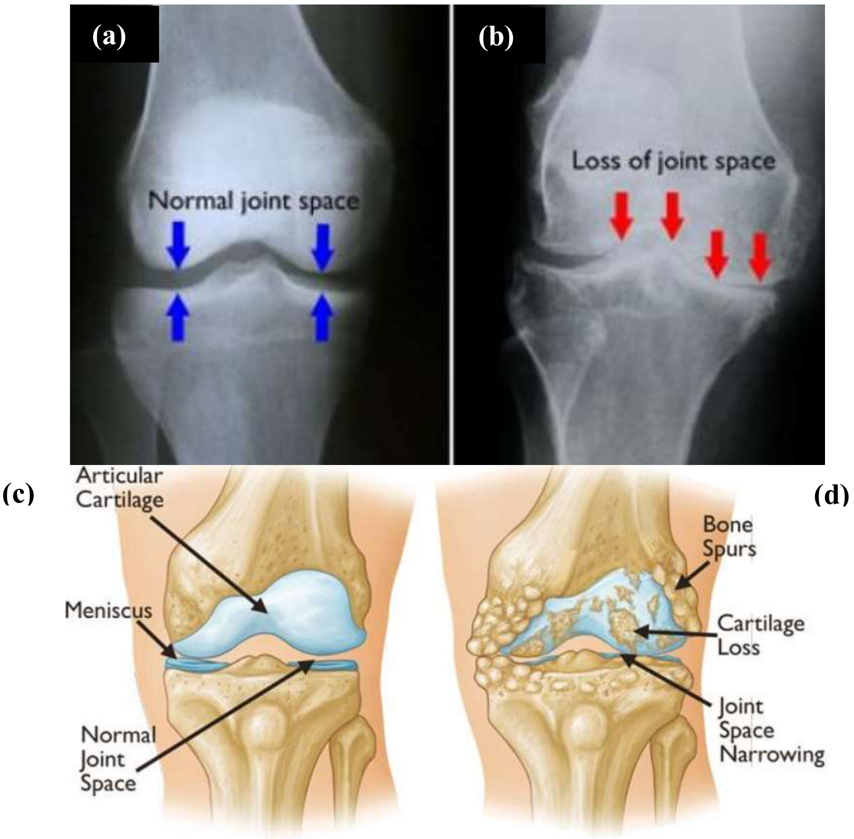

Figure 2: The difference between a healthy knee and one with osteoarthritis (OA). The first difference is evident in the comparison of joint space, which shows a substantial decrease of joint space in an arthritic knee in X-ray image (b) and good cartilage in a normal and healthy knee in X-ray image (a). The second difference between the images of a healthy knee in (c) and knee OA in (d) is the bony growths known as osteophytes (bone spurs). This is because OA frequently causes bone rubbing on the bone, making osteophytes (bone spurs) a common appearance.

Introduction to AI Techniques

AI is revolutionizing various fields by enabling machines to perform tasks that typically require human intelligence, such as problem-solving, understanding language, and recognizing patterns. At its core, AI encompasses a wide range of techniques and methodologies designed to create intelligent systems. Within this broad field, machine learning (ML) and its subset, deep learning (DL), stand out as key drivers of recent advancements. Figure 3 illustrates the hierarchical relationship between AI, ML, and DL, and provides a categorization of the types of ML along with specific examples of algorithms used in each type. This helps in understanding how different AI techniques are structured and their applications in various domains.

The term AI in healthcare embraces the use of ML algorithm methods and other intelligent technologies in medical settings [26], [27] . In simpler terms, AI refers to machines mimicking human thinking abilities. These machines are capable of learning, analyzing information, and making decisions. The ML methods can either be supervised or unsupervised (Figure 3). Unsupervised ML methods involve unlabeled data and unknown results, whereas supervised ML methods involve known outcomes and labeled data.

Two additional categories have been further proposed: semi-supervised learning and reinforcement learning, with uncertain outcomes [28]. There are two types of data used in semi-supervised learning: labeled and unlabeled. While it relies on a smaller amount of labeled data for guidance, it leverages the vast amount of unlabeled data to improve learning. Meanwhile, reinforcement learning uses a different approach. The model is trained iteratively through trial and error. Successful actions will receive rewards and will adjust the approach based on the rewards, ultimately aiming to maximize its performance. Supervised ML methods are the most frequently used in medicine and healthcare [29] .

Depending on the type of analysis, it can differentiate between various supervised ML methods, such as Convolutional Neural Networks (CNNs), Random Forest (RF), and Support Vector Machine (SVM) [30]. Deep Learning (DL) is a subset of ML methods that uses multiple layers of a neuron-architecture network via algorithms known as *Artificial Neural Networks* (ANNs) to enable the model to learn and enhance itself. This leads to high accuracy with the extraction of high-level features from input data [31]. DL method is an advanced variant of ML methods.

The application of AI on knee OA has increased significantly in the last decade [32], [33], [34], [35], [36], [37], [38], [39], [40], [41]. AI and ML modeling is a new decision-making tool in knee OA diagnosis, patient selection, preprocedural planning for total knee arthroplasty (TKA), disease progression prediction, and treatment outcome estimation. Larger datasets and technology advancements make these tools better, but thorough validation is still necessary. Thus, the application of AI in healthcare may provide better support to evaluate patient data and possibly forecast future results, with the ultimate goal of enhancing patient care and quality of life.

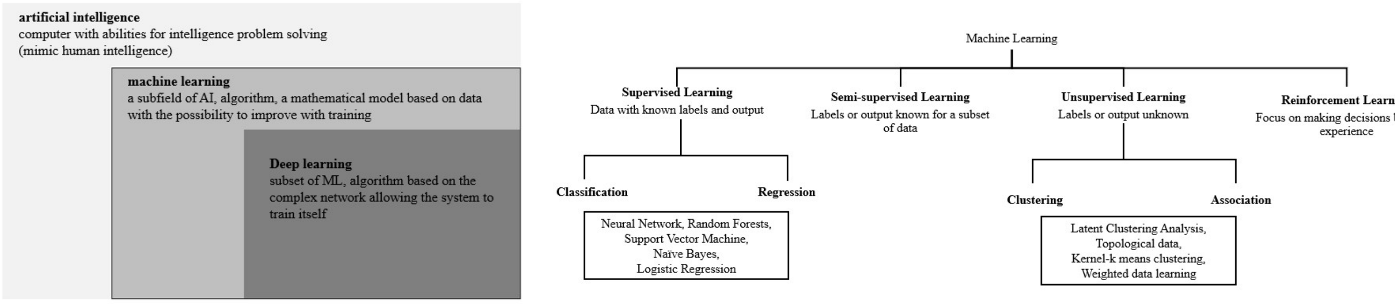

Figure 3: Definition of artificial intelligence (AI), machine learning (ML), and deep learning (DL) and summary of the different algorithms used in ML (adapted from Binvigat et al,2022)

Recent Studies Utilizing AI for Knee OA Diagnosis, Treatment, Rehabilitation, and Management

Knee OA is a prevalent degenerative joint disease characterized by the breakdown of cartilage, leading to pain, swelling, and decreased mobility. Accurate diagnosis and management are crucial for improving patient outcomes. Recent advancements in artificial AI, ML, and DL have shown significant promise in enhancing the diagnosis, rehabilitation, and treatment of knee OA. Table 2 summarizes key studies employing AI/ML/DL algorithms to assess knee OA severity, highlighting their clinical significance and the potential they hold for transforming patient care.

Tiulpin et al. (2018) utilized a deep convolutional neural network (DSCNNs) architecture to classify OA severity based on KL grades, using different datasets for training and testing, which offered robust evaluation[42]. Despite this strength, the validation and testing sets were derived from the same dataset, potentially limiting the generalizability of the results. Their work provided probability distributions for KL grade classifications, aiding clinical decision-making in ambiguous cases. Norman et al. (2019) applied DenseNets architecture, achieving sensitivity and specificity comparable to manual grading [43]. Their study also highlighted the limitation of using the same dataset for training, validation, and testing, which may introduce bias and affect the model's performance in real-world settings, particularly in cases involving hardware in the knee. Li et al. (2023) implemented U-Net architecture with prior knowledge in ResNets, demonstrating higher accuracy with multiview images compared to experienced radiologists, though the same dataset was used for validation and testing [44]. This model assists in preliminary diagnosis and treatment decisions, thus potentially enhancing patient care.

Smolle et al. (2023) employed CNNs and KOALA, providing numerical results with graphical overlays on X-rays, offering reliable and homogeneous evaluations, thus improving care for knee OA patients [45]. The large dataset used in this study further strengthened the model's reliability and clinical applicability. Wang et al. (2022) introduced a piezoresistive measurement instrument to classify OA severity based on KL grades, notable for its accuracy and low cost, although further analysis is needed to understand biomechanical mechanisms. This tool adds dynamic auxiliary tests to enhance clinical diagnosis and teaching, offering a comprehensive tool for knee OA assessment. Kotti et al. (2017) applied random forests (RF) and support vector machine (SVM) to develop an objective scale for knee OA severity, though they excluded subjects with bilateral OA due to data complexity, thus providing a sensitive diagnostic tool for personalized healthcare [46].

Tan et al. (2022) used long short-term memory (LSTM) for knee joint sagittal plane kinematics, which required less preprocessing and was suitable for real-time applications, though initial data points had reduced accuracy [47]. This model could be combined with human activity recognition systems for treatment monitoring. Zhang et al. (2020) utilized ResNets and Convolutional Block Attention Module (CBAM), improving KL grade classification accuracy using high-resolution radiographs, though generalizability analysis is needed [18]. Despite this limitation, the model and pre-processing pipeline developed in this study provide significant benefits to the OA research community, contributing to more accurate and reliable classification methods. Tri Wahyuningrum et al. (2020) accelerated the classification of knee OA severity based on joint space narrowing (JSN) from X-ray images using DCNNs, reducing radiologist subjectivity, despite reliance on large, labeled datasets [48]. The study emphasized the importance of a clinician's assessment to specify knee OA severity, thus supporting the integration of AI tools into clinical practice.

Swiecicki et al. (2021) incorporated lateral (LAT) radiographs with R-CNNs, performing a realistic clinical evaluation, though computationally expensive, and providing accurate, reproducible OA severity measures [49]. However, the computational expense of the model, especially for large datasets of medical images, was a notable limitation. Nonetheless, this approach holds promise for enhancing research and clinical decision-making in knee OA. Kashyap et al. (2021) proposed an automated physiotherapy system using a one-dimensional convolutional neural network (1D-CNN) model, which is cost-effective and provides personalized routines, despite limited data [50]. Rodríguez-Merchán (2022) demonstrated high accuracy in differentiating implant types and detecting prosthetic loosening using ANNs and CNNs, offering a comprehensive assessment for total knee arthroplasty (TKA) patients, though not meeting clinical usefulness thresholds [39]. Nonetheless, this system offers a comprehensive assessment of patients undergoing TKA, improving mobility and rehabilitation compliance.

Bonnin et al. (2023) used CNNs to develop AI tools for interpreting post-TKA X-rays, achieving high accuracy and standardization, though limited by a single-center study [51]. The study's limitation was its single-center nature, necessitating larger multi-center validation. Despite this, X-TKA holds the potential to assist surgeons in post-TKA X-ray interpretation, potentially improving accuracy and standardization. Batailler et al. (2022) explored various AI technologies such as robotic, computer-aided systems (CAS), sensors, augmented reality (AR), and mixed reality (MR) in surgical outcomes, enhancing precision and patient outcomes, though challenged by high costs and the need for specialized training [52]. Despite these challenges, AI technologies can lead to better functional outcomes, reduced complications, and faster recovery for patients undergoing knee replacement surgery. Guan et al. (2020) combined clinical data with DL models (YOLO and DenseNet) to predict pain progression in knee OA, aiding in risk stratification and personalized treatment, though limitations were not specified [53]. Lee et al. (2019) predicted pain progression trajectories using MRI data with Gaussian Mixture Models (GMM) and 3D CNN based on DenseNet 121, identifying patients at risk of worsening pain for early intervention [54]. The study achieved reasonable accuracy, though it focused solely on MRI data, excluding other clinical or demographic factors that could impact pain progression. This approach helps identify patients at risk of worsening pain, enabling early intervention and targeted treatment strategies.

In conclusion, the integration of AI/ML/DL in diagnosing and managing knee OA demonstrates significant potential in enhancing clinical accuracy, efficiency, and personalization of patient care. Despite challenges such as dataset limitations, computational costs, and the need for further validation, these technologies offer promising tools for improving outcomes in knee OA diagnosis and treatment. Future research should focus on overcoming these limitations, expanding datasets, and validating models across diverse patient populations to fully realize the potential of AI in knee OA management. This evolving field holds the promise of transforming how knee OA is diagnosed and managed, ultimately leading to better patient outcomes and more efficient healthcare delivery.

5. CHALLENGES AND LIMITATIONS

AI systems are completely dependent on the quality and quantity of data for training. In healthcare, access to large, diverse, and well-annotated datasets is challenging due to privacy concerns, data exclusion, and inconsistent data formats due to different healthcare providers. One could consider the lack of pertinent data as the obstacle to knee OA. Large datasets of high-quality patient data, including X-ray images, MRI scans, and the details of clinical history, are required for training AI models. Currently, there may be a scarcity of datasets for knee OA and the existing datasets may exhibit inconsistencies in the methods used to collect data. For knee OA, this can result in inconsistent performance in diagnosing and predicting disease progression. As mentioned by Ebrahimkhani et al. (2020), there is a lack of a standard database, and different databases might affect the accuracy resulting from the model[55].

According to El-Tallawy et al. (2024), the feeling of pain holds great magnitude as a health issue, making pain assessment essential for proper diagnosis, follow-up, and effective pain management [56]. However, conventional methods of pain assessment often suffer from subjectivity and variability, depending on pain scales and patient reporting. Therefore, AI models may provide support with the need to account for this subjectivity to make accurate predictions.

Recent studies have shown that AI models can achieve high accuracy in diagnosing knee OA from radiographic images. For instance, CNNs have been used to assess the KL grade of knee OA with performance comparable to expert radiologists. A study by Tiulpin et al. demonstrated that a DL model could automatically grade knee radiographs with high accuracy, suggesting potential for clinical deployment [42]. AI models also have been developed to predict the progression of knee OA, helping clinicians to identify patients at high risk of rapid disease progression. In this case, a model developed by Liu et al. utilized clinical and imaging data to predict the risk of knee OA progression over several years, offering a tool for personalized treatment planning. AI also is being used to tailor treatment plans based on individual patient data, including genetic, clinical, and imaging information. This approach aims to improve outcomes by providing personalized therapeutic strategies. The research conducted by Guan et al. focused on integrating multi-modal data to develop personalized treatment plans, showing promise in improving patient-specific outcomes in knee OA management.

Ethical considerations in the application of AI in healthcare are founded on three major principles: fairness, accountability, and transparency [57]. These principles have become the rallying points for researchers advocating for a more robust ethical framework in this domain. Biased AI models may result from the data used to train them, which may lead to unfair or inaccurate outcomes for patient demographics. Mitigating bias requires careful data selection and algorithmic design [58]. If the training data does not reflect the diversity of the real-world knee OA population, the model's recommendations might not be generalizable. This means ensuring that AI applications for knee OA should comply with legal standards and ethical practices.

Sometimes, AI models function as "black boxes", and DL models usually make it difficult for practitioners to understand how they arrived at a certain recommendation. This lack of transparency can hinder the trust and application of AI tools. Successfully integrating AI tools into existing clinical workflows is critical for practical use. Physicians need a user-friendly interface and clear guidance on how AI results should be incorporated into their decision-making process. However, the development, maintenance, and application of AI tools can be expensive and require significant hardware resources. Reimbursement structures may need to adapt to instigate the use of these new technologies.

Two of the most prevalent worries about the use of AI in healthcare are privacy violations and data breaches. For this reason, stringent confidentiality regulations must be followed when using patient data in AI research [59]. This has grown far more concerning now that Google's servers are openly used for AI usage [60]. A well-defined legal and ethical framework that handles liability in AI-driven healthcare is necessary to guarantee that all patients have impartial access to AI-powered healthcare services. Prior to fully incorporating AI into the treatment of knee OA, these are the few key challenges that need to be resolved. Despite these obstacles, AI has a great deal of potential to improve healthcare. In the future, by overcoming the limitations through further research and development, AI can hold greater promise of providing patients with knee OA with tailored and effective treatment.

6. CONCLUSIONS

Knee OA has been classically managed with pharmacotherapy, physical therapy, and ultimately, surgical options. Nevertheless, the application of AI technologies has great potential to disrupt the diagnosis, prognosis, and tailored treatment of this major disease. The recent findings of the research suggest the auspicious utilization of DL techniques for learning from medical imaging data such as X-rays, CT scans, and MRI scans. These AI-based models have demonstrated accuracy for knee OA diagnosis and tracking knee OA progression, even outperforming traditional clinical assessment in some cases. Additionally, the utilization of multi-modal data including imaging biomarkers and longitudinal follow-up to track changes over time can enhance the predictive performance of those AI models. It might also help in more accurate prediction of disease

To summarize, AI holds the potential to revolutionize healthcare, and it is undeniable that AI has made significant contributions in various aspects. Conversely, humans cannot be replaced by AI, as they are the ones who create and provide its foundation. Medical professionals should always bear in mind that their patients are vulnerable human beings with lives that are equally valuable to them as their own. Thus, it is essential to develop a sincere, personal, and sympathetic relationship with their patients, which is a bond of understanding and compassion that cannot be given by machinery [61]. AI and people must cooperate to resolve any conflicts and ensure that the public receives the finest treatment possible in the healthcare sector without becoming enslaved to one another.

Several crucial challenges must be addressed to fully harness the potential of AI in healthcare and achieve its transformative benefits including ensuring data protection, addressing social concerns, addressing ethical issues, tackling hacking difficulties, and overcoming development. By tackling these challenges, AI can enhance patient outcomes, enable precise diagnosis, and facilitate effective treatment planning, which ultimately leads to a better quality of life. Another key fact to remember is that establishing a positive connection between physicians and patients is vital for the effectiveness of therapy and recuperation [62]. It is of utmost importance to keep in mind that the primary aim of incorporating AI, especially in healthcare, is to support humans in reducing or eliminating errors, rather than compounding them.

Table 2: Summary of Reviewed Studies on the Diagnosis, Treatment, Rehabilitation and Management of Knee Osteoarthritis (OA) which entails the details of the author by year and journal, prediction outcome, types of Artificial Intelligence (AI)/Machine Learning (ML)/Deep Learning (DL) algorithm(s) used, strengths, weaknesses and clinical significance of the study.

Author (Year) and Journal	Prediction Outcome	AI/ML/DL Algorithm (s)	Strengths	Weaknesses	Clinical Significance of the Study
Kotti et al. (2017) Medical Engineering &Amp; Physics	OA severity based on KL grade classification	RF and SVM	An objective scale for the degree of knee OA and parameters were extracted to distinguish between normal and knee OA subjects	Subjects with OA on both knees were removed because of the complexity of the data	An objective, sensitive, and diagnostic tool to personalize healthcare
Tiulpin et al. (2018) Scientific reports	OA severity based on KL grade classification	DSCNNs architecture	Use different datasets for initial training and testing	The selection for the validation and testing sets are from the same dataset	The provision of a probability distribution for each KL grade classification may assist clinicians in choosing it in ambiguous cases
Norman et al. (2019) Journal of digital imaging	OA severity based on KL grade classification	DenseNets architecture	Comparable sensitivity and specificity to manual grading and previous automatic systems employing different AI/ML algorithms	The selection for the training, validation, and testing sets are from the same datasets, and misclassifications of KL grades typically occur if there is a presence of hardware in the knee	Provides additional data to support the potential of AI in the automatic assessment of OA radiological severity
Lee et al, (2019) Osteoarthritis and Cartilage	To predict pain progression trajectories in OA patients using	Gaussian Mixture Model (GMM) and a 3D CNN based on the DenseNet 121 architecture	Able to predict the pain trajectories with reasonable accuracy, using only baseline MRI data	The study focused solely on MRI data and did not incorporate other clinical or demographic factors	Predicting pain progression trajectories in knee OA patients can help identify those at risk of progressively worsening pain, who may benefit from early

	structural MRI data.			that could impact pain progression.	intervention or targeted treatment strategies.
Zhang et al. (2020) 2020 IEEE 17th International Symposium on Biomedical Imaging (ISBI)	OA severity based on KL grade classification	ResNets and CBAM	Able to improve the KL grade classification accuracy using the radiographs with inherent spatial resolution, which highlights the importance of higher spatial resolution and contrast in the medical image classification task	Using the OAI dataset for training and testing the models and the validity of generalizable models using different patient groups or hospital settings needs to be further analyzed.	KL grade classification model and pre-processing pipeline will benefit the OA research community
Tri Wahyuningrum et al. (2020) 8th International Conference on Information Technology: IoT and Smart City	OA severity based on JSN	DCNNs	Able to accelerate the classification of knee OA severity based on information obtained from X-ray images and reduce the subjectivity of radiologists	DCNNs heavily rely on large amounts of labeled data for training and are difficult to interpret.	A clinician assessment can provide support to specify the knee OA severity
Swiecicki et al. (2021)	OA severity based on KL grade classification	R-CNNs	The model incorporates LAT radiographs into the view of the KL grade classification and	Computationally expensive, especially for large datasets of medical images.	Provide an accurate and reproducible measure of OA severity for research and clinical decision-making

Computers in biology and medicine			performs a reader study with five radiologists to evaluate the model in a realistic clinical setting		
Kashyap et al (2021) Global Transitions Proceedings	An automated physiotherapy system	1D-CNN model	The system is computationally inexpensive, faster in determining the quality of the knee, and provides personalized physiotherapy routines based on the determined cluster.	The proposed model has limited data	The proposed system has the potential to reduce the cost and increase the accessibility of physiotherapy sessions.
Guan et al, (2022) Skeletal Radiology	To predict pain progression in knee osteoarthritis patients using deep learning (DL) models	▪ Clinical Model: An ANN that used demographic and radiographic risk factors to predict pain progression. ▪ DL Model: A combination of two deep convolutional neural networks (YOLO and DenseNet). ▪ Combined Clinical and DL Model: This model integrated	The feasibility of using a DL approach, along with clinical data, to predict knee pain progression.	The study did not mention potential limitations or weaknesses.	This approach could potentially aid clinicians in risk stratification and personalized treatment planning for knee osteoarthritis patients.

		the clinical data with the feature vector extracted from radiographs by DenseNet.			
Wang et al. (2022) IEEE Access	OA severity based on KL grade classification	A piezoresistive measurement instrument	Accurate, low-cost, wearable, and portable	Need further analysis to see the differences between subjects with and without knee OA, which is significant for a better understanding of the disease progression and biomechanical mechanisms	Dynamic auxiliary tests would be an important addition to clinical diagnosis and teaching
Tan et al. (2022) Sensors	Knee joint sagittal plane kinematics	LSTM	Less pre-processing compared to other DL approaches, such as CNNs, and is more suitable for real-time applications	LSTM only uses past data points, which reduces the accuracy of the first few data points	The model proposed in this study could be combined with a human activity recognition system to monitor the response for the treatment concerning people with knee OA
Rodríguez-Merchán, (2022) EFORT Open Reviews	The current role of the virtual elements of artificial intelligence in total knee arthroplasty	ANNs and CNNs model	The system can differentiate between different implant types with near-perfect accuracy and can detect prosthetic loosening from radiographs	The models did not reach the predetermined threshold for clinical usefulness	It offers a more complete assessment of patients undergoing TKA in terms of mobility and rehabilitation compliance.
Batailler, et al (2022). Arthroplasty	AI tools can assist in accurate implant	The use of various AI technologies such as robotics,	▪ Intra-operative data collection (image-based, 3D models,	the cost and availability of advanced AI technologies, the need for specialized training	can potentially improve surgical precision, implant positioning, ligament balancing, and tissue preservation, leading to better

	positioning, ligament balancing, tissue preservation, and pre-operative planning, which can potentially improve surgical outcomes and patient	computer-aided systems (CAS), sensors, augmented reality (AR), mixed reality (MR), and navigation systems.	augmented/mixed reality) for accurate surgical planning and execution. ▪ Implant positioning and alignment based on native knee anatomy and adjustments before bone resections. ▪ Ligament balancing through measurements before and after total knee arthroplasty (TKA) or unicompartmental knee arthroplasty (UKA).	for surgeons, and the potential for technical errors or malfunctions.	functional outcomes, reduced complications, and faster recovery for patients undergoing knee replacement surgery.
Li et al. (2023) Quantitative Imaging in Medicine and Surgery	OA severity based on KL grade classification	U-Net architecture, prior knowledge concerning specific zones, was incorporated into ResNets	The accuracy of the DL model with multiview images and prior knowledge is better compared to that of an experienced radiologist	The selection for the validation and testing sets are from the same dataset	The DL grading model can help clinicians make a preliminary diagnosis and assist them in making treatment decisions to a certain extent
Smolle et al. (2023) Knee Surgery, Sports Traumatolog	OA severity based on KL grade classification	CNNs and KOALA	Able to provide numerical results together with graphical overlays on X-rays showing measurement points	Use a large dataset	Reliable and homogenous evaluation of radiological images to improve the care of knee OA patients through timely treatment planning

y, Arthroscopy					
Bonnin et al (2023) The Journal of Arthroplasty	AI tools called X-TKA assist in the interpretation of X-rays after total knee arthroplasty (TKA).	CNNs model	X-TKA achieved high accuracy in detecting interface anomalies, comparable to senior surgeons. Can automate measurements and provide standardized analysis, reducing variability and subjectivity.	The study was conducted on a single-center database, and larger multi-center validation is needed.	X-TKA can assist surgeons in the interpretation of post-TKA X-rays, potentially improving the accuracy and standardization of assessment.

The abbreviations : Artificial Intelligence (AI), Machine Learning (ML), Deep Learning (DL), osteoarthritis (OA), Kellgren-Lawrence (KL), Deep Siamese Convolutional Neural Networks (DSCNNs), Convolutional Neural Networks (CNNs), Densely Connected Convolutional Neural Networks (DenseNets), Residual Neural Networks (ResNets), Knee Osteoarthritis Labeling Assistant (KOALA), Random Forest (RF), Support Vector Machine (SVM), Long Short-Term Memory (LSTM), Convolutional Block Attention Module (CBAM), Osteoarthritis Initiative (OAI), joint space narrowing (JSN), Deep Convolutional Neural Networks (DCNNs), Region-based Convolutional Neural Networks (R-CNNs), and lateral (LAT).

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REFERENCES

[1] A. Litwic, M. H. Edwards, E. M. Dennison, and C. Cooper, "Epidemiology and burden of osteoarthritis," *Br Med Bull*, vol. 105, no. 1, pp. 185–199, Mar. 2013, doi: 10.1093/bmb/lds038.

[2] T. Vos *et al.*, "Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019," *The Lancet*, vol. 396, no. 10258, pp. 1204–1222, Oct. 2020, doi: 10.1016/S0140-6736(20)30925-9.

[3] H. Long *et al.*, "Prevalence Trends of Site-Specific Osteoarthritis From 1990 to 2019: Findings From the Global Burden of Disease Study 2019," *Arthritis & Rheumatology*, vol. 74, no. 7, pp. 1172–1183, Jul. 2022, doi: 10.1002/art.42089.

[4] T. Vos *et al.*, "Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015," *The Lancet*, vol. 388, no. 10053, pp. 1545–1602, Oct. 2016, doi: 10.1016/S0140-6736(16)31678-6.

[5] J. D. Steinmetz *et al.*, "Global, regional, and national burden of osteoarthritis, 1990–2020 and projections to 2050: a systematic analysis for the Global Burden of Disease Study 2021," *Lancet Rheumatol*, vol. 5, no. 9, pp. e508–e522, Sep. 2023, doi: 10.1016/S2665-9913(23)00163-7.

[6] V. Silverwood, M. Blagojevic-Bucknall, C. Jinks, J. L. Jordan, J. Protheroe, and K. P. Jordan, "Current evidence on risk factors for knee osteoarthritis in older adults: a systematic review and meta-analysis," *Osteoarthritis Cartilage*, vol. 23, no. 4, pp. 507–515, Apr. 2015, doi: 10.1016/j.joca.2014.11.019.

[7] V. K. Srikanth, J. L. Fryer, G. Zhai, T. M. Winzenberg, D. Hosmer, and G. Jones, "A meta-analysis of sex differences prevalence, incidence and severity of osteoarthritis," *Osteoarthritis Cartilage*, vol. 13, no. 9, pp. 769–781, Sep. 2005, doi: 10.1016/j.joca.2005.04.014.

[8] I. J. Wallace *et al.*, "Knee osteoarthritis has doubled in prevalence since the mid-20th century," *Proceedings of the National Academy of Sciences*, vol. 114, no. 35, pp. 9332–9336, Aug. 2017, doi: 10.1073/pnas.1703856114.

[9] K.-Y. Jeong and H. J. Lee, "Prevalence of Knee Osteoarthritis and Health-Related Quality of Life in Stroke Patients over 60 Years Old: A Cross-Sectional Study Using Korean National Health and Nutrition Examination Survey V," *Ann Geriatr Med Res*, vol. 25, no. 3, pp. 178–186, Sep. 2021, doi: 10.4235/agmr.21.0053.

[10] S. S. Kamsan, D. K. A. Singh, M. P. Tan, and S. Kumar, "Healthcare Utilization and Knee Osteoarthritis Symptoms among Urban Older Malaysian," *Int J Environ Res Public Health*, vol. 18, no. 7, p. 3777, Apr. 2021, doi: 10.3390/ijerph18073777.

[11] B. R. Deshpande *et al.*, "Number of Persons With Symptomatic Knee Osteoarthritis in the US: Impact of Race and Ethnicity, Age, Sex, and Obesity," *Arthritis Care Res (Hoboken)*, vol. 68, no. 12, pp. 1743–1750, Dec. 2016, doi: 10.1002/acr.22897.

[12] A. Postler *et al.*, "Prevalence and treatment of hip and knee osteoarthritis in people aged 60 years or older in Germany: an analysis based on health insurance claims data," *Clin Interv Aging*, vol. Volume 13, pp. 2339–2349, Nov. 2018, doi: 10.2147/CIA.S174741.

[13] K. W. AlKuwaity, T. N. Mohammad, M. A. Hussain, A. J. Alkhanani, and A. M. B. Ali, "Prevalence and Determinant Factors of Osteoarthritis of the Knee Joint among Elderly in Arar, KSA," *Egypt J Hosp Med*, vol. 72, no. 9, pp. 5173–5177, Jul. 2018, doi: 10.21608/ejhm.2018.10737.

[14] H. J. Cho, V. Morey, J. Y. Kang, K. W. Kim, and T. K. Kim, "Prevalence and Risk Factors of Spine, Shoulder, Hand, Hip, and Knee Osteoarthritis in Community-dwelling Koreans Older Than Age 65 Years," *Clin Orthop Relat Res*, vol. 473, no. 10, pp. 3307–3314, Oct. 2015, doi: 10.1007/s11999-015-4450-3.

[15] B. AN, K. FANG, Y. WANG, Y. ZENG, and K. DAI, "New variables for measuring joint space width to evaluate knee osteoarthritis," *Chin Med J (Engl)*, vol. 124, no. 23, pp. 3886–3890, 2011.

[16] J. H. Kellgren and J. S. Lawrence, "Radiological Assessment of Osteo-Arthrosis," *Ann Rheum Dis*, vol. 16, no. 4, pp. 494–502, Dec. 1957, doi: 10.1136/ard.16.4.494.

[17] J. Bajwa, U. Munir, A. Nori, and B. Williams, "Artificial intelligence in healthcare: transforming the practice of medicine," *Future Healthc J*, vol. 8, no. 2, pp. e188–e194, Jul. 2021, doi: 10.7861/fhj.2021-0095.

[18] B. Zhang, J. Tan, K. Cho, G. Chang, and C. M. Deniz, "Attention-based CNN for KL Grade Classification: Data from the Osteoarthritis Initiative," in *2020 IEEE 17th International Symposium on Biomedical Imaging (ISBI)*, IEEE, Apr. 2020, pp. 731–735. doi: 10.1109/ISBI45749.2020.9098456.

[19] N. Maricar, M. J. Callaghan, M. J. Parkes, D. T. Felson, and T. W. O'Neill, "Interobserver and Intraobserver Reliability of Clinical Assessments in Knee Osteoarthritis," *J Rheumatol*, vol. 43, no. 12, pp. 2171–2178, Dec. 2016, doi: 10.3899/jrheum.150835.

[20] A. M. Alshami, "Knee Osteoarthritis Related Pain : A Narrative Review of Diagnosis and Treatment," *Int J Health Sci (Qassim)*, vol. 8, no. 1, pp. 85–104, Jan. 2014, doi: 10.12816/0006075.

[21] R. Kijowski, S. Demehri, F. Roemer, and A. Guermazi, "Osteoarthritis year in review 2019: imaging," *Osteoarthritis Cartilage*, vol. 28, no. 3, pp. 285–295, Mar. 2020, doi: 10.1016/j.joca.2019.11.009.

[22] C. L. Piccolo, C. A. Mallio, F. Vaccarino, R. F. Grasso, and B. B. Zobel, "Imaging of knee osteoarthritis: a review of multimodal diagnostic approach," *Quant Imaging Med Surg*, vol. 13, no. 11, pp. 7582–7595, Nov. 2023, doi: 10.21037/qims-22-1392.

[23] F. W. Roemer, A. Guermazi, S. Demehri, W. Wirth, and R. Kijowski, "Imaging in Osteoarthritis," *Osteoarthritis Cartilage*, vol. 30, no. 7, pp. 913–934, Jul. 2022, doi: 10.1016/j.joca.2021.04.018.

[24] M. C. Hochberg *et al.*, "American College of Rheumatology 2012 recommendations for the use of nonpharmacologic and pharmacologic therapies in osteoarthritis of the hand, hip, and knee," *Arthritis Care Res (Hoboken)*, vol. 64, no. 4, pp. 465–474, Apr. 2012, doi: 10.1002/acr.21596.

[25] A. J. Thirumaran, L. A. Deveza, I. Atukorala, and D. J. Hunter, "Assessment of Pain in Osteoarthritis of the Knee," *J Pers Med*, vol. 13, no. 7, p. 1139, Jul. 2023, doi: 10.3390/jpm13071139.

[26] J. M. Helm *et al.*, "Machine Learning and Artificial Intelligence: Definitions, Applications, and Future Directions," *Curr Rev Musculoskelet Med*, vol. 13, no. 1, pp. 69–76, Feb. 2020, doi: 10.1007/s12178-020-09600-8.

[27] L. Cao, "Data Science," *ACM Comput Surv*, vol. 50, no. 3, pp. 1–42, May 2018, doi: 10.1145/3076253.

[28] I. H. Sarker, "Machine Learning: Algorithms, Real-World Applications and Research Directions," *SN Comput Sci*, vol. 2, no. 3, p. 160, May 2021, doi: 10.1007/s42979-021-00592-x.

[29] L. Lo Vercio *et al.*, “Supervised machine learning tools: a tutorial for clinicians,” *J Neural Eng*, vol. 17, no. 6, p. 062001, Dec. 2020, doi: 10.1088/1741-2552/abbff2.

[30] J. A. M. Sidey-Gibbons and C. J. Sidey-Gibbons, “Machine learning in medicine: a practical introduction,” *BMC Med Res Methodol*, vol. 19, no. 1, p. 64, Dec. 2019, doi: 10.1186/s12874-019-0681-4.

[31] V. Pedoia, “Machine Learning and Artificial Intelligence,” *Osteoarthritis Cartilage*, vol. 28, p. S16, Apr. 2020, doi: 10.1016/j.joca.2020.02.010.

[32] G. B. Joseph, C. E. McCulloch, J. H. Sohn, V. Pedoia, S. Majumdar, and T. M. Link, “AI MSK clinical applications: cartilage and osteoarthritis,” *Skeletal Radiol*, vol. 51, no. 2, pp. 331–343, Feb. 2022, doi: 10.1007/s00256-021-03909-2.

[33] S. M. Ahmed and R. J. Mstafa, “A Comprehensive Survey on Bone Segmentation Techniques in Knee Osteoarthritis Research: From Conventional Methods to Deep Learning,” *Diagnostics*, vol. 12, no. 3, p. 611, Mar. 2022, doi: 10.3390/diagnostics12030611.

[34] M. Binvignat *et al.*, “Use of machine learning in osteoarthritis research: a systematic literature review,” *RMD Open*, vol. 8, no. 1, p. e001998, Mar. 2022, doi: 10.1136/rmdopen-2021-001998.

[35] L. S. Lee *et al.*, “Artificial intelligence in diagnosis of knee osteoarthritis and prediction of arthroplasty outcomes: a review,” *Arthroplasty*, vol. 4, no. 1, p. 16, Dec. 2022, doi: 10.1186/s42836-022-00118-7.

[36] L. Si *et al.*, “Deep learning in knee imaging: a systematic review utilizing a Checklist for Artificial Intelligence in Medical Imaging (CLAIM),” *Eur Radiol*, vol. 32, no. 2, pp. 1353–1361, Feb. 2022, doi: 10.1007/s00330-021-08190-4.

[37] M. Banjar, S. Horiuchi, D. N. Gedeon, and H. Yoshioka, “Review of Quantitative Knee Articular Cartilage MR Imaging,” *Magnetic Resonance in Medical Sciences*, vol. 21, no. 1, p. rev.2021-0052, 2022, doi: 10.2463/mrms.rev.2021-0052.

[38] Q. D. Buchlak, J. Clair, N. Esmaili, A. Barmare, and S. Chandrasekaran, “Clinical outcomes associated with robotic and computer-navigated total knee arthroplasty: a machine learning-augmented systematic review,” *European Journal of Orthopaedic Surgery & Traumatology*, vol. 32, no. 5, pp. 915–931, Jul. 2022, doi: 10.1007/s00590-021-03059-0.

[39] E. C. Rodríguez-Merchán, “The current role of the virtual elements of artificial intelligence in total knee arthroplasty,” *EFORT Open Rev*, vol. 7, no. 7, pp. 491–497, Jul. 2022, doi: 10.1530/EOR-21-0107.

[40] A. Almhdie-Imjabbar, H. Toumi, and E. Lespessailles, “Radiographic Biomarkers for Knee Osteoarthritis: A Narrative Review,” *Life*, vol. 13, no. 1, p. 237, Jan. 2023, doi: 10.3390/life13010237.

[41] F. Hinterwimmer *et al.*, “Machine learning in knee arthroplasty: specific data are key—a systematic review,” *Knee Surgery, Sports Traumatology, Arthroscopy*, vol. 30, no. 2, pp. 376–388, Feb. 2022, doi: 10.1007/s00167-021-06848-6.

[42] A. Tiulpin, J. Thevenot, E. Rahtu, P. Lehenkari, and S. Saarakkala, “Automatic Knee Osteoarthritis Diagnosis from Plain Radiographs: A Deep Learning-Based Approach,” *Sci Rep*, vol. 8, no. 1, p. 1727, Jan. 2018, doi: 10.1038/s41598-018-20132-7.

[43] B. Norman, V. Pedoia, A. Noworolski, T. M. Link, and S. Majumdar, “Applying Densely Connected Convolutional Neural Networks for Staging Osteoarthritis Severity from Plain Radiographs,” *J Digit Imaging*, vol. 32, no. 3, pp. 471–477, Jun. 2019, doi: 10.1007/s10278-018-0098-3.

[44] W. Li *et al.*, “Deep learning-assisted knee osteoarthritis automatic grading on plain radiographs: the value of multiview X-ray images and prior knowledge,” *Quant Imaging Med Surg*, vol. 13, no. 6, pp. 3587–3601, Jun. 2023, doi: 10.21037/qims-22-1250.

[45] M. A. Smolle *et al.*, “Artificial intelligence-based computer-aided system for knee osteoarthritis assessment increases experienced orthopaedic surgeons’ agreement rate and accuracy,” *Knee Surgery, Sports Traumatology, Arthroscopy*, vol. 31, no. 3, pp. 1053–1062, Mar. 2023, doi: 10.1007/s00167-022-07220-y.

[46] M. Kotti, L. D. Duffell, A. A. Faisal, and A. H. McGregor, “Detecting knee osteoarthritis and its discriminating parameters using random forests,” *Med Eng Phys*, vol. 43, pp. 19–29, May 2017, doi: 10.1016/j.medengphy.2017.02.004.

[47] J.-S. Tan *et al.*, “Predicting Knee Joint Kinematics from Wearable Sensor Data in People with Knee Osteoarthritis and Clinical Considerations for Future Machine Learning Models,” *Sensors*, vol. 22, no. 2, p. 446, Jan. 2022, doi: 10.3390/s22020446.

[48] R. Tri Wahyuningrum, A. Yasid, and G. Jacob Verkerke, “Deep Neural Networks for Automatic Classification of Knee Osteoarthritis Severity Based on X-ray Images,” in *Proceedings of the 2020 8th International Conference on Information Technology: IoT and Smart City*, New York, NY, USA: ACM, Dec. 2020, pp. 110–114. doi: 10.1145/3446999.3447020.

[49] A. Swiecicki *et al.*, “Deep learning-based algorithm for assessment of knee osteoarthritis severity in radiographs matches performance of radiologists,” *Comput Biol Med*, vol. 133, p. 104334, Jun. 2021, doi: 10.1016/j.compbiomed.2021.104334.

[50] S. Kashyap, V. Venkatesh, M. K. Pushpa, S. Narasimhan, and V. Chittaranjan, “Adaptive, AI-based automated knee physiotherapy system,” *Global Transitions Proceedings*, vol. 2, no. 2, pp. 484–491, Nov. 2021, doi: 10.1016/j.gltp.2021.08.052.

[51] M. Bonnin, F. Müller-Fouarge, T. Estienne, S. Bekadar, C. Pouchy, and T. Ait Si Selmi, “Artificial Intelligence Radiographic Analysis Tool for Total Knee Arthroplasty,” *J Arthroplasty*, vol. 38, no. 7, pp. S199-S207.e2, Jul. 2023, doi: 10.1016/j.arth.2023.02.053.

[52] C. Batailler, J. Shatrov, E. Sappey-Marinier, E. Servien, S. Parratte, and S. Lustig, “Artificial intelligence in knee arthroplasty: current concept of the available clinical applications,” *Arthroplasty*, vol. 4, no. 1, p. 17, Dec. 2022, doi: 10.1186/s42836-022-00119-6.

[53] B. Guan *et al.*, “Deep learning approach to predict pain progression in knee osteoarthritis,” *Skeletal Radiol*, vol. 51, no. 2, pp. 363–373, Feb. 2022, doi: 10.1007/s00256-021-03773-0.

[54] J. J. Lee, F. Liu, S. Majumdar, and V. Pedoia, “Can AI predict pain progression in knee osteoarthritis subjects from structural MRI,” *Osteoarthritis Cartilage*, vol. 27, p. S24, Apr. 2019, doi: 10.1016/j.joca.2019.02.036.

[55] S. Ebrahimkhani, M. H. Jaward, F. M. Cicuttini, A. Dharmaratne, Y. Wang, and A. G. S. de Herrera, “A review on segmentation of knee articular cartilage: from conventional methods towards deep learning,” *Artif Intell Med*, vol. 106, p. 101851, Jun. 2020, doi: 10.1016/j.artmed.2020.101851.

[56] S. N. El-Tallawy *et al.*, “Incorporation of ‘Artificial Intelligence’ for Objective Pain Assessment: A Comprehensive Review,” *Pain Ther*, vol. 13, no. 3, pp. 293–317, Jun. 2024, doi: 10.1007/s40122-024-00584-8.

[57] T. Hagendorff, “The Ethics of AI Ethics: An Evaluation of Guidelines,” *Minds Mach (Dordr)*, vol. 30, no. 1, pp. 99–120, Mar. 2020, doi: 10.1007/s11023-020-09517-8.

[58] M. Anderson and S. Anderson, "How Should AI Be Developed, Validated, and Implemented in Patient Care?," *AMA J Ethics*, vol. 21, no. 2, pp. E125-130, Feb. 2019, doi: 10.1001/amajethics.2019.125.

[59] M. K. Baowaly, C.-C. Lin, C.-L. Liu, and K.-T. Chen, "Synthesizing electronic health records using improved generative adversarial networks," *Journal of the American Medical Informatics Association*, vol. 26, no. 3, pp. 228–241, Mar. 2019, doi: 10.1093/jamia/ocy142.

[60] S. Hamid, "The Opportunities and Risks of Artificial Intelligence in Medicine and Healthcare."

[61] V. Rampton, "Artificial intelligence versus clinicians," *BMJ*, p. m1326, Apr. 2020, doi: 10.1136/bmj.m1326.

[62] S. D. Goold and M. Lipkin, "The doctor-patient relationship," *J Gen Intern Med*, vol. 14, no. S1, pp. S26–S33, Jan. 1999, doi: 10.1046/j.1525-1497.1999.00267.x.