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#### **Appendix 1.**

**Due to the large number of different surgeons, lesion sizes and locations, no standard surgical technique was utilized, but previously described principles of effective surgical resection were followed, including attempts at complete resection of the lesion, leaving no residual myxomatous tissue or cartilage cap, to minimize risk for recurrence.**

**Radiographic/fluoroscopic assistance was utilized to ensure that the resection was performed at the proper location and in line with the native cortex, so as not to weaken the integrity of the normal, residual bone. For some larger lesions, 1-2mm of the base was preserved to decrease fracture risk. Size and location of incisions were made judiciously, paying close attention to the location of neurovascular structures. Post-operatively, sterile dressings and soft wraps were applied, with no range of motion restrictions and crutches provided for comfort, but no formal weight bearing protection, other than several instances of large lesions with a base >5cm.**

#### **Appendix 2.**

**Clavien- Dindo Classification: ‘Major’ complications were defined by symptoms or disability >6 months or those requiring re-operation. ‘Minor’ complications were any meeting criteria for Grade I (any deviation from normal post-operative course without need for pharmacological treatment) or Grade II (requiring pharmacologic treatment with drugs other than those allowed for Grade I complications)**

#### **Appendix 3.**

**Three patients developed a recurrence of their index OCE requiring another surgical resection, 1 developed a deep wound infection requiring irrigation and debridement, 1 sustained an iatrogenic injury to the superficial femoral artery and vein and underwent intra-operative repair of the injured vessels, and 1 developed persistent knee pain prompting a diagnostic arthroscopy, which revealed significant chondromalacia and mild arthrofibrosis. All three ‘recurrence’ patients were skeletally immature at the time of the first resection with lesion bases >4cm. Two lesions were in the posterior distal femur and the third was just adjacent to the tibial tubercle.**