Musculoskeletal – Knee Pain Referral and Management Pathway – Update March 2013

**Patient Presentation**

**Chronic knee pain**
Knee problem > 1 month

Exclude hip/spine pathology (especially in children) & inflammatory arthritis
N.B. BMI >35; weight loss may reduce need for surgery, is associated with improved outcomes if surgery proceeds and will reduce surgical complication rate

**Acute knee pain**
Sudden onset of symptoms

**GP/Physiotherapist**
History & examination

**Disabling Symptoms:**
• Pain at rest and/or disturbed sleep?
• Significant reduction in walking ability?

**History of previous significant injury?** (feeling of pop/snap, rapid swelling, inability to complete activity?)
• Episodes of true locking (block to full extension)?
• Episodes of true giving way (not just fear)?
• Effusion Swelling?
• Joint line pain/tenderness?
• Associated with existing meniscal tears, ligamentous instability or loose bodies?

**GP**
Consider –
• Analgesics/NSAIDs, Walking aid
• Advise to stay active, continue normal activities
• Weight management
• Intra-artic steroid
• Physiotherapy referral

Advanced/Moderate OA
Early/Moderate OA
Referral if failure to improve after 3 months of conservative management

**Physiotherapist**
Assessment / treatment

Refer if failure to improve after 3 months

**GP/Physiotherapist**
Treatment

Refer if failure to improve 4-6 weeks

Refer to A&E, MIU or Orthopaedic Trauma Clinic as per local arrangements

Refer to Secondary Care Orthopaedic Dept. for Assessment (or MSK Assessment Hub if available locally)

**Infection or Previous surgery - Refer for Emergency Review**

Infammatary disease (including gout/ pseudogout - unless recurrent gout suspected)

Rheumatology

**Information for Patients**
NHS24: 08454 24 24 24
www.patient.co.uk
www.nice.org.uk
www.OARSI.org

**Patient Presentation**

**Anterior knee pain**

History & examination

Pain in front of knee
• often bilateral
• exacerbated by stairs/hills

Consider –
• Analgesics/NSAIDs, walking aid, weight management, physiotherapy referral if failure to improve after 6 weeks
• Advise to stay active, continue low impact activities

**GP**

**Patient Presentation**

**Anterior knee pain**

Sudden onset of symptoms

**GP/Physiotherapist**
History & examination

No

Yes

**GP**
Consider –
• Analgesics/NSAIDs, Walking aid
• Advise to stay active, continue normal activities
• Weight management
• Intra-artic steroid
• Physiotherapy referral

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Arthroscopy

Arthroscopy is the operative technique of choice for dealing with:

• Meniscus injury, particularly where there are mechanical symptoms or pain in keeping with symptomatic meniscus pathology. N.B. Meniscus pathology can occur at any age, even in the presence of mild OA.
• Cruciate reconstruction
• Other intra-articular pathologies (e.g. loose bodies, localised persistent joint line pain despite conservative management)

Arthroscopy should only be carried out after some form of pre-operative imaging of the knee, usually MRI. Arthroscopy may be appropriate where MRI findings are equivocal or diagnosis remains in doubt after scanning e.g. suspected lateral meniscus tears with persistent symptoms.

N.B. –
• Arthroscopy is not appropriate for meniscus pathology in the presence of severe OA.
• Arthroscopy for anterior knee pain is rarely indicated.
• Bi-lateral arthroscopy is rarely indicated and would always require pre-operative MRI scanning.
• Arthroscopy should not be routinely used for diagnostic purposes where non-invasive imaging may be more appropriate.
• Evidence is clear that arthroscopy with washout/debridement is not an appropriate treatment for established OA of the knee.

Referral for Knee Imaging

Plain X-Rays
Indicated in the following situations:
• There is a history of acute trauma and associated knee swelling
• Patient remains unable to bear weight on the affected limb after knee injury
• Other situations where fracture is clinically suspected
• OA is suspected (patient over 45 or clinical signs indicative) N.B. Requires weight-bearing AP (single leg standing) /Lateral X-Rays
• Loose intra-articular body suspected

MRI
MRI is the most accurate non-operative method of diagnosing meniscal and ligament pathology.
It is indicated in the following situations:
• In suspected cases of meniscus and ligament injury
• In suspected cases of patellar dislocation where extensor mechanism injury is suspected
• Where there is doubt about diagnosis

N.B. Direct access to MRI for Knees by GPs and ‘straight to test’ (at vetting stage, pre-outpatients appointment) options are being piloted at a number of Boards. Once results have been evaluated this pathway may be updated.

Ultrasound Scanning
Ultrasound scanning may be indicated where there is the clinical suggestion of extensor mechanism injury.

Useful Information for Patients

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Source: Scottish Orthopaedic Services Development Group - Update March 2013