Knee Injury Pathway

Differential diagnosis:

ACL rupture:

There will be a significant injury in the history, e.g.: injured during Football, Netball, Skiing, and Dance etc. Usually injury involves non-contact running associated with an acceleration/deceleration and change of direction. Torn ACL is common in skiing due to knee position and skiing impact/twisting injuries.

Symptoms: Often patients describe a “pop” or a “snap” in the knee and they have an immediate Haemarthrosis. Some describe the knee as ‘it dislocated’, meaning the Tib/Fem joint itself rather than a dislocated patella.

Test Lachman’s, (this is more reliable than anterior draw but hard to an inexperienced clinician). Suspect torn ACL if the injury is described in the history. Patients will describe giving way/buckling/swelling and it “not feeling right/stable”. Test all other ligaments/menisci, (see below). If suspect torn ACL +/- associated injury, refer directly to Orthopaedic Consultant.

Acute Meniscal tear:

In young people usually Meniscal injury is an associated injury. Always suspect that the ACL has been injured, menisci are often injured during weight bearing and twisting.

Symptoms: sharp/stabbing pain on the med or lat joint line/locking/giving way and effusion. They usually lack extension/can be locked/can lack end range flexion and have positive Meniscal tests: positive scoop test, painful joint line palpation, possibly positive McMurrays/Thessaly’s.

Refer urgently to Orthopaedic Consultant.

MCL injury:

Valgus injury, Grade I, II or III: Medial knee pain/local swelling/bruising possibly tracking down the leg. Check if lax in extension and slight flexion and check for associated injury. If lax and suspect other injured structures, e.g.: ACL/Med meniscus: refer urgently to Orthopaedic Consultant. If mild local pain only, no instability or suspected associated injury refer to Physio urgently.

LCL injury/Posterolateral corner (PLC):

Varus injury Grade I, II or III: Lateral pain, this is a more serious injury and often has associated damage to meniscus/ACL/PCL/PLC. Check if lax in extension and slight flexion,
check gait and if knee gives into varus +/- is effused and has increased movement, check dial test and refer urgently to Orthopaedic Consultant. If stable, refer to Physio.

**PCL injury:**

Hyperextension injury/dashboard injury, suspect associated Postero-lateral Corner (PLC) damage. Suspect PFJ chondral damage/ pain and possible Meniscal damage. Observe posterior sag and test posterior draw. If sag is obvious and knee not settled, refer to Orthopaedic Consultant. If sag minimal and knee feels stable and settled, refer to Physio.

**Chondral injury/defects:**

Usually are associated injuries. If there is persistent effusion/pain/locking/ catching/possible loose body/ (Osteochondritis Dessicans), refer to Orthopaedic Consultant.

**Patella Dislocation/Subluxation:**

Can be traumatic or recurrent. Often painful medial to the patella border. Possible associated avulsion fracture of the MPFL, possible inferior pole patella fracture. Usually have inhibited/atrophied quads and AKP. If acute and effused with positive apprehension, refer urgently to Orthopaedic Consultant. If settling and negative apprehension, refer to Physio.

**AKP/possible plica:**


Other considerations:

**ITB friction syndrome:**

Often report a clicking/snapping lateral knee pain as the ITB flicks over the lateral femoral condyle. Refer to Physio for full biomechanical/muscle imbalance assessment.

OA flare up - see OA knee pathway.

**Knee Osteoarthritis Pathway**

**Differential diagnosis:**

**Referred pain from the Lumbar spine/Lumbar radiculopathy**

Symptoms of leg pain, parathesia/anaesthesia, altered neural tests. (See Back pathway)

**Referred pain from the hip**

OA hip often causes knee pain. (See Hip pathway)

**Meniscal tear, acute or chronic degenerative**

You often see a block to end range extension +/- flexion. Refer to consultant for consideration for Arthroscopy only if got mechanical locking/giving way/effusion.