Lancashire Care NHS
NHS Foundation Trust

Knee Pathway

Patient presents with knee symptoms

Confirm diagnosis (see attached notes)

Secondary Care

Primary Care

Please refer the following directly to Secondary Care

History of or suspected malignance, investigate and refer as appropriate. Consider red flags of unexplained weight loss, night pain and high inflammatory markers.

Suspected fracture, dislocation or infection, refer to A&E

Acutelylockedknees can have urgent referral to Orthopaedic Knee Surgeon

Suspected inflammatory conditions investigate and refer to Rheumatology

Knee Joint OA

Investigations

MRI not indicated. X-rays AP (standing), lateral and skyline

Management

Consider conservative management, physio, maximise analgesia/NSAIDs all ages.

Injections

Consider x1 into knee joint depending on severity of symptoms and X ray findings.
Not indicated if surgery might be an option.

Referral

Non-surgical -Where surgery not indicated and no improvement with 6 weeks of conservative management, refer to MSK CATS.

CommonThresholdforKneereplacement:

Patient experiencing moderate – severe persistent pain not adequately relieved by an extended course of non-surgical management and pain is at a level at which it interferes with activities of daily living– washing, dressing, sleeping and quality of life AND
The patient is fit for surgery with a BMI <35. Patients with a BMI >35 should be advised and given appropriate support with referral to specialist services if indicated and this should be documented. AND
X-rays of: Knee, AP (standing) Lateral and Skyline views which confirm evidence of OA have been carried out within the past 6 months.

Self Help/ patient information www.nhs.uk www.arthritisresearchuk.org

PF Joint OA

Investigations

X-rays AP (standing), lateral and skyline if suspicion of osteophytes, moderate/severe OA

Management

Consider analgesia and NSAIDs

Injections

Consider x1 into knee joint depending on severity of symptoms and X ray findings.
Not indicated if surgery might be an option.

Referral

If no improvement with 6 weeks of conservative management refer to MSK CATS. / Orthopaedics

Self Help/ patient information

www.nhs.uk
www.arthritisresearchuk.org

Acute Knee Injury

(See differential diagnosis)

Investigations

All acute knee injuries with haemarthrosis should be treated as a torn ACL until proven otherwise and referred to Orthopaedic Knee Surgeon.

All acute injuries of this type require X- ray AP, lateral and skyline views to rule out fracture MRI not indicated.

Management

Consider analgesia and NSAIDs.
Advise PRICE.

Injections

Not indicated

Referral

Refer to differential diagnosis advice – possible referral to physio

Self Help/ patient information

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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/Postero-lateral 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:

Presenting symptoms weakness/clicking/pseudo locking/giving way/pain. Not usually a surgical problem. Can flare up due to fall onto the knee. Refer to Physio for full biomechanical/muscle imbalance assessment.

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.