NHS

NHS Bournemouth and Poole

NHS Dorset

Musculoskeletal Treatment Guidelines — Knee

KNEE	Signs & Symptoms	Treatment	Consider onward referral	Diagnostic tests/ investigation prior to referral	Indication for surgery/ secondary care referral
OA Knee **ESTABLISHED**	Constant pain not relieved by analgesia / NSAID / Aids Present at rest/ unresponsive to conservative treatment Functional disability affecting work and ADL Progressive deformity, decreased ROM (esp. Ext), recurrent effusion or swelling / thickening Joint line tenderness	Mobilisation, Strengthening Lifestyle advice ADL Simple analgesia or and / NSAIDs Steroid Injection (limiting as weight bearing joint) Use of appropriate aids	Onward Not responding to treatment and there are no contraindications for surgery: ie General medical Vascular Skin ulcers Chronic UTI	Generic referral AP/lateral affected knee AP/lateral over 55	Direct Significant Functional disability affecting work and ADL Decreasing ROM Progressively increasing joint deformity Previous knee surgery
Early OA	Episodic, Morning stiffness, Pain and swelling activity related, Pseudo locking Joint line tenderness	Mobilisation, Strengthening exercises Proprioceptive training Lifestyle advice ADL Steroid Injection	Not resolving Functional disability	Generic referral AP/lateral affected knee WB for any H/O trauma age 35-50 and sporty AP standing /lateral/skyline/ Tunnel view of affected knee	Inflammatory Arthritis MUST be ruled out and a referral made to rheumatology if any doubt about diagnosis.
Anterior Knee Pain / Patellofemoral OA	Anterior knee discomfort, worse after sustained positions, Pain worse on going up and down stairs. Pseudo giving way Pain on deep squat S&S indicative of Hypermobile syndrome Retropatellar crepitus	Physiotherapy and biomechanical assessment Advice on activities ie Involving knee flexion to extension, squatting Podiatry assessment Orthotics	Surgery has very little to offer in vast majority	Skyline views for assessing tracking of patella, degenerative changes at PFJ	
Bursitis – Housemaids knee Retropatella	Swelling and achy pain localised to the position of bursa	CSI Physiotherapy Life style advice	? Unsuitable for referral to secondary care		

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Bakers Cyst	Fluctuating swelling at the posterior aspect of the knee joint Associated with pathology in the knee joint (?OA)	Treatment should be directed at the knee joint pathology – meniscal tear / OA	Unresponsive to IOS treatment if symptomatic. If asymptomatic NO referral required	Ultrasound scan Plain x-rays depending on suspected OA or knee pathology	
Patella tendinitis	Anterior knee pain, inferior pole of patella, gradual onset Pain on resisted extension and going down stairs Localised tenderness	Physiotherapy eccentric exercise regime Steroid injection	Unsuitable for referral to secondary care		
Meniscal Tear	History of true locking and / or instability associated with pain, may be intermittent Inability to extend Effusion	physiotherapy	If persistent	+ve McMurray test Joint line tenderness WB x-ray MRI scan	Genuine mechanical problem
Acute Knee trauma – Clinical evidence of fracture Hemarthrosis Patella dislocation Locked knee	Effusion, limited ROM, inability to weight bear Inability to SLR Ligament laxity / instability Audible 'pop' during injury				Direct referral to secondary care
Ligament Injuries – MCL, LCL, ACL, PCL	Knee joint instability ACL usually H/O trauma – immediate swelling, difficulty WB MCL, LCL: Worse after inactivity, achy	Physiotherapy proprioceptive training	Onward referral - Not responding to treatment	MRI scan	Direct referral – gross knee instability