East Sussex MSK Community Partnership

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Knee Triage Guidelines

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Isolated Knee pain <45	**Assessment:** • Exclude any traumatic injuries • Any physical signs • No previous operative intervention within the last 12/12 • If evidence of inflammation i.e. swelling, follow the Rheumatology Guidelines for acute mono-arthritis • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Consider diagnoses of PFJ, Meniscal or ligamentous injury **Diagnostics:** • Not required **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Patient education • Exercise sheets • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Advise activity modification as pain allows • Versus Arthritis knee pain information booklet **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**6 weeks of conservative management in primary care, with appropriate patient advice** **Refer to Physiotherapy if:** • Symptoms persistent and new symptoms present for > 6 weeks • No response to analgesics • Symptoms affecting ADLs / occupation - Please state how in the referral • Swelling but no locking or giving way. **Refer to Advanced practitioner if:** • Potential acute or severe meniscal pain • At least 3/12 of previous evidence-based physiotherapy has been tried and been unsuccessful, Information and exercise sheets from FCP does not constitute physiotherapy • If persistent or recurring pain >6m duration • True locking and giving way	**Assessment:** **Diagnostics:** • Plain X-ray (AP standing, lateral (and skyline if indicated) • MRI **Management:** • Physiotherapy • Patient education • Patient choice following SDM **Referral to Orthopaedics (from AP) if:** • Symptoms substantially affect quality of life • Non-surgical management is ineffective or unsuitable • Diagnostics identify surgical target **Refer to Physiotherapy (from AP or Consultant) if:** • No surgical target • Patient choice • Comprehensive physiotherapy programme not undertaken

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Isolated Knee pain >45 years of age **Including suspected or established OA** **No previous intervention**	**Assessment:** • Exclude any traumatic injuries • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** **NOTE: OA is a clinical diagnosis and imaging is not essential for purely diagnostic purposes** **Please be clear on your radiology request as to why you are requesting an x-ray ie This will inform a change in management such as consideration of an invasive technique or surgical intervention or you are concerned about an additional or alternative diagnosis.** **Please include key findings eg** • Moderate to severe pain • Early morning stiffness • Loss of function eg sitting to standing • Loss of range of motion • Joint effusion If they meet these criteria, please request Weight bearing AP and lateral x rays 1. If NOT considering invasive treatment (injection / surgery) and requesting Physiotherapy, then **no imaging required** 2. Repeat X-ray not required within 12 months unless significant deterioration or change in symptoms **Primary care Management (including condition-specific self-care options):** • Self-management advice: - Knee | Sussex MSK Partnership East • Medication optimisation • Consider use of Fit note if patient is working • Consider Physiotherapy • Patient signposted to Smoking Cessation/ Weight loss advice if indicated • If BMI 35-40 should routinely offer 'One You East Sussex' referral (One You East Sussex | Free Health & Wellbeing Service). • If BMI >40 needs bariatric service before TKR routinely funded. • Consider steroid injection to support exercise management for Mild–Moderate OA (if available in primary care). **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**6 weeks of conservative management in primary care, with appropriate patient advice** **Refer to Physiotherapy if:** • Ongoing pain >6/52 • Symptoms affecting ADLs or occupation, please detail • Diagnostic uncertainty **Refer to Advanced practitioner if:** • No response to physiotherapy • Refer to Advanced OA pathway, if documented, trial of conservative management, x ray with mod – severe OA, patient wanting TKR **Refer to Orthopaedics if:** • Meets all required CEC criteria • Symptoms substantially affect quality of life • Non-surgical management is ineffective or unsuitable • If BMI > 40 only refer to NHS Trust • Patient choice following SDM NHS England » Decision support tool: making a decision about knee osteoarthritis.	**Assessment:** **Diagnostics:** • X-ray (AP standing, lateral) - If not already done in primary care. • Consider MRI if x-ray NAD, Disproportionate pain to x ray findings, or does not explain symptoms **Management:** • Knee Decision Aid for OA patients – Making a decision about knee osteoarthritis (england.nhs.uk) • Steroid injection • Consider further Physiotherapy • Consider bracing • Patient education • Patient choice following SDM • Pre-operative rehab and care (signposting to exercise groups and Keeping well whilst waiting) Keeping Well Whilst Waiting | Sussex MSK Partnership East **Refer to physiotherapy (from AP) if:** • Patient does not want or is not fit for surgery • Patient wants additional physiotherapy input **Refer to Consultant (from AP or physiotherapy) for TkR if** • Meets all required CEC criteria (see below) • Symptoms substantially affect quality of life • Non-surgical management is ineffective or unsuitable • If BMI > 40 only refer to NHS Trust **Only refer to Secondary Care for TKR opinion if (as in CCG 'Clinically Effective Commissioning Policy' 2018):** • Intense pain with at least moderate functional impairment. • At least 6 months of conservative treatment including; physiotherapy (unless bone on bone/severe OA), medication optimisation (OTC or opioids), OA education and advice. • Decisions need to incorporate a shared decision making (SDM) process and patients given the opportunity to use a decision aid tool. • Smoking Cessation advice if indicated • Weight loss advice if indicated: ➢ BMI 35-40 offer 'One You East Sussex' referral ➢ Over 40 needs bariatric service before TKR routinely funded. ➢ Unless patient is in immediate danger of losing their independence or severe structural deformity.

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Painful TKR/ Unicompart-mental replacement.	**Assessment:** • Explore any traumatic injuries • Identify date of surgery • Consider infection and would check (if acute) • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** **Please be clear on your radiology request as to why you are requesting an x-ray ie** • Significant change in pain levels • A reduction in previous levels of function eg sitting to standing • A reduction in range of motion / increased swelling If they meet these criteria, please request Weight bearing AP and lateral x rays plus Skyline if considering new onset of Patellofemoral involvement • Consider bloods if clinically suspect infection **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Reassurance recovery times post-surgery are 6-12 months • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Re start exercises given post operatively **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to A&E if:** • Systemically unwell/Fever • Suspected infection/risk of sepsis **Refer to Refer to Physiotherapy if:** • If no signs of prosthetic loosening **Refer to Advanced Practitioner if:** • If unsuccessful Physiotherapy **Urgent referral to Orthopaedic Consultant in acute hospital site if:** • If signs of prosthetic loosening **Note: if surgery within last 12 months - refer patient back to original surgeon who did the original procedure**	**Assessment:** **Diagnostics:** • Plain X-ray (AP standing, lateral and skyline) **Management:** • Physiotherapy • Patient education • Patient choice following SDM • Consider review by orthopaedic consultant • Consider pain team review **Refer to AP (from physiotherapy) if:** • No improvement with comprehensive rehab programme **Refer to physiotherapy (from AP) if:** • Patient does not want or is not fit for surgery • Patient wants additional physiotherapy input **Refer to pain team (from AP) if:** • Patient does not want or is not fit for surgery • Patient wants input from pain team **Note: this patient group are rarely suitable for injection due to high risk of infection.**

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Suspected Knee Infection **I.e. swollen, hot joint, patient systemically unwell, raised inflammatory markers**	**Assessment:** • History • Consider recent injuries • Consider presence of wounds and need for wound check • Establish if systemically unwell/fever present Diagnostics: Bloods **Management (including condition-specific self-care options):** • Antibiotics • Patient education • Watchful waiting	**Refer to A&E if:** • Systemically unwell with features of joint infection **Urgent referral to Orthopaedic Consultant in acute hospital site if:** • Systemically well but with features of joint infection	**If knee infection is suspected at triage or in clinic setting:** **Refer to A&E if:** • Systemically unwell with features of joint infection **Refer urgently to Orthopaedic consultant if:** • Patient systemically well but with features of joint infection • Consider liaising with GP to organise bloods/antibiotics

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Patella Dislocation - Acute & Recurrent	**Assessment:** • History • Examination/ Assessment • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Explore any history of patella dislocation **Diagnostics:** • None **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Consider the use of Fit notes if patient is working **Chronic only:** • Advise to keep moving • Exercise sheets • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Advise patient of physiotherapy management steps https://www.esht.nhs.uk/wp-content/uploads/2022/12/1036.pdf **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer as urgent to Fracture Clinic if:** • Acute (for bracing and imaging) **Refer to physiotherapy if:** • Ongoing symptoms following a dislocation **Refer to Advanced Practitioner if:** • Previous Physiotherapy unsuccessful • Recurrent dislocations despite physiotherapy	**Assessment:** **Diagnostics:** • MRI **Management:** • Physiotherapy • Patient Education • Patient choice following SDM **Routine referral to Orthopaedic Consultant (from AP) if:** • Recurrent patella dislocation • All conservative measures failed • Severe ongoing symptoms • Patient wants surgery **Refer to physiotherapy (from AP) if:** • Patient does not want or is not fit for surgery • Patient wants additional physiotherapy input

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Bakers Cyst (Popliteal Cyst)	**Assessment:** • History • Examination/ Assessment including palpation • Exclude red flags if there is a high suspicion of serious alternative diagnosis such DVT & popliteal aneurysm • Identify patients' beliefs and needs, include psychosocial issues and chronicity. • A Bakers cyst is unlikely the primary cause of a patient's symptoms. Optimise management of common underlying conditions such as: ➢ OA - please follow the Isolated Knee pain >45 years of age pathway **Diagnostics:** • None (specifically for Bakers Cyst) **Management (including condition-specific self-care options):** • If asymptomatic no further treatment required • Analgesia, rest, ice compression • Consider the use of Fit notes if patient is working • Explain that excision is generally not recommended as the Baker's cyst may resolve by treating any underlying condition. • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Self-management • Reassure • Baker's Cyst: Causes, Symptoms, and Treatment (patient.info) **Note: Direct aspiration in primary care is not recommended (NICE 2016)** **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to physiotherapy if:** • For management of underlying pathology (ie Osteoarthritis, degenerate meniscal tear) **Refer to Advanced Practitioner if:** • Symptomatic with ongoing pain despite conservative management • Unsuccessful course of conservative management (3/12 course clinically recommended) • Symptoms affecting ADL's and occupation • If assessment of underlying knee pathology required • Diagnostic uncertainty **Refer to Orthopaedics if:** • Neuro vascular compromise	**Assessment and examination** **Diagnostics:** • USS for characterisation • US guided aspiration and fluid analysis for differentiation between inflammatory, infection and mechanical causes • X Ray - if not completed in primary care to assess bony structures • MRI – assessment of internal knee structures **Management:** • Advise • Self-management • Patient education • Patient choice following SDM • Assessment and diagnostic information will inform the clinical diagnosis and ongoing management pathway

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Knee Injury	**Assessment:** • History • Explore history of trauma • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Examination/ Assessment including palpation and tests for instability **Diagnostics:** • X-ray = Only if fracture suspected (if acute A&E) • No MRIs in primary care **Management (including condition-specific self-care options):** • Self-management advice • Pain relief in line with agreed formularies / guidance • Consider bracing and elbow crutches (if appropriate) • Consider the use of Fit notes if patient is working • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Exercise and advice sheet • Versus Arthritis knee pain information booklet **Note: Direct aspiration in primary care is not recommended (NICE 2016)** **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to A&E if <6/52:** • Severe injury with suspected fracture • Ligament injury with gross instability **Urgent referral to Orthopaedics and Physiotherapy if:** • >6/52 with suspected or confirmed Ligament rupture (ACL, MCL or LCL) **Urgent referral to Advanced Practitioner and Physiotherapy if:** • Acute injury and no signs of instability **Refer to Physiotherapy if:** • Mild injury (i.e. sprain)	**Assessment:** **Diagnostics:** • MRI • Plain X-ray (AP weight bearing, lateral and consider skyline view) **Management:** • Physiotherapy – If Mild/Moderate injury (i.e. sprain) or patient not wanting surgery • Consider bracing and elbow crutches (if appropriate) • Consider physio for 'prehab' if considering surgery • Patient education • Patient choice following SDM **Refer urgently to Orthopaedic Consultant (from AP) if:** • Surgical target identified and clinically appropriate for surgery • All conservative measures failed • Severe ongoing symptoms • Patient wants surgery **Refer to physiotherapy (from AP) if:** • Patient does not want or is not fit for surgery • Patient wants additional physiotherapy input

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Patello-femoral Pain **Including:** **Adults with previous diagnosis of Osgood Schlatter**	**Assessment:** • History • Examination/ Assessment • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • None **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Consider the use of Fit notes if patient is working • Self-management advice hh-patellofemoral-pain-patient-leaflet-v10.pdf (hordercentre.co.uk) • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**6 weeks of conservative management in primary care, with appropriate patient advice** **Refer to Physiotherapy if:** • >6 weeks • Symptomatic with ongoing pain despite conservative management advice • Symptoms affecting ADL's and occupation • Diagnostic uncertainty	**Assessment:** **Diagnostics:** • X Ray • MRI **Management:** • Patient education • Patient choice following SDM • Self-management • Physiotherapy • Consider adjuncts including: ➢ Injection ➢ Q braces ➢ Orthotics **Refer to Advanced Practitioner (from physiotherapy) if:** • Unsuccessful course of conservative physiotherapy management **Refer to pain management (from physiotherapy or AP clinic) if:** • Severe ongoing symptoms • Failed conservative management • No/minimal structural changes found on imaging **Note: Pain Team will determine management plan which may include medication review, pain management programme, pain psychologist input, or nerve blocks etc.**

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Tendino-pathy	**Assessment:** • Manage in primary care • Consider menopausal factors, rheumatological cause • History • Examination/ Assessment • Identify patients' beliefs and needs, include psychosocial issues and chronicity **Diagnostics:** • None **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Consider the use of Fit notes if patient is working • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service)	**6 weeks of conservative management in primary care, with appropriate patient advice** **Refer to Physiotherapy if:** • >6 weeks • Symptomatic with ongoing pain despite conservative management advice • Symptoms affecting ADL's and occupation	