LRI Emergency Department

Clinical guideline for:

Acute knee pain management in adults

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Consider:

- Age
- General health
- Mechanism
- Site of pain
- Speed of onset of swelling (<2h?)
- Weight-bearing status
- Previous episodes & their management
- Fever
- Night pain

Trauma

Non-trauma (trauma might be 'red herring')

NB: **PSEUDO**-locking limits both extension & flexion, and is usually just due to the *feeling* of something catching. It can usually be overcome with analgesia.

TRUE locking is a block to full extension only, much rarer and usually caused by a stuck meniscus.

Apply Ottawa knee rules; X-ray if:

- Age ≥ 55 years
- Inability to flex knee to 90°
- Tenderness of fibular head
- Tenderness of the patella
- Inability to bear weight for 4 steps **BOTH** immediately **AND** in the ED

Patella dislocation

Soft tissue injury

 # or dislocation

- **TRUE** knee locking
- Significant effusion
- Significantly ↓ ROM
- Unable to weight-bear
- High-energy trauma
  - Sports injury
  - Motorcycle / bicycle
  - Fall from >2m

- Small / no effusion
- Reasonable ROM
- All ligaments stable
- Able to weight-bear at least partially with or without crutches

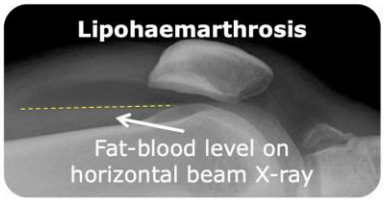
- Gross instability
- Inability to SLR
- Sensory changes
- Foot drop
- Absent pulses
- Sluggish cap refill
- Pain uncontrollable
- Haemarthrosis
- Lipohaemarthrosis

Consider:

- Serious pathology, e.g. septic arthritis
- Bleeding disorder
- Patellofemoral issue
- Prepatellar bursitis
- Referred pain from hip or back

- Reduce (penthrox or entonox)
- Obtain x-rays
- Cricket pad splint for 2/52
- Provide Knee exercises PIL (**NB**: Exercises 2 - 4 only)

- Crutches if unable to weight-bear
- Cricket pad splint only if significant collateral ligament instability



- Refer to fracture clinic on ICE, clearly stating all applicable referral criteria, relevant history and clinical findings (also state clearly if referring for a '**FIRST TIME** patella dislocation'
- Discharge with fracture clinic PIL

NB: If patient discharged with cricket pad splint, complete 'VTE risk management for ambulatory adults with immobilised leg' proforma

- Provide crutches if required
- Discharge with Knee exercises PIL and GP F/U PRN
- In discharge letter, ask GP to consider referral via PRISM or e-RS on 'MSK hip or knee pain pathway' to 'Orthopaedics - knee clinic' if problems persist > 2/52

NC referral to on-call orthopaedic team

NB: If patient discharged with an immobilised leg, complete 'VTE risk management for ambulatory adults with immobilised leg' proforma

Discuss options with ED senior

- Immediate referral to appropriate team
- Referral to appropriate outpatient clinic
- Self-management with GP follow-up as needed