

Knee Pathway (V10.3) 24.11.2023

SELF-CARE AND SELF-MANAGEMENT

Integrated MSK Service Website: <https://sussexmskpartnershipcentral.co.uk/>

OUTCOME MEASURES

- MSK-HQ
- Oxford Knee Score

**Referral reason /
Patient presentation**

Osteoarthritis Knee Established

Primary Care Management

Consider 6 weeks of conservative management prior to referral.

Examination, History & Assessment

- Age
- History
- Co-morbidities
- Joint examination
- Signpost patient to NHS England/Versus Arthritis Decision Support Tool [NHS_knee osteoarthritis decision tool \(england.nhs.uk\)](https://www.nhs.uk/healthcareprofessionals/versus-arthritis-decision-support-tool/)

Investigation:

WBing AP & Lateral X-Ray if appropriate

Management (including condition-specific self-care options)

see NICE guidelines NG226 published 19/10/2022:

- [Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE](https://www.nice.org.uk/guidance/ng226)
- [NG226 Visual summary \(nice.org.uk\)](https://www.nice.org.uk/guidance/ng226/visual-summary)

Activity and Exercise:

- For all people with osteoarthritis, offer therapeutic exercise tailored to their needs (for example, local muscle strengthening, general aerobic fitness).
- Consider supervised exercise sessions.
- Consider combining therapeutic exercise with an education programme or behaviour change approaches in a structured treatment package.

Weight management:

For people with osteoarthritis who are overweight or living with obesity, offer interventions to help weight loss: Offer Sign Posting to people with osteoarthritis who are overweight or obese: including Health Trainers or specific referral onto weight loss programmes. **Those with advanced osteoarthritis wishing to be considered for joint arthroplasty should be advised that having a BMI over 40 will require referral to a bariatric accepting centre and longer surgical wait times.** Reducing BMI to below 40 will enable routine pathway care as well broader health benefits.

- For further information see NICE guidelines CG189 [Overview | Obesity: identification, assessment and management | Guidance | NICE](https://www.nice.org.uk/guidance/cg189)

	<p>Information, support, and education:</p> <ul style="list-style-type: none"> • Individualised and accessible format • Information leaflet: http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/11/OA-Hip-1.pdf • Osteoarthritis (OA) of the knee Knee pain Versus Arthritis • ESCAPE-pain online – ESCAPE-pain <p>Pharmacological management</p> <ul style="list-style-type: none"> • Stepwise approach to analgesia – follow the analgesic ladder.
<p>Thresholds for Primary Care to initiate a referral</p>	<p>Refer to General Physiotherapy if: Flare ups are not settling, and patient would benefit from a supervised exercise and education program.</p> <p>Refer to Advanced Practitioner (ICATS) if:</p> <ul style="list-style-type: none"> • Patient wants surgery e.g., night pain / reduced ADLs / failure to respond to analgesia & therapy / tried appropriate exercise programme for more than 6 months. • If severe OA on X-Ray • For further advice on patients who may be suitable for joint arthroplasty, please see the document Clinically Effective Commissioning (CEC). (X-Ray required patient wants surgery e.g., night pain / reduced ADLs / failure to respond to analgesia & therapy - exercise programme for more than 6 months) <p>Refer to Orthopaedic Consultant if:</p> <ul style="list-style-type: none"> • Second opinion advised by another orthopaedic surgeon.

<p>Management Pathway for the Integrated MSK Service</p>	<p>see NICE guidelines NG226 published 19/10/2022: Overview Osteoarthritis in over 16s: diagnosis and management Guidance NICE</p> <p>Assessment</p> <ul style="list-style-type: none"> • Patient information • Assessment and Examination: • Clinical examination and history <p>Investigation</p> <ul style="list-style-type: none"> • AP & Lateral knee X-Ray • MRI if considering injection/surgery and X-Ray normal • MRI if symptoms inconsistent with X-Ray findings • MRI if considering unicompartmental knee replacement/HTO <p>Intervention:</p> <ul style="list-style-type: none"> • Consider use of knee Decision Support Tool NHS knee osteoarthritis decision tool (england.nhs.uk) • Patient education and information • Offer therapeutic exercise tailored to the patient's needs (as appropriate) • Discuss medication • Consider the provision of appropriate walking aids. • Consider Social Prescriber/Health Trainers/Local weight management service for support regarding lifestyle changes and weight-loss as appropriate. • Consider signposting options. • Consider X-Ray if not already performed. • Consider intra-articular steroid joint injection in mild-moderate disease. Ensure patient is informed no surgery within 3-6 months • Unloader brace for consideration in the presence of medial or lateral unicompartmental disease. <p>If considering joint arthroplasty</p> <ul style="list-style-type: none"> • See NICE guidelines NG157 Recommendations Joint replacement (primary): hip, knee and shoulder Guidance NICE • If patient has unicompartment disease on X-Ray consider MRI to establish suitability unicompartmental knee replacement/ high tibial osteotomy (HTO)
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	<ul style="list-style-type: none"> • Consider using NJR Decision support tool for joint replacement Patient Decision Support Tool for Joint Replacement (shef.ac.uk) • Consider use of Oxford Score
<p>Thresholds for referral for Intervention</p> <p>Offer patient choice of provider</p>	<p>Consider using NJR Decision support tool for joint replacement Patient Decision Support Tool for Joint Replacement (shef.ac.uk)</p> <p>When considering joint arthroplasty ensure compliance with CEC guidelines: add link (CEC exclusions)</p> <ul style="list-style-type: none"> • Established OA on X-Ray • Uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of conservative treatment or management • Physiotherapy, patient education, orthosis, lifestyle improvements management framework • BMI > 35 offer weight loss management services • Do not exclude those with a BMI >40 from referral for an orthopaedic opinion on joint arthroplasty, however, note those with a BMI > 40 will not routinely be listed for arthroplasty • Those with advanced osteoarthritis wishing to be considered for joint arthroplasty should be advised that having a BMI over 40 will require referral to a bariatric accepting centre and longer surgical wait times. Reducing BMI to below 40 will enable routine pathway care as well broader health benefits. • Offer patient choice of provider if patient needs and wants surgery.
<p>Management pathway for Specialist In-patient care</p>	<p>Surgery as appropriate (ensure referral to appropriate secondary care provider if considering surgery other than TKR)</p> <p><u>Options may include:</u></p> <ul style="list-style-type: none"> • Unicompartmental knee replacement • High tibial Osteotomy • TKR • Patellofemoral joint replacement <p>Arthroscopy is not indicated in the presence of OA.</p>

Referral reason / Patient presentation	<h2 style="text-align: center;">Locked Knee (Suspecting Acute Meniscal Tear)</h2> <p>Locked knee definition: Sudden onset, complete mechanical block to flexion or extension of the knee that which does not resolve with adequate analgesia. (BASK 2019)</p>
Primary Care Management	<p>Assessment</p> <ul style="list-style-type: none"> • History trauma/trigger/insidious red flags • Examination • Exclude inflammatory pathology / rheumatology opinion <p>Management (including condition specific self-care options). E.g.:</p> <ul style="list-style-type: none"> • Pain relief in line with agreed formularies / guidance
Thresholds for Primary Care to initiate a referral	<p><u>Refer to A&E for a completely locked knee</u></p>
Management Pathway for the Integrated MSK Service	<p>See Bask Treatment Guidance: Arthroscopic Meniscal Surgery (Flow Chart) FLOW v10 (baskonline.com)</p> <p>Assessment</p> <ul style="list-style-type: none"> • History (as before) • Examination (as before) <p>Management: <u>Refer to A&E for a completely locked knee</u></p>
Thresholds for referral for Intervention Offer patient choice of provider	<p>Sudden onset, complete mechanical block to flexion or extension of the knee that which does not resolve with adequate analgesia. (BASK 2019)</p>
Management pathway for Specialist In-patient care	<p>Urgent arthroscopic meniscus surgery</p>

Referral reason / Patient presentation	Acute Meniscal Tear
Primary Care Management	<p>Assessment</p> <ul style="list-style-type: none"> • History trauma/trigger/insidious red flags/mechanical signs e.g., locking/instability • Examination-ROM, swelling, ligament testing, joint line tenderness, meniscal provocation tests. • Diagnostics-consider WB XR AP / Lat if considering a differential diagnosis of OA • Exclude inflammatory pathology / rheumatology opinion <p>Management (including condition specific self-care options). E.g.:</p> <ul style="list-style-type: none"> • Pain relief in line with agreed formularies / guidance • Advice upon basic exercises and activity modification

**Thresholds for
Primary Care
to initiate a referral**

Refer to A&E for a completely locked knee.

See **Bask** Treatment Guidance: Arthroscopic Meniscal Surgery (Flow Chart) [FLOW v10 \(baskonline.com\)](#)

(Patient may be a suitable candidate for meniscal preservation surgery)

Urgent referral to ICATS if:

- Knee is not completely locked
- Pain due to suspected meniscus tear following acute injury/trauma (joint line tenderness, pain on meniscal provocation testing).
- <50 years old (unless highly active prior to trauma).

OR

- Significant mechanical symptoms OR Severe pain and functional impact

Routine Referral to ICATS if:

- Pain due to suspected meniscus tear following acute injury/trauma (joint line tenderness, pain on meniscal provocation testing).
- >50 years old (unless highly active prior to trauma).
- No significant mechanical symptoms/low pain severity

Urgent Referral to physiotherapy if:

- Pain due to suspected meniscus tear following acute injury (joint line tenderness, pain on meniscal provocation testing).
- >50 years old.
- No locking
- No instability
- Definitively does not want surgery.

Management as per osteoarthritis guidelines if:

- Known established osteoarthritis/suspected osteoarthritis in affected knee.

Management Pathway for the Integrated MSK Service	<p>See Bask Treatment Guidance: Arthroscopic Meniscal Surgery (Flow Chart) FLOW v10 (baskonline.com)</p> <p>Assessment</p> <ul style="list-style-type: none"> • History (as before) • Examination (as before) <p>Management</p> <ul style="list-style-type: none"> • Diagnostics – MR (In patients where OA is not suspected, MRI is the first line investigation) • Exercise program • Activity modification • Signposting to relevant self-management support (e.g. weight loss support)
<p>Thresholds for referral for Intervention</p> <p>Offer patient choice of provider</p>	<p>See Bask Treatment Guidance: Arthroscopic Meniscal Surgery (Flow Chart) FLOW v10 (baskonline.com)</p> <p><u>Urgent</u> referral to Orthopaedic centre/surgeon offering meniscal repair surgery.</p> <ul style="list-style-type: none"> • Acute traumatic meniscal tear • MRI confirmed painful meniscal target (“bucket-handle” tear, displaced meniscal tear, meniscal root failure) or possible meniscus target (Radial tear, horizontal or longitudinal tear) • +/- Locking knee • Patient wants surgery (<50 years old or >50 years old AND highly active prior to trauma, patient may be appropriate for meniscal preservation surgery) • No significant OA on X-Ray <p>Routine referral to orthopaedics</p> <ul style="list-style-type: none"> • >50 years (unlikely to be repair candidate unless highly active levels prior to meniscus tear) • No improvement 3/12 conservative treatment/ rehabilitation (+/- injection) <p>Referral to physiotherapy</p> <ul style="list-style-type: none"> • Patient prefers to manage conservatively.
Management pathway for Specialist In-patient care	<p>Arthroscopic meniscal repair Arthroscopic partial meniscectomy</p>

Referral reason / Patient presentation	meniscal tear (non-acute)
Primary Care Management	<p>Assessment</p> <ul style="list-style-type: none"> • Age • History trauma / trigger / insidious red flags / mechanical signs e.g., locking / giving way, previous surgery • Examination-ROM, swelling, ligament testing, joint line tenderness, pain meniscal provocation testing. • Diagnostics-consider WB XR AP / Lat (MRI usually unnecessary unless true locking / giving way / severe pain / red flags – in which case refer to AP clinic) • Exclude inflammatory pathology – rheumatology opinion <p>Management (including condition specific self-care options). E.g.:</p> <ul style="list-style-type: none"> • Pain relief in line with agreed formularies / guidance including NSAIDs • Consider steroid injection if symptoms are persistent. • Patient education / exercise sheet Knee pain exercise sheet. (versusarthritis.org) • Activity modification • Advise if pain increases, re-present to GP • If pain persists following 5/52 conservative management, consider referral to physiotherapy for guided rehabilitation. • If severe pain or significant mechanical symptoms or symptoms persists despite rehabilitation refer to ICATS

<p>Thresholds for Primary Care to initiate a referral</p>	<p>See Bask Treatment Guidance: Arthroscopic Meniscal Surgery (Flow Chart) FLOW v10 (baskonline.com)</p> <p>Refer to Physiotherapy if:</p> <ul style="list-style-type: none"> • If no improvement at 6/52 or significant functional impairments • No significant mechanical symptoms • XR +/- osteoarthritis <p>Refer to Advanced Practitioner (ICATS) if:</p> <ul style="list-style-type: none"> • No improvement following 3/12 of rehabilitation OR mechanical signs of locking OR significant loss of function / ADLs • Poor response to analgesics / severe pain
<p>Management Pathway for the Integrated MSK Service</p>	<p>Assessment</p> <ul style="list-style-type: none"> • History (as before) • Examination (as before) • Diagnostics – X-Ray / MRI <p>Management</p> <ul style="list-style-type: none"> • Weight loss • Exercise program including referral to physiotherapy/rehabilitation. • Signposting to relevant self-management support • Consider steroid injection. <p>Signposting /self-management info https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2018/07/Meniscal-Tears.pdf</p>
<p>Thresholds for referral for Intervention</p> <p>Offer patient choice of provider</p>	<p>Secondary care</p> <ul style="list-style-type: none"> • Compliant with clinically effective commissioning (CEC) guidelines. Attach CEC form • No improvement following 3/12 of rehab +/- injection • Mechanical signs: significant mechanical symptoms • MRI confirms meniscal target or possible meniscal target (“bucket-handle” tear, displaced meniscal tear, meniscal root failure, Radial tear, horizontal, longitudinal, complex tear)

	Offer patient choice of provider if patient wants surgery.
Management pathway for Specialist In-patient care	Arthroscopic partial meniscectomy may be considered if the patient is still symptomatic after 3 months of appropriate conservative management

Referral reason / Patient presentation	MCL sprain
Primary Care Management	<p>Assessment</p> <ul style="list-style-type: none"> • History: mechanism of onset, focal location of pain over MCL, examination. No diagnostic. • Examination • Working / differential diagnosis <p>Management</p> <p>If no significant loss of function or strength</p> <ul style="list-style-type: none"> • Pain relief in line with agreed formularies / guidance. • Patient advice and education: PRICE • Patient education / exercise sheet file:///5p6fs003/5p6p-rdf/BarnardK/Downloads/knee-pain-pamphlet%20(1).PDF • Activity modification. • Advise to self-refer to physiotherapy if pain not improving within 4-6 weeks
Thresholds for Primary Care to initiate a referral	<p>Urgent referral to ICATS/acute knee clinic within 6/52 if:</p> <ul style="list-style-type: none"> • Difficulty weight bearing, instability, and loss of function <p>Refer to physiotherapy if:</p> <ul style="list-style-type: none"> • Patient can WB. • No instability. • Symptoms persist beyond 4 weeks

Management Pathway for the Integrated MSK Service	<p>Assessment</p> <ul style="list-style-type: none"> • History: sudden vs gradual onset. • Examination: significant joint effusion, localised pain, and positive ligament stress testing. • Differential diagnosis Acute vs chronic MCL vs medial meniscus <p>Diagnostics</p> <ul style="list-style-type: none"> • Consider investigations (MRI and XR) if symptoms persist despite physio. <p>Management</p> <ul style="list-style-type: none"> • Consider hinged knee brace. • Consider referral to physiotherapy If isolated MCL injury. • With co-existing injury, management in ICATS as per co-existing pathology
Thresholds for referral for Intervention Offer patient choice of provider	N/A
Management pathway for Specialist In-patient care	N/A

Referral reason / Patient presentation	Osteochondral Defect (OCD) Pathway
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<p>Primary Care Management</p>	<p>Assessment</p> <ul style="list-style-type: none"> • Often < 35 years • Mechanism of injury – often torsional weight bearing trauma • Pain may be present at rest • Likely exacerbated with weight bearing • The knee may give way if a long-standing injury results in substantial muscle wasting or there is associated ligamentous instability • Locking is reported if a loose fragment impedes articular movement • There may be an effusion • Tenderness is found on palpation of the joint line, with pain induced both by passive and active movements • Wasting of the quadriceps will be seen later on. • Crepitus is palpable on passive joint movement in a usually stable knee
<p>Thresholds for Primary Care to initiate a referral</p>	<p><u>Urgent referral to fracture clinic or acute knee clinic if Acute (< 6 weeks)</u></p> <ul style="list-style-type: none"> • Evidence of relevant mechanism of injury • Effusion • Locking • Weight bearing X-Ray <p><u>Urgent referral to ICATS (>6 weeks)</u></p> <ul style="list-style-type: none"> • Evidence of relevant mechanism of injury • Effusion • Locking • Weight bearing X-Ray <p><u>Routine ICATS referral Chronic (> 6 months)</u></p> <ul style="list-style-type: none"> • Chronic OCD often picked up incidentally on imaging.

<p>Management Pathway for the Integrated MSK Service</p>	<p>History</p> <ul style="list-style-type: none"> • Question nature of activity / sport • Confirm specific mechanism and nature of injury • Onset of swelling • Ongoing locking • Pain at rest • Worse with weight bearing <p>Assessment</p> <ul style="list-style-type: none"> • Effusion • Palpable crepitus • Ongoing locking • Tender predominantly over joint line • Common differentials or co-injuries may include: OA, meniscal injury, patellofemoral pain, or ligamentous injury <p><u>MRI scan if OCD suspected</u></p> <p>Management</p> <p>Consider:</p> <ol style="list-style-type: none"> 1. DAPOT X-Ray if not done 2. MRI 3. Physiotherapy if patient declines surgery 4. Off-loader brace 5. Pain relief 6. Referral to orthopaedics
<p>Thresholds for referral for Intervention</p> <p>Offer patient choice of provider</p>	<p>Osteochondral defects should be referred for a surgical opinion unless the patient declines surgical management</p>

Management pathway for Specialist In-patient care	<p>Surgical management may include:</p> <ol style="list-style-type: none"> 1. Micro fracture and drilling 2. Pinning 3. Mosaicplasty 4. Allograft 5. Osteoarticular Transplantation (OATS)
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Referral reason / Patient presentation	<p>Subchondral Insufficiency Fracture of the knee (SIFK) Formally known as Spontaneous Osteonecrosis of the knee (SONK) SONK typically is not associated with significant degenerative change in the joint.</p>
Primary Care Management	<p>Assessment</p> <ul style="list-style-type: none"> • History - acute onset of knee pain, atraumatic, worse on weight bearing, Night pain. • Examination - Effusion, Medial femoral condyle tenderness. Pain out of proportion to any X-Ray findings • X-Ray (usually normal) useful to rule out severe OA, other fracture <p>Management:</p> <ul style="list-style-type: none"> • NSAIDs • Reduce weight bearing/ non-weight bearing • Weight loss • Vitamin D deficiency • If established osteoarthritis on XR then manage as per osteoarthritis pathway.

<p>Thresholds for Primary Care to initiate a referral</p>	<p>Urgent referral to ICATS if:</p> <ul style="list-style-type: none"> • significant/severe pain (typical of SIFK/SONK) with exquisite condylar tenderness and normal appearance on X-Ray.
<p>Management Pathway for the Integrated MSK Service</p>	<p>Investigations</p> <ol style="list-style-type: none"> 1. Urgent MRI if suspecting SIFK/SONK (no/minimal osteoarthritis on XR) 2. Consider bloods <p><u>SIFK Broadly fall into 2 typical categories:</u></p> <ol style="list-style-type: none"> 1. Associated with advanced osteoarthritis typically in the older patient 2. Not associated with osteoarthritis <p>1. <u>Management Insufficiency fracture associated with advanced osteoarthritis</u> (Usually an older patient, XR/MRI confirms established osteoarthritis/ MRI scan confirms insufficiency #)</p> <ul style="list-style-type: none"> • 3 months of conservative treatment/unloading the knee • Management as per osteoarthritis pathway • If symptoms persist referral for consideration of TKR <p>2. <u>Management (If not associated with significant OA, typical of a SONK type insufficiency fracture)</u></p> <ul style="list-style-type: none"> • Modify weight bearing with appropriate walking aids. • Consider unloader bracing if not suitable for walking aids or cannot use elbow crutches. • Reassessment at 6/52 for improvement in pain and tenderness before allowing increased weight bearing. • Consider reimaging to assess bone oedema • Consider referral to bone health specialist • Consider referral to physiotherapy
<p>Thresholds for referral for Intervention</p> <p>Offer patient choice of provider</p>	<p><u>SONK type SIFK</u></p> <ul style="list-style-type: none"> • Failure to improve after 3/12 of non-operative treatment, WB protection • Size of lesion >3.5cm² or specific clinical concern • Any chondral collapse on repeat imaging

Management pathway for Specialist In-patient care	<p><u>Osteoarthritis associated Insufficiency #</u> (XR/MRI confirms osteoarthritis)</p> <ul style="list-style-type: none"> TKR <p><u>SONK type SIFK</u></p> <ul style="list-style-type: none"> Core decompression
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Referral reason / Patient presentation	Patella Tendinopathy
Primary Care Management	<p>Assessment:</p> <ul style="list-style-type: none"> Associated with increased training volume and frequency. Linked to activities demanding energy storage and release from the tendons Pain localised to the inferior pole of the patella Load dependent pain increases as load increases Rarely pain at rest <p>Management:</p> <ul style="list-style-type: none"> Reduce load to tendon with exercise/ training modification. Possibly use patella tendon strap Pain relief in line with agreed formularies / guidance Advise to self-refer to physiotherapy if does not improve within 6 weeks
Thresholds for Primary Care to initiate a referral	<p>Referral for physiotherapy treatment if:</p> <ul style="list-style-type: none"> Pain persists and does not respond to activity modification and pain relief for a period of 6 weeks <p>Refer to ICATS if:</p> <ul style="list-style-type: none"> Pain persists and does not respond to 3 months of appropriate physiotherapy
Management Pathway for the Integrated MSK Service	<ul style="list-style-type: none"> Consider ultrasound if pain persists and does not respond to physiotherapy treatment.

Thresholds for referral for Intervention Offer patient choice of provider	Consider opinion of orthopaedic knee specialist if not responding to conservative treatment in the form of extensive rehabilitation over 6 months, exercise modification and pain relief and imaging confirms patella tendinopathy.
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Patellofemoral Pain
Primary Care Management	<p>Assessment</p> <ul style="list-style-type: none"> • Mechanism of injury • Location of pain – over patella <p>Management (including condition specific self-care options). Eg:</p> <ul style="list-style-type: none"> • Pain relief in line with agreed formularies / guidance • Patient education / exercise sheet http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/07/Managing-my-patellofemoral-pain.pdf • Reassurance • Activity modification • Advise if pain does not respond to 6 weeks of conservative management to self-refer to physiotherapy
Thresholds for Primary Care to initiate a referral	Refer to physiotherapy if: Symptoms persist beyond 6 weeks

Management Pathway for the Integrated MSK Service	<ul style="list-style-type: none"> • Physiotherapy for at least 3 months has not helped • X-Ray – AP/lateral – weight bearing AND SKYLINE • Consider MRI (with tracking views) if Ax demonstrates possible patella instability or abnormal tracking • Consider psychosocial drivers • Consider steroid injection • Consider Formfit brace or equivalent
Thresholds for referral for Intervention Offer patient choice of provider	If MRI demonstrates abnormal/significant P/F pathology- OA or damage to extensor mechanism
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Patella dislocation Acute
Primary Care Management	<p>Assessment</p> <ul style="list-style-type: none"> • History: often traumatic lateral dislocation of the patella • Examination: painfully limited range of movement with pain anteriorly <p>Diagnostics</p> <p>X-Ray to rule out bony injury</p> <p>Management</p> <ul style="list-style-type: none"> • Immobilise • Refer to physiotherapy urgently

<p>Thresholds for Primary Care to initiate a referral</p>	<p>Referral to A&E if: patella not reduced</p> <p>Urgent referral to physiotherapy if:</p> <ul style="list-style-type: none"> • patella reduced • Patient may benefit from rehabilitation. <p>Referral to ICATS if:</p> <ul style="list-style-type: none"> • it does not respond to 6 weeks of physiotherapy • Recurrent dislocation despite 3 months of rehabilitation
<p>Management Pathway for the Integrated MSK Service</p>	<p>1st time dislocation-DAPOT X-Ray if not done by primary care and consider MRI (with tracking views)</p>
<p>Thresholds for referral for Intervention</p> <p>Offer patient choice of provider</p>	<p>Urgent referral to secondary care: If MRI shows rupture of quadriceps mechanism</p> <p>If MRI demonstrates abnormal significant P/F pathology- OA or damage to extensor mechanism</p>
<p>Management pathway for Specialist In-patient care</p>	

Referral reason / Patient presentation	Patella dislocation Chronic/Recurrent
Primary Care Management	Assessment <ul style="list-style-type: none"> • History: recurrent history of patella dislocation • Examination Diagnostics None Management If no significant loss of function or pain <ul style="list-style-type: none"> • Pain relief • Activity modification Advise to self-refer to physiotherapy if symptoms persist more than 6 weeks
Thresholds for Primary Care to initiate a referral	Referral to Physiotherapy Routine- if symptoms persist after 6 weeks. Refer to ICATS if patient not responding to physiotherapy after 3/12 of rehabilitation
Management Pathway for Physiotherapy	
Management Pathway for the Integrated MSK Service	Consider MRI scan (with tracking views)
Thresholds for referral for Intervention	If pain and function significant- onward referral for possible MPFL reconstruction, tibial tubercle transfer or trochleoplasty

Offer patient choice of provider	
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Muscle strain
Primary Care Management	<p>Assessment</p> <ul style="list-style-type: none"> • History- • Examination – pain on activity, stretching, palpation • Consider serious pathology <p>No Diagnostics</p> <p>Management</p> <p>URGENT Referral to secondary care: where evidence of functional loss (particularly affecting knee extensor mechanism) and clear evidence of injury (# clinic <6w, Orthopaedics >6w)</p> <p>If no significant loss of function or strength</p> <ul style="list-style-type: none"> • Pain relief in line with agreed formularies / guidance • Patient advice and education: PRICE and HARM • Activity modification, consider immobilisation for a few days or use of crutches • Review after 5-7 days if lack of improvement, difficulty walking or unable to weight-bear. • Advise to self-refer to physiotherapy if not improving.

<p>Thresholds for Primary Care to initiate a referral</p>	<p><u>Urgent referral to secondary care (# clinic <6w, Orthopaedics >6w)</u> URGENT Referral to secondary care: where evidence of functional loss and clear evidence of injury particularly affecting knee extensor mechanism.</p> <ul style="list-style-type: none"> • tendon rupture or complete tear • Acute weakness • Palpable gap • History of trauma <p>Urgent referral to ICATS if:</p> <ul style="list-style-type: none"> • suspected significant tendon or mm injury but no functional loss • or any diagnostic uncertainty <p>Routine referral to ICATS if: Not responding to physiotherapy</p> <p>Refer to Physiotherapy if:</p> <ul style="list-style-type: none"> • Suspected tear with functional loss • Symptoms not showing signs of improvement
<p>Management Pathway for the Integrated MSK Service</p>	<p>Examination and Diagnostics:</p> <ul style="list-style-type: none"> • US or MRI to confirm injury exclude any other cause of symptoms
<p>Thresholds for referral for Intervention</p> <p>Offer patient choice of provider</p>	<p><u>Urgent referral to secondary care</u> URGENT Referral to secondary care: where evidence of functional loss and clear evidence of injury particularly affecting knee extensor mechanism.</p> <ul style="list-style-type: none"> • tendon rupture or complete tear • Acute weakness • Palpable gap • History of trauma • Confirmation of significant muscle/tendon tear with functional loss. <p>Refer to Physiotherapy if:</p> <ul style="list-style-type: none"> • No functional loss • Symptoms not showing signs of improvement

Management pathway for Specialist In-patient care	
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Referral reason / Patient presentation	Anterior Cruciate Ligament Injury Pathway
Primary Care Management	<p>Assessment:</p> <ul style="list-style-type: none"> • Mechanism of injury (flexion/valgus/internal rotation or hyperextension), immediate swelling +/- bruising, ongoing reported instability. • Instability on testing, effusion present • Reported instability = true giving way <p><u>Diagnostics</u></p> <ul style="list-style-type: none"> • nil <p><u>Management: Suspected Acute Rupture:</u></p> <ul style="list-style-type: none"> • Urgent referral to ICATS. • Urgent referral to physiotherapy • Advice around protection, rest, ice, compression, elevation, range of movement exercises with a focus on achieving and maintaining full knee extension. <p><u>Suspected Chronic Rupture</u></p> <ul style="list-style-type: none"> • Routine referral to physiotherapy if not already been provided • Routine referral to ICATS • Advice upon exercise rehabilitation • Counsel upon risk of instability with multidirectional sports and activities.

<p>Thresholds for Primary Care to initiate a referral</p>	<p><u>Acute (< 6 months)</u></p> <p>1. Urgent Referral iCATS:</p> <ul style="list-style-type: none">• Evidence of relevant mechanism of injury• Evidence of instability on assessment• Effusion• Reported instability <p><u>Chronic (> 6 months)</u></p> <p>1. Routine Physiotherapy Referral:</p> <ul style="list-style-type: none">• Evidence of relevant mechanism of injury• Possible instability on testing• Nil reported instability• Has not had any effective rehabilitation• Able to carry out activities somewhat to pre-injury level <p>2. Routine iCATS referral:</p> <ul style="list-style-type: none">• Evidence of relevant mechanism of injury• Evidence of instability on testing• Reported instability• May be appropriate for ACL reconstruction• Unable to carry out activities to pre-injury level• Co-existing knee pain limiting rehabilitation
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<p>Management Pathway for the Integrated MSK Service</p>	<p>History:</p> <ul style="list-style-type: none"> • Question nature of activity / sport • Confirm specific mechanism and nature of injury • Onset of swelling • Ongoing reported instability <p>Assessment:</p> <ul style="list-style-type: none"> • Instability (effusion may mask this) • Effusion • Differentials or co-injuries may include: PCL injury, posterolateral corner injury, tibial plateau / fibular head fracture, isolated or co-existing meniscal injury, isolated or co-existing collateral ligament tear. <p><u>MRI scan if ACL injury suspected</u></p>
<p>Thresholds for referral for Intervention</p> <p>Offer patient choice of provider</p>	<p>All patients should be offered physiotherapy regardless of surgical or conservative management of confirmed ACL rupture.</p> <p>Discussion with patient explaining risks and benefits of ACL reconstruction – offer choices.</p> <ul style="list-style-type: none"> • ACL reconstruction may reduce risk of subsequent osteoarthritis and meniscus tears. <p>Before referring on consider:</p> <ul style="list-style-type: none"> • What are the patient’s goals and expectations of potential surgery? • Age • Degree of osteoarthritis <p>MSKP ACLR leaflet https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2018/07/Revised-ACL-risk-benefit-doc.pdf</p>
<p>Management pathway for Specialist In-patient care</p>	<ol style="list-style-type: none"> 1. Physiotherapist led rehabilitation prior to surgery 2. ACL Reconstruction

Knee group 17th December 2013

Peter Devlin (GP, BICS)
Matthew Prout (ESP Physiotherapist, SCT)
Ian Francis (Consultant Radiologist, MIP)
Johan Holte (Consultant Physiotherapist, BICS)
Chris Mercer (Consultant Physiotherapist, WSHT)
Samantha Hook (Orthopaedic Consultant, WSHT)
Ruy Dassuncao (Orthopaedic Consultant, WSHT)
Guy Slater (Orthopaedic Consultant, Horder Healthcare)
Matthew Carr (Service Manager, Horder Healthcare)
Nick Patton (GP)
Andrew Kemp (ESP Physiotherapist, MTW)
Mary McAllister (ESP Physiotherapist, SCT)
Helen Harper-Smith (ESP Physiotherapist, ESHT)

Knee group 1st July 2014

Natalie Blunt (BICS, Service Manager)
Peter Devlin (BICS, Clinical Director)
Johan Holte (BICS, Consultant Physiotherapist)
Kasia Kaczmarek (BICS, Integrated Care Manager)
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Iben Altman (SCT, Chief Pharmacist)
Laura Finucane (SCT, Consultant Physiotherapist)
Sandeep Chauhan (BSUH, Orthopaedic Consultant)

Anita Vincent (SASH, Service Manager)
Sally Dando (SASH Head of Therapies)
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Rachel Dixon (Horder Healthcare, Clinical Director)

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Knee group 11th October 2018

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Stuart Osborne (HERE, Advanced Practitioner)
Emma Paskett (SCFT, Advanced Practitioner)
Rahul Pathak (SCFT, Advanced Practitioner)
Tim Price (HERE, Pathway Operational Manager)

Knee group 20th November 2018

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Ben Hodgson (HERE, Advanced Practitioner)
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Knee group 12/04/24

Georgia Aloof (SCFT, Advanced Practitioner)
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Mr James Gibbs (Consultant Orthopaedic surgeon)
Paul, Hegenbarth (SCFT, Advanced Practitioner)
Ben Hodgson (HERE, Advanced Practitioner)
Rachel Hughes (HERE, UHS, Advanced Practitioner)
Paul Jones (HERE, Advanced Practitioner)
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Ali Loughran (SCFT, Advanced Practitioner)
Oliver Lucas (SCFT, Advanced Practitioner)
Grant McEwan (SCFT, Advanced Practitioner)
Stuart Osborne (HERE, Advanced Practitioner)
Elaine Sawyer (SCFT, Advanced Practitioner)
Toby Smith (SCFT, Advanced Practitioner)
David Stanley (SCFT, Professional lead)