

**Clinical Guideline:** OA Knee Site: FPH

Incidence increases with age, unlikely in under 50 year old age group.

Predominantly affects one compartment of the knee although is only truly unicompartmental in about 25% of cases.

Pain is localised to Patello-Femoral Joint (PFJ) or joint lines and is worse with activity and at night.

Walking distance is reduced.

History

General Information

Examination

Confirm diagnosis and any associated pathology. Specifically, is the hip the source of the pain?

Palpate joint lines and PFJ to look for maximal tenderness

Assess range of movement, particularly loss of extension.

Assess varus or valgus angulation, particularly if increased from contra-lateral side

Plain 3-view weight-bearing X-rays

Investigation

Referral Guidelines – red flag signs

**When to Refer**

Worsening pain and function.

Typically inability to walk 1000m, night pain and pain refractory to analgesia and NSAIDs

**Patients unlikely to gain from Specialist Referral**

Mild symptoms / activity restriction not sufficient to warrant surgery.

Patient not willing to consider surgical options and activity/work restrictions during rehabilitation**.**

**Thresholds for Elective Surgical Intervention**

Failure of adequate conservative treatment (e.g. minimum 3-6 months)

Significant impact on quality of life

Disturbance of sleep / self-care

Impairment of ability to work / care for others

**The inability to pursue leisure activity should not be the primary reason for intervention. Pain affecting sleep and immobility are better determinants for referral**

If co existing medical problems would preclude an anaesthetic then the patient cannot be considered for surgery

**Surgical options:**

**Tricompartmental osteoarthritis**; Total knee replacement (TKR) and involves replacing all the articular surface with a metal and plastic prosthesis and the patient will be in hospital for about 4 days.

Postoperatively: mobilised fully weight bearing with crutches for 4-6 weeks. They can return to driving at 6 weeks and work at 10-12 weeks. Improvement in symptoms will continue for 6 months. Residual problems are related to persistent pain and stiffness and may be permanent

**Unicompartmental osteoarthritis:** The treatment is a uni-compartmental knee replacement (UKR). It is typically done for isolated medial compartment osteoarthritis. Only the worn medial femur and medial tibia are replaced. There is a smaller incision and this operation will give a better range of movement than a total knee replacement. The patient will be in hospital for about 3 days. Postoperatively they will be mobilised fully weight bearing with crutches which they will need for 3-4 weeks. They can return to driving at 6 weeks and work at 8-10 weeks. Improvement in symptoms will continue for 6 months. Residual problems are related to persistent pain and may be permanent

**Patello femoral osteoarthritis**: This is a patello-femoral replacement. This is typically done for isolated osteoarthritis of the PFJ. Only the worn anterior femur and posterior patella are replaced. There is a smaller incision and this operation will give a better range of movement than a total knee replacement. Rehabilitation milestones are as for a UKR

**Initial Management**

Management of majority of patients with OA of the knee can be taken in primary care:

**Mild symptoms only-**

physiotherapy is the initial treatment.

Encourage mobility

**BMI>35** encourage patient to lose weight

**Moderate symptoms;**

regular NSAID and mild opiate painkiller as required

Steroid injection may improve moderate symptoms for several months but should not be performed more than 3 times

Advice and Treatment