10-MINUTE CONSULTATION

Chronic knee pain

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This is part of a series of occasional articles on common problems in primary care. The *BMJ* welcomes contributions from GPs

A 57 year old self employed painter and decorator presents with a six month history of pain and stiffness in his left knee. The onset was insidious, and the pain has worsened over the past few weeks.

What issues you should cover

- Chronic knee pain affects one in four people aged above 55 years. Usually symptoms are mild to moderate. Osteoarthritis—presenting as activity related pain and limitation of movement, crepitus, and intermittent swelling in the absence of constitutional symptoms—is the commonest working diagnosis. Routine blood tests are not needed in these patients. Up to 70% of people with chronic knee pain will have radiographic evidence of osteoarthritis, but radiography results are only weakly related to symptoms. Plain radiography is not recommended for routine confirmation of the clinical diagnosis of osteoarthritis.
- Exclude "red flags" signs and symptoms that indicate immediate referral (significant trauma, evidence of severe local inflammation, sepsis). Do an initial investigation before specialist referral if you suspect an inflammatory cause. Consider extra-articular (referred pain from hip or back) and peri-articular (bursitis) causes.
- Useful indicators of prognosis are level of disability, severity of pain, body mass index, and psychological status. His occupation and employment status may be important in deciding management options.
- Be alert to comorbid conditions that may affect the pain and its management (such as further mobility restric tion, polypharmacy).

What you should do

- Aim to reach a shared understanding of the problem and formulate a management plan that will enable him to control his pain, minimise disability, and prevent progression.
- Have a look at both knees and assess the joint. This will help form your differential diagnosis. Basic examination should include range of movement (including hip rotation), muscle strength, ligament stability, and varus or valgus malalignment. The absence of findings such as crepitus and bony enlargement does not rule out osteoarthritis.
- Discuss his worries and the probable cause of his pain and disability and disabuse him of common myths about arthritis (see box). Reassure him and be positive—referring, for example, to "wear and repair" of the joint, not "wear and tear."
- Written material and contact details (such as those of the Arthritis Research Campaign) may help him understand the diagnosis and in self help. Find out what treatments he has already tried and what his preferences are.
- Non-pharmacological interventions are an important part of management for all patients. Encourage him to stay active, lose weight (if he is overweight or obese), consider a regular exercise routine, and, if necessary, modify his occupational activities.
- Review his treatment, including over the counter painkillers and supplements. He may want advice on glucosamine or chondroitin sulphate; results of trials have been mixed, and the latest show little benefit to symptoms. Paracetamol is the recommended first-line oral analgesic, with the option of moving up (and down) the analgesic ladder when appropriate. Discuss the risks and benefits of oral non-steroidal anti-inflammatory drugs (NSAIDs) if these are being considered. He may prefer to live with slightly more pain for less chance of serious side effects or to use topical NSAIDs. Injections of corticosteroid into the joint are also a future option for pain relief.
- Referral to physiotherapy can give him access to a range of effective non-pharmacological treatments, including exercise instruction and supervision, acupuncture, walking aids, and advice on activity.
- Consider referral to rheumatology or orthopaedics only if he has red flag symptoms or an unclear diagnosis; if he needs surgery; or if he does not respond to primary care treatment.

Common myths about arthritis

- Nothing can be done about it
- You mustn't exercise if you have it
- Only elderly people get it
- Surgery always makes you better
- The only options are paracetamol and surgery
- You can't work if you have arthritis

Source: Department of Health, Musculoskeletal Services Framework

USEFUL RESOURCES

Arthritis and Musculoskeletal Alliance Standards of Care. www.arma.uk.net

Chard J, Smith C, Lohmander S, Scott D. Osteoarthritis of the knee. Clinical evidence. www.clinicalevidence.com/ceweb/conditions/msd/1121/1121.jsp

Department of Health. Musculoskeletal Services Framework. Available at www.18weeks.nhs.uk

Jordan K, Arden N, Doherty M, et al. EULAR recommendations 2003: an evidence based approach to the management of knee osteoarthritis. Report of a task force of the standing committee for international clinical studies including therapeutic trials (ESCISIT). Ann Rheum Dis 2003;62:1145-55

UK Arthritis Research Campaign. www.arc.org.uk