**Clinical Pearls for Managing Atraumatic Knee Pain**

**BY HEIDI SPLETE**
Senior Writer

WASHINGTON — Atraumatic knee pain, especially on the outside of the knee, is a common complaint in primary care offices, and although its mechanisms are poorly understood, the pain is real, even in those lacking clinical symptoms such as redness or swelling.

Often, atraumatic knee pain is related to the cartilage behind the kneecap. Dr. Scott Flinn said at the annual meeting of the American Academy of Family Physicians.

"The retropatellar cartilage behind the knee is the thickest in the body—5 mm—and when the patella is extended, the cartilage causes pressure across the kneecap," said Dr. Flinn, a family physician, Specialty Leader for Sports Medicine to the Surgeon General, and Force Surgeon for Commander Naval Surface Forces in San Diego, Calif.

Dr. Flinn presented diagnostic pearls, treatment strategies, and rehabilitation tips for getting patients with the following symptoms in and out of pain, especially on the outside of the knee, which may be a common complaint in primary care of- fices.

- Patellar Tendinitis
- Prepatellar Bursitis
- Prepatellar Bursitis
- Patellar Tendinitis

As treatment, Dr. Flinn recommends treating for gram-positive Staphylococcus aureus, which is the cause of 80% of these infections. Meticillin-resistant St. aureus (MRSA), Mycobacterium tuberculosis, and M. marinum are rare causes. Treatment should be based on cultures, whenever possible.

Prescribe ice packs and NSAIDs for non-septic patients, and recommend a knee pad for protection in nonacute cases. Rehab for nonseptic patients is similar to strategies for other atraumatic anterior knee injuries and is based on the PRICEMM principles (see box). Focus on stretching and strengthening the quadriceps, hamstrings, and iliotibial band, and recommend the use of a cushioned knee pad, perhaps with a hard exterior shell, when the patient resumes activity.

**Surgery Relieves Pain From Degenerative Lumbar Scoliosis**

**BY BRUCE K. DIXON**
Chicago Bureau

SEATTLE — A majority of adults with degenerative lumbar scoliosis experienced pain relief after undergoing posterior de- compression and fusion, according to a 42- patient study presented at the annual meet- ing of the North American Spine Society. At an average follow-up of just over 4 years, 95% of patients reported excellent or good relief of leg pain, and nearly 90% had the same response when asked about back pain. In addition, 86% felt there was improvement in their lifestyle postopera- tively, said Dr. Christopher Furey.

"Pain, function, image, and quality of life were all significantly improved, and 80% of patients felt their preoperative ex- pectations had been met or exceeded," said Dr. Furey, of the department of or- thopedic surgery at Case Western Reserve University in Cleveland.

This type of repair is a major under- taking, he said. "Adults with degenerative lumbar scoliosis frequently have signifi- cant medical issues—incuding osteopenia and osteoporosis—that make them more of a challenge. These are lengthy surgeries with the potential for significant blood loss and hospital stay, and complications are common," Dr. Furey explained.

All patients in this retrospective analysis were first treated conservatively, and only those who were ready to proceed with elective surgery underwent decompress- ion and fusion with pedicle screw instru- mentation and iliac crest graft.

All levels with spinal stenosis were de- compressed, including bilateral foramino- tomes. All levels decompressed were fused, as were any levels with lateral lis- thesis greater than 6 mm. The proximal extent of the fusion was at the lowest neu- tral vertebra in the upper lumbar or low- er thoracic spine. Fusion was extended to the sacrum only if an L5-S1 spondylitis- thesis was present, but otherwise was stopped at L5, Dr. Furey said.

"Two patients developed deep infections that required surgical debridement, and misplaced pedicle screws in two others had to be adjusted, he said. "Excluding those who had immediate postoperative treatment for infections, there was a 21% reoperation rate, which is high," he said.

Dr. Furey and his coauthor, Dr. Sanford Emery of West Virginia University, Charleston, said that because the procedure poten- tially can cause significant complications, it should be reserved for those who have failed con- servative management and who are suit- able medical candidates. "These patients deserve respect, and optimizing medical issues—including good intraoperative anes- thesia support and postoperative obser- vation—is critical," Dr. Furey said.