

Knee Examination

Patient Standing

- Look at walking aids, wear on shoes, orthotics
- **Patient facing you**
 - Alignment (Varus/Valgus/Normal?)
 - Obvious effusion/swelling
- **Patient facing sideways**
 - Ask patient to push knees back. Can they fully extend? is there hyperextension?
 - Scars?
- **Patient facing away**
 - Popliteal creases: are they level?
 - Popliteal masses (e.g. Baker's Cyst)
- **Gait**
 - Antalgic gait: shortened stance phase due to pain when weight bearing
 - Others: Ataxic gait, Trendelenburg gait, Drop foot

Ask patient to do a squat, as this provides a good basic strength and patellofemoral alignment assessment.

Patient Sitting On Edge of Bed

- Place fingers on the sides of the patella, and ask the patient to extend and flex their knee, feeling for crepitus
- Ask patient to extend their leg again, and test for quadriceps power
- Lag: Difference between active and passive movement due to muscle weakness or lengthening

Lying on Bed

- **Flat with knees in full extension**
 - Patella tap: only useful for large effusions
 - Patella swipe test: More sensitive for smaller effusion
 - Try grasping the patella, will be slippery if there is synovitis
 - Ask patient to bend their knees as far as possible, and note what angle they can get to
- **Knees to 90°**
 - Check for posterior subluxation of the tibia (PCL injury). There should be a step off of between 5-10 mm between the femur and tibia.
 - Palpate the collateral ligaments, bony prominences, etc.
 - Sit on foot to stabilise the leg
 - Posterior draw: PCL
 - Anterior draw: ACL (chronic ACL particularly)
 - McMurray's test: flex and extend knee in external and internal rotation (meniscal damage)
- **Knees to 30°**
 - ligamentous tests: collaterals act more purely at this angle with less support from muscle
 - Lachman test: More sensitive test for acute injury of the ACL

Further Testing

- Screen joints above and below
- **Neurovascular Assessment**
 - Dorsalis Pedis pulse
 - Posterior Tibial pulse
 - Peroneal Nerve: sensation on dorsum of foot and dorsiflexion
 - Posterior Tibial Nerve: sensation on soles and plantarflexion
- X-Ray of the joint
 - OA: Loss of Joint Space, Osteophytes, Sclerosis, Subchondral cysts.

Patella Tests

- At 0°: check patella glide -> should move further lateral than medial
- At 30°: place lateral force on the patella, and ask if patient is concerned it will dislocate if their leg is straightened (patella apprehension test)

Q Angle

- Angle between the quads and the patella formed by a line from the ASIS to the centre of the patella, and from the tibial tubercle to the centre of the patella
- A smaller Q angle → patella tracks more medially
- Larger Q angle → Patella tracks more laterally, leading to higher risk of patella subluxation/ dislocation, and also may contribute to ACL injury
- *NOTE: This does not need to routinely be assessed, typically done if a patient does have recurrent patella dislocation. Included for interest/completeness.*

Tips

- Always compare to the other side
- Generalised ligamentous laxity can mimic tendon rupture if only one side is tested, whereas testing both will reveal that that degree of movement is normal for the patient