



Attributing Priority to Elective Knee Operations/Patients during the re-introduction of Elective Care May 2020.

General Considerations:

This document does not seek to contradict any guidelines or advice from NHSE, PHE, Joint Surgical Colleges or BOA, but provides practical suggestions for clinicians regarding the allocation of priority level to specific elective knee conditions and operations. Most of us will have been asked to “prioritise” our waiting lists. Some knee injuries or infected knee conditions will be treated via normal urgent/emergency pathways. This will focus on Elective procedures that may warrant P2, P3 or P4 classification.

It is likely that the clinician will be told by NHSE, commissioners, hospital management or Medical Directors, what level of priority can be performed in that unit at that time. This will vary widely across the country based on local capacity to cope with all the components of the patient pathway, as well as local Covid-19 infection rates.

The priority ratings are based on Time Categories suggested by the Joint Surgical Colleges:

P1a: surgery needed within 24hrs

P1b: surgery needed within 72hrs

P2: surgery can be deferred for up to 4 weeks

P3: surgery that can be delayed for up to 3 months

P4: Surgery that can be delayed for more than 3 months

The RCS guidelines give some examples of procedures in different categories but little detail of specific knee conditions, which has led to some questions from our membership asking for more clarity. The definitions of time windows may fit better/worse with certain specialities but have been maintained for consistency. There is, however, some room for ambiguity about whether one is defining the timing by the upper or lower time limit e.g. a peri-prosthetic fracture is called P2 – in most cases this would not be left “up to 4 weeks” but may be reasonable to say it does not “need to be done within 72 hours”. As in this example, there are certain knee procedures, where defining the timing by the shorter end of the timing-window is more appropriate and we have defined these by adding a “*” to that priority e.g. P2* indicates that it can wait longer than 72 hours, whereas a standard P2 can wait up to 4 weeks.

We should not under-estimate the benefits that our surgery gives to patients in terms of pain relief, mobility, function, social interaction or work. Anything “can be delayed” but there is a clinical decision to be made about the severity or

nature of compromise caused by that delay, which may be specific to the procedure or the patient. So a patient who could “be delayed for more than 3 months” (P4), when placed on a waiting list, may already have waited 6 months before the Covid pandemic and is likely to have already been subjected to an additional 2 month wait with suspension of elective service thus far. It is likely that the full effect of Covid will add considerably more time to most waiting lists until normal service is resumed. These patients cannot reasonably be expected to wait on the lowest category of priority indefinitely. The condition of patients on the waiting list may change and require a new priority allocation. Surgeons or patients may choose to defer an operation given the complexity, comorbidities and risk, while Covid conditions prevail. These guidelines are specifically to cope with the dire situation of Covid 19 recovery for elective orthopaedics and are not necessarily applicable for normal practice after Covid-19. This prioritising document purely relates to timing, not the value of a particular intervention and, as such, cannot be used for financially driven or capacity rationing. All patients are on waiting lists having agreed with their treating clinicians that they need or would benefit from surgery.

Within a specified clinical priority group, it may be reasonable to start with the fitter patients, simpler operations, or those that can be done as day-cases (e.g. arthroscopy, ACL, UKA). This should reduce patient risk by not exposing them to an in-patient stay. The risk stratification table from the CDC (in the recent BOA document) is useful for assessing the effect of co-morbidity. Surgeons should discuss with patients, who are high risk but low surgical priority, the option of suspending plans for surgery until we are further down the path of Covid recovery.

P4 patients who have waited longer than the standard waiting time in a department (Pre-Covid) should ideally have their priority level reassessed. Within a specified clinical priority group, it may be reasonable to start with patients already recruited into research trials, where delay may compromise the trial validity or funding. These decisions should be agreed in individual departments. Many national trials have suspended recruitment at this time, and some may allow more flexibility with timing of interventions.

With so many variables affecting the decision for a specific operation in a specific individual at a specific time, BASK strongly supports guidance recommending that patients being considered for surgery at this time are discussed by two consultants, or in an MDT setting, until more information is available about the safety of elective pathways and the progress of the Covid-19 pandemic.

Primary Knee Arthroplasty

Considerations: There is no differentiation between TKR, UKR and PFR. (but consider role for day-case). Ideally avoid new implants or techniques that may affect surgical time/inpatient stay or follow-up requirements.

Priority:

Primary arthroplasty but: <ul style="list-style-type: none"> • Severe pain & reduced mobility • PROMS scores in the lowest quartile or demonstrable deterioration in score • Significant or impending collapse • Progressive deformity/bone loss • Severe valgus but MCL still intact • Requiring sequential replacement of more than one joint • Mobility has deteriorated by one grade on waiting list (e.g. 1 stick to 2 sticks) • Already cancelled for non-medical reasons 	P3
Elective knee arthroplasty with no mitigating factors	P4

Revision Knee Arthroplasty

Considerations: Periprosthetic fracture patients for fixation will require assessment and treatment through normal emergency or urgent pathways. Septic PJI patients will require urgent or emergency intervention via usual pathways although the procedure may range from aspiration to washout, DAIR or 1st stage or 1 stage revision, or amputation as appropriate.

Priority:

Peri-prosthetic fracture for Endo-prosthesis/Revision	P2*
Unstable patient, chronic infection, sinus – planning salvage with plastics	P2*
Acute extensor rupture / Fracture – urgent pathway or	P2*
Acute component breakage requiring revision/potential salvage of original implant if done soon	P2*
TKA or revision TKA – early post-operative stiffness for MUA - assuming being seen 6 – 8 weeks postop	P2
Stable patient, chronic infection, sinus – planning revision/salvage with plastics	P3
Aseptic loosening TKA – risk of collapse/fracture/change to complexity of reconstruction and implant	P3
Patient between stages of 2-stage revision. Infection	P3

controlled, spacer unstable/poor function	
Patient between stages of 2-stage revision or staged arthrodesis, infection controlled, no issues with spacer	P4
Stable patient, chronic infection awaiting rev TKA – 1 or 2 stage	P4
Standard revision for aseptic loosening, instability, stiffness	P4
Secondary PFJ resurfacing OR revision of PKA for arthritis progression	P4
Chronic extensor mechanism disruption – planning reconstruction +/- allograft +/- arthrodesis	P4
Stiff TKA or Revision TKA for arthrolysis/TTO	P4

Ligament Injury

Considerations: Injuries that include fracture/dislocation may need treatment via emergency or urgent pathways, particularly if displaced, still dislocated or associated with vascular injury, open or with compartment syndrome. Decisions for timing of intervention for multi-ligament injuries depend on surgical plan to either repair/augment/reconstruct or if plan is only to do delayed reconstructions. Urgency of ACL reconstruction will vary depending on associated meniscal or chondral injury, age or degree of laxity that may increase potential for secondary injury.

Priority:

ACL	
ACL tear + locked knee	P2*
ACL tear + osteochondral/chondral fracture requiring fixation	P2*
ACL for re-attachment/repair	P2
ACL in paediatric patients	P3
ACL tear + meniscal tear (except bucket-handle)	P3
ACL isolated tear for reconstruction	P4
Revision ACL reconstruction (providing criteria not present as for primary ACL)	P4
Multi-Ligament PCL + PLC Injury	
Knee dislocation: not controlled in brace requiring ex-fix	P2*
Multi-ligament injury + additional chondral/meniscal injury	P2*
Postero-lateral Corner avulsion/fracture/tear with intended repair	P2*
Multi-ligament injury including PLC, planning combined repair and reconstruction	P2*
Multi-ligament injury planned for reconstructions	P3
PCL tear (isolated)	P4
Patellar Instability	
Patellar dislocation with osteochondral/chondral injury requiring fixation	P2*

Patellar dislocation missed or unreduced	P2*
Recurrent patellar dislocation with gross instability	P3
Recurrent patellar dislocation/instability for stabilisation (MPFL, TTO, proximal re-alignment, trochleoplasty)	P4
Tendon	
Patellar or quadriceps rupture	P2*

Meniscus, Cartilage & Early Intervention

Comments: Timing of interventions for meniscal tears will vary depending on displacement, quality of meniscus, age of patient and perceived ability to repair the meniscus.

Priority:

Meniscus tear with locked knee	P2*
Acute loose body with locked knee	P2*
Paediatric displaced OCD	P2*
Degenerate/Chronic loose bodies now locked	P2
Paediatric or adult unstable OCD lesion	P2
Potentially repairable meniscus	P2
Revision osteotomy for overcorrection or fixation failure	P2
Degenerate/multiple loose bodies with mechanical symptoms	P3
Flap tear meniscus with mechanical symptoms	P3
Arthroscopic debridement of symptomatic chondral lesion	P3
Osteotomy to protect recent meniscal/chondral surgery	P3
Symptomatic degenerate meniscal tear, no mechanical symptoms (failed conservative Rx)	P4
Meniscal augmentation or allograft	P4
Injection treatments for OA	P4
Osteotomy for degenerative disease	P4
Revision osteotomy	P4

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