

<b>Policy title</b>	<b>Knee replacement surgery for treatment of osteoarthritis in adults (primary total and partial knee replacement) V3.0</b>
<b>Policy position</b>	<b>Criteria Based Access</b>
<b>Date of Forum recommendation</b>	<b>September 2018, updated June 2021</b>
<b>Date of ICB recommendation</b>	<b>August 2025</b>

The most common indication for planned knee replacement is degenerative arthritis (osteoarthritis) of the joint. It is the most common type of arthritis and is most often seen in older people. Osteoarthritis (OA) causes pain, stiffness and problems moving the joint.

Symptoms of OA may be mild, or more severe and affect everyday life. Symptoms can vary between joints and over time and do not always deteriorate. Sometimes symptoms can flare up and settle back down again.

The aims of knee replacement are the relief of pain and improvement in function, and this operation can be very successful for appropriate patients. A small number of patients who have a planned knee replacement require a second replacement operation within their lifetime which is a much more complex procedure. Therefore, patients should not be considered for joint replacement until their condition has become chronic and conservative methods have failed.

### **Imaging<sup>1</sup>**

The diagnosis of knee OA can be effectively made in general practice and community services based upon the patient's history and physical examination. In particular, NICE recommends diagnosing osteoarthritis clinically, and without investigations, in patients who:

- Are 45 or over AND
- Have activity-related joint pain AND
- Has either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes.

Patients with persistent symptoms should be referred to secondary care and should have imaging of the knee to investigate for OA and/or other pathology. The first-line investigation of potential knee OA is weight bearing plain radiography. If the patient has a pattern of disease that allows surgical treatment to be adequately planned with plain radiographs, then MRI is not required.

Note: Referral to Secondary Care for diagnostics, imaging or to be reviewed by a consultant must come via the Community MSK Service; GP direct referrals will be refused and not funded.

## **Management<sup>2</sup>**

Initial management should take place within general practice and community services. Recommended core treatments may include therapeutic exercise, weight reduction (if appropriate) and adequate doses of analgesics including topical non-steroidal anti-inflammatory drugs (NSAIDs). Walking aids such as walking sticks may also be considered.

Patients should be advised that undertaking regular and consistent exercise (even though this may initially cause pain or discomfort) will be beneficial for their joints. Adherence to a long-term exercise plan increases its benefits by reducing pain and increasing functioning and quality of life.

Patients with OA who are overweight or obese should be advised that weight loss is likely to improve their quality of life, physical function and reduce pain. Health professionals should support patients to choose a weight loss goal and explain that any amount of weight loss is likely to be beneficial. However, for example losing 10% of their body weight is likely to have more benefit than a loss of 5%.

Do not routinely offer paracetamol or weak opioids unless they are only used infrequently for short-term pain relief and all other pharmacological treatments are contraindicated, not tolerated or ineffective. Do not offer glucosamine or strong opioids to patients to manage OA.

Consider intra-articular corticosteroid injections when other pharmacological treatments are ineffective or unsuitable, or to support therapeutic exercise. Explain that these only provide short-term relief (2 to 10 weeks).

Do not offer acupuncture for the management of OA.

**Symptoms that are suggestive of a rapid deterioration in the joint or persistent symptoms which are causing severe disability necessitate urgent referral to orthopaedic services.**

**Routine referral from Community MSK Services to Secondary Care for consideration of primary total or partial knee replacement surgery will be supported where there is:**

- Moderate-to-severe persistent pain not adequately relieved by at least 6 months of core treatments (therapeutic exercise, weight loss if relevant and appropriate analgesia)<sup>2</sup>
- AND Clinically significant functional limitation\* resulting in diminished quality of life
- AND Radiographic evidence of joint damage.

\*The severity of functional limitation should be assessed using Oxford Knee Score (OKS). For patients with a score of 0-19 consideration should be given for orthopaedic surgical opinion. For patients with an OKS of over 20, conservative measures should be continued for 3-6 months, with referral if no improvement after this time. Patients with an OKS score of 30 or more should be informed of the lower chances of meaningful improvement with higher OKS scores<sup>2</sup>.

**For patients who are overweight or obese and/ or active smokers:** General practice and community services should offer referral to patients for weight loss and smoking cessation support at the earliest opportunity and in any case at the same time as referral to secondary care. See associated BLMK ICB policy, Weight Management Services in Adults.

**For all patients<sup>5,6</sup>:** Use of a quality assured [decision support aid](#) is encouraged to support discussion of the risks, benefits and consequences of the treatment options available in the context of each person's life and what matters to them.

#### **Partial knee replacement<sup>4</sup> (guidance for supporting discussions in secondary care)**

In some patients with arthritis confined to the medial compartment of the knee, a partial knee replacement may be suitable as an alternative to a total knee replacement. The evidence suggests that there are advantages and disadvantages to both procedures. The outcomes for each type of surgery are thought to be similar although recovery after partial knee replacement tends to be faster, with a shorter stay in hospital and less pain during the recovery period. Complications such as infections, blood clots, heart attacks or stroke are rare for both procedures, but are thought to be rarer after partial than total knee replacement. Partial knee replacement leaves more of the original knee intact, but the remaining parts of the knee could develop arthritis and may need to be replaced in the future. The National Joint Registry data indicate a greater likelihood of revision surgery within 10 years after partial knee replacement. Total and partial knee replacement are very different types of procedure, and surgeons need to ensure they perform a sufficient number of each procedure every year to ensure good surgical outcomes.

#### **Recommendations for partial knee replacement**

- NICE<sup>4</sup> recommends that a choice of partial or total knee replacement is offered to patients with isolated medial compartmental OA
- Lateral or patellofemoral replacement may also be considered for carefully selected patients with OA confined to these compartments but as these procedures are less common, patients should be made aware of the current limited evidence base
- The potential benefits and risks of each option should be discussed with the person.
- Initial non-surgical management must have been provided as outlined earlier in this guidance, and the person must meet the above referral criteria
- The procedure must be undertaken by a surgeon who can evidence that they complete a minimum of 10 partial knee replacements<sup>9</sup> per year.

#### **Patella Resurfacing**

NICE<sup>4</sup> recommends that resurfacing of the patella should be offered to patients having primary elective total knee replacement.

Due to lack of sufficient evidence of clinical benefit and cost effectiveness to support routine resurfacing of the patella alone, stand-alone patellar resurfacing is **not normally funded**.

## Second knee and bilateral knee replacement

If more than one knee replacement is being considered, EACH surgery requires evaluation against the policy criteria on its own merits. Of particular note if a patient has completed a knee replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required. For bilateral simultaneous replacement, discussion of the risks and impact on rehabilitation should form part of a clinician-patient shared decision making process. This should be documented in the medical record.

A range of resources are available to support patients prepare for surgery, these are listed on the [My Hospital Journey](#) website.

### References:

1. Academy of Medical Royal Colleges (2020) Evidence-Based Interventions List 2 Guidance
2. NICE NG226: Osteoarthritis in over 16s: diagnosis and management. Published October 2022.
3. Price A et al. The Arthroplasty Candidacy Help Engine tool to select candidates for hip and knee replacement surgery: development and economic modelling. Health Technol Assess. 2019 Jun;23(32):1-216.
4. NICE NG157: Joint replacement (primary): hip, knee and shoulder. Published June 2020.
5. NICE NG197: Shared decision making. Published June 2021.
6. NHS England. Decision support tools: making a decision about knee osteoarthritis. Published July 2022.  
<https://www.england.nhs.uk/publication/decision-support-tools-making-a-decision-about-a-health-condition/>
7. Getting it Right First Time: Orthopaedics Follow-up Report. Published February 2020. <https://gettingitrightfirsttime.co.uk/wp-content/uploads/2020/02/GIRFT-orthopaedics-follow-up-report-February-2020.pdf>

### NOTE:

- This policy will be reviewed in the light of new evidence or new national guidance e.g. from NICE
- Where a patient does not meet the policy criteria or the intervention is not normally funded by the NHS, an application for clinical exceptionality can be considered via the ICB's Individual Funding Request (IFR) Policy and Process

### Clinical coding:

Age range: ≥19 years

### IDC10 M17.- Gonarthrosis

### Total Knee Replacement

Primary OPCS:

W40.1: Primary total prosthetic replacement of knee joint using cement

W40.9: Unspecified total prosthetic replacement of knee joint using cement

W41.1: Primary total prosthetic replacement of knee joint not using cement  
W41.9: Unspecified total prosthetic replacement of knee joint not using cement  
W42.1: Primary total prosthetic replacement of knee joint NEC  
W42.9: Unspecified other total prosthetic replacement of knee joint  
O18.1: Primary hybrid prosthetic replacement of knee joint using cement  
O18.9: Unspecified hybrid prosthetic replacement of knee joint using cement

**Unicompartmental Knee Replacement**

W58.1: Primary resurfacing arthroplasty of joint (knee)

<b>Policy update record</b>	
v2.0 22.6.2021 BLMK 3CF meeting	Addition of Evidence Based Interventions phase 2 recommendation on imaging in primary care: section 'Imaging'.
August 2025 BLMK ICB Executive Team	<ul style="list-style-type: none"> <li>• Change of policy title to include reference to osteoarthritis</li> <li>• Management/ self-care section/ replacement options updated in line with NICE NG226: Osteoarthritis in over 16s: diagnosis and management (October 2022) and NICE NG157: Joint replacement (primary): hip, knee and shoulder (June 2020).</li> <li>• Incorporation of the role of the community MSK service for onward referrals</li> <li>• Clarification that referral can be made for patients with an Oxford Knee Score (OKS) of 30 or above provided that the patient is made aware that the chances of meaningful improvement following surgery are reduced with higher OKS</li> <li>• Clarification that weight loss is not required for onward referral and promotion of weight loss programmes/ inclusion of reference to the weight management in adults policy</li> <li>• Incorporation of the NHS England national shared decision-making tool</li> <li>• Removal of the secondary care guidance/ appendix on total knee replacement</li> <li>• Addition of consideration of lateral and patellofemoral replacement options for partial knee replacement</li> <li>• Addition of a statement in relation to second knee or bilateral procedures</li> <li>• An update of references.</li> </ul>

Key words: knee replacement, total knee replacement, TKR, partial knee replacement, unicompartmental knee replacement