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:                                                                                                                                  | P3          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| • 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                                                                                                                |             |

| 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                                                                             |             |
| 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 | P2* |
| 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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