Knee Osteoarthritis
GP Update, 2024

Your shortcut to the updated Australian Clinical Care Standard for knee osteoarthritis.

The updated standard refines best practice for adults ≥45 with suspected knee OA. Emphasis shifts to diagnosis without routine imaging, clear, non-catastrophic communication, and lifestyle-first management. Aim: help patients stay active, informed, and independent while minimising low-value care.

Area	What to do (in clinic)	Pearls & pitfalls
Dx & first consult	Diagnose clinically (Hx + focused knee exam). Screen for red flags (infection, fracture, malignancy, inflammatory disease). Explore goals & psychosocial factors.	Avoid "wear & tear/bone-on-bone" language. Use: "stiffness, sore joint, muscles around the knee, you can improve this."
Imaging	No routine imaging to diagnose OA. If atypical/red flags → X-ray first line.	MRI/CT/US not indicated for typical OA in primary care. Imaging severity ≠ pain severity.
Education & self-management	Provide a simple OA explanation; bust myths (movement harms the joint). Co-create a plan.	Link to community programs; reinforce patient control over symptoms.
Exercise & activity	First-line. Prescribe regular, progressive exercise (aerobic, strengthening, balance; hydro OK). SMART goals + review.	Even small gains help pain/function. Consider EP/physio referral; avoid passive electrotherapies/therapeutic US.
Weight & nutrition	Discuss weight kindly; set a realistic target (e.g. 5–10% loss). Offer dietitian; consider VLED, pharmacotherapy, or bariatric referral.	Even 2–5 kg loss improves symptoms. Keep focus on health & function, not only load.
Medicines	NSAIDs first-line (low dose). Limited paracetamol (second-line). Topical NSAIDs useful. Duloxetine help persistent pain. Intra-articular steroid: short-term relief for flares.	Avoid routine opioids (harms > benefits). Not recommended: PRP/stem cells, hyaluronic acid, medicinal cannabis, gabapentinoids for OA knee pain.
Structured review	Plan reviews to check goals, function, meds, side effects, adherence, mood/sleep. Adjust.	Book a dedicated review — don't only "add on" at the end of other visits.
Referral	Refer to sports / exercise physician / rheum / ortho when severe, persistent functional impairment despite optimal non-surgical care. Do X-ray before surgical consult.	While waiting, continue active care (exercise, weight, analgesia). Avoid "holding pattern."
Surgery	Consider TKR when criteria above met and patient informed (benefits/risks; 1 in 5 may not achieve major benefit). Prehab matters.	Arthroscopy not for uncomplicated OA. Continue lifestyle measures pre/post-op.
Equity & safety	Embed cultural safety, address access barriers; use NCD/mental-health supports.	Language, cost, transport, and carer roles affect adherence — plan around them.

In summary, lead with education, exercise, and weight management; use medicines sparingly and safely; avoid unnecessary imaging and opioids; review on a schedule; and refer in a timely way when function remains poor despite best conservative care. Communicate with hope and practicality.

Where to next

🎓 Explore **Micro-Course** in osteoarthritis or **Certificate pathways** in MSK Medicine: **healthcert.com/msm**