Knee Osteoarthritis
GP Update, 2024

Frequently Asked Questions, with Dr Simone Gonzo

Q: Do I need an x-ray to diagnose knee OA?
A: No. Typical OA is a clinical diagnosis (history + exam). Image only if atypical features or red flags; use x-ray first. X-ray will be required for referral to public hospital.

Q: What words should I avoid when explaining OA? What should I say instead?
A: Avoid "wear & tear/bone-on-bone/degeneration." Try: "OA affects the joint and surrounding muscles; movement helps joints stay healthy; you can improve pain and function with the right plan."

Q: What's first-line treatment?
A: Exercise (aerobic + strengthening + balance) and weight optimisation. Add education, pacing, sleep strategies, and community supports.

Q: Which medicines work best?
A: If needed: topical NSAIDs, then oral NSAIDs (if safe, lowest effective dose, intermittent). Paracetamol has modest benefit at best. Duloxetine can help persistent pain. Short-term steroid injection may be used for flares or bridging.

Q: Should I use opioids?
A: Avoid for OA knee — harms outweigh benefits. Consider only short-term, exceptional use when severe pain persists despite optimal care and while awaiting specialist/surgery, with a plan to taper.

Q: Do PRP, stem cells, hyaluronic acid, cannabis, or gabapentin help?
A: Not recommended for knee OA (insufficient benefit, cost/risks). Focus on proven core treatments.

Q: How do I set exercise targets for busy patients?
A: Use SMART goals: e.g. "20-minute walk, 3 mornings/week for 4 weeks," or build incidental activity (stairs, walk during kids' sport, hydro while they swim).

Q: How much weight loss is "worth it"?
A: Even 2–5 kg helps pain/function. Aim for 5–10% over months. Consider dietitian, VLEDs, meds, or bariatric referral where appropriate and acceptable.

Q: When should I refer for surgery?
A: When there is severe, persistent functional impairment despite optimal non-surgical care. Arrange X-ray, continue prehab and active management while waiting.

Q: Is arthroscopy useful for OA?
A: Not for uncomplicated knee OA.

Q: What if imaging is "mild" but the patient's pain is severe (or vice versa)?
A: Treat the person, not the picture. Imaging severity doesn't predict pain or function. Keep building the conservative plan.

Q: How often should I review?
A: Plan a review in 4–12 weeks, then space according to progress. Recheck goals, function, adherence, AEs, mood/sleep; adjust.

Q: Any tips for equity and access?
A: Use culturally safe communication; consider cost/transport/carer duties. Offer home programs, group walks, hydro, community classes, and social supports.

Where to next

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