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Title

Why the Wobble? Cracking the Case of Knee Swelling and Limp in a Young Patient

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Case history (875/900)

A 5-year-old previously healthy male presents for leg pain. He had been having diffuse intermittent pains on both legs, worse at night for the past 6-12 months. However, he has had a new, worsening pain in the back of his left knee and limp for the last 1-2 weeks. There was no obvious injury or trauma, but he does like jumping off the playground structures. Last night, when dad was trying to put on his pajamas, he heard some cracking, and the patient reported significant pain. Dad isn't sure if there was any weird positioning or motion.

Today, the patient doesn't endorse any pain. The parents waited to bring the patient in since they thought it was just growing pains, but the worsening limp was concerning enough that they scheduled an appointment. They haven't noticed any other joint swelling. There was no fever, chills, rash, nausea, vomiting, cough, or diarrhea.

Physical Exam (694/700)

Left Knee exam:

INSPECTION

No deformity, erythema, or overlying skin changes. Normal alignment noted. Mild lateral knee effusion.

PALPATION

No tenderness to palpation over patella, patella tendon, patellar facets, proximal fibular head, posterior knee. +lateral joint line tenderness

ROM

Full ROM flexion. Decreased extension to 10 deg

STRENGTH TESTING

5/5 strength in knee flexion and extension

NEUROVASCULAR

Distal pulses intact and equal. SLTI

STABILITY TESTING

Neg anterior drawer

Neg posterior drawer

Neg lachman's at 30 degrees

Neg varus and valgus stress at zero and 30 degrees

SPECIAL TESTS

Neg mcmurray's

Neg patellar grind

MSK

+guarding with IR/ER ipsilateral hip

GAIT

toe-walking on left

Ddx

JIA

Septic arthritis

Discoid meniscus/meniscal tear

Transient synovitis

Fracture

Tests/Results (485/500)

X-ray: No acute findings.

MRI

Significant diffuse abnormality of the lateral meniscus with findings likely representing a displaced bucket handle type tear superimposed on a background of discoid morphology of the lateral meniscus.

CBC

WBC 12.1, Hgb 12.2, Hct 34.7, Plt 292

ESR

5mm

CRP

<0.1 mg/dL

EUA

The lateral meniscus demonstrated a complex tear, involving the laterally unstable discoid meniscus. There was a noted medial plica with no evidence of medial condyle cartilage wear.

Final/Working diagnosis (200)

Torn discoid meniscus

Discussion (698/700)

Discoid lateral meniscus deformities have an estimated prevalence of up to 5% in the US. As many as 25% of cases are bilateral. The thicker and disc-shaped meniscus causes more instability and injury. Classically, there's a "snapping knee syndrome" with painless clunking or snapping that does not prevent activity. Exam may demonstrate antalgia, effusion, decreased extension, or a visible anterolateral bulge. X-rays can be normal but can present with a widened joint space, among other changes. MRI is the best modality and can display a classic "bow tie" sign. Asymptomatic discoid menisci should be observed, but symptomatic discoid menisci should be surgically repaired.

Outcome (371/400)

Initial x-rays were normal, and an MRI was ordered. Concurrently, the patient was referred to orthopedics. Given the MRI findings of a torn discoid meniscus, the family decided to proceed with surgery. He underwent successful arthroscopic saucerization and debridement. No repair was needed. Post-operatively, he was placed in an immobilizer and progressed appropriately.

Return to activity/Follow-up (380/400)

Post-op recovery follows the same progression as other meniscectomies. Generally, patients advance activity as tolerated. The majority of patient return to running, jumping, and sport-specific training at approximately 6 weeks. Knee pain and effusion have generally resolved at this point and strength improved. This patient followed organizational protocol with good improvement.