

**Figure 6-1.** McMurray test for a meniscal tear.

## Controversial Indications

- ▶ Tear amendable to repair
- ▶ Asymptomatic tear
- ▶ Stable tear (typically < 1.5 cm in length and incomplete, particularly in a patient with an anterior cruciate ligament [ACL]-deficient knee<sup>4,5</sup>)
- ▶ Degenerative tear in patients with evidence of osteoarthritis (30% nonoperative failure rate requiring conversion to surgery<sup>6</sup>)

## PERTINENT PHYSICAL FINDINGS

Assessment of an injured knee always begins with a history. Meniscal tearing in a young patient is typically a relatively traumatic event. With age, meniscal tissue does degenerate, and tearing of the meniscus requires less force. Typically, a flexion rotation stress is associated with a tear, and when the tear is in the avascular portion of the meniscus, pain and swelling often take 24 hours or more to develop. In the middle-aged population, there may be no recollection of injury prior to the tear or simple activities, such as squatting down or kneeling, may be followed by increasing pain and swelling over a period of 24 hours or more associated with a tear. When history and physical examination are considered together, the overall sensitivity to diagnose a meniscal tear is 88% and specificity is 94%.<sup>7</sup>

- ▶ Effusion (acute injuries)
- ▶ Joint line tenderness (sensitivity of 86% for medial and 92% for lateral; specificity of 67% for medial and 97% for lateral)<sup>8</sup>
- ▶ McMurray test (Figure 6-1; with audible clunk sensitivity of 98% and specificity of 15%)<sup>9</sup>
- ▶ Steinman test
- ▶ Apley test

## PERTINENT IMAGING

- ▶ Plain x-rays: Weightbearing anteroposterior and posteroanterior, lateral, and sunrise
- ▶ Magnetic resonance imaging (MRI)
- ▶ Ultrasound