Lower Extremity Pain CLINICAL GUIDELINES for Workup

Definition

Lower extremity musculoskeletal pain is common, the possible etiologies are broad, ranging from benign to serious. The goal of this practice guideline is to present the tools for a provider to determine the diagnosis for a child with lower extremity pain in an efficient manner. This practice guideline is a reference for providers when caring for a patient with lower extremity musculoskeletal pain.

Signs and symptoms

The list of differential diagnoses’ for lower extremity pain is extensive and broad. A thorough history and physical exam will aid the provider in identifying the correct diagnoses. Always be familiar with the child’s medical history

Focused History of Musculoskeletal Pain

Timing of Pain
Timing can aid in diagnosis. Acute onset of symptoms suggests a more acute diagnosis such as septic arthritis, osteomyelitis, fracture, or malignancy. In contrast, morning symptoms that improve through the day are more suggestive of a rheumatologic etiology. Pain after activities is suggestive of an overuse syndrome or stress fracture. Night waking pain can be a benign etiology such as growing pains or more serious etiologies such as malignancy or osteoid osteoma. Identify any preceding activities and/or sports played surrounding the symptoms.

Sample questions:

- When did the pain start? What makes the pain better/worse? Rate pain on a scale
- Is the pain activity related?
- Is the pain bad enough to prevent the child from their activities, sports/play or school?
- How does the child feel after sports or play activities?
- Is the pain night waking versus in the AM or after naps?

Associated Systemic Features

Serious conditions will typically cause systemic symptoms. Be concerned by children who have stopped playing or teens who are limiting athletics or social activities.

Sample questions:

- Presence and time of fevers.
- Association with any rashes, weight loss, change in activity, decreased appetite, lethargy and/or a change in sleep patterns.
Nature & Location of Pain
Children are often better at demonstrating the location of the pain. In verbal children it may be beneficial ask them to use their index finger to identify the point of maximum tenderness.

Sample questions:
• Asking the patient to show them with their finger “the one pin point place that hurts the most, where would that be”?
  o If the child is unable to locate the area of maximum tenderness, ask them to draw a line with their finger demonstrating where the pain starts and stops. In non-verbal children, rely on the parent’s perceptions of where the pain is.
• Can you describe the pain? Where does the pain start/stop?

PHYSICAL EXAM
A thorough musculoskeletal examination is important for diagnosis. The focused musculoskeletal examination includes pediatric orthopaedic, neurologic and rheumatologic aspects. Always start with a presumed non-painful area, especially in small children, performing the examination of the painful area last. Musculoskeletal exam features
• Inspect and palpate both lower extremities
  o Identify the site of maximal tenderness
• Examine the joints for swelling and range of motion
• Evaluate range of motion to all upper and lower extremities including bilateral shoulders, elbows, wrists and fingers, hips, knees, ankles, and toes.
  o Be aware of the knee-hip-back triad. Often hip pain is referred to the knee. Back pain can refer to the hip or radicular pain from the spine will present with pain down the leg.
  o When evaluating knee pain always include evaluation of the hip.
• Include palpation of all extremities.
  o Assess for joint range limitation, warmth, and swelling.

Neuromuscular exam
• Evaluate the undressed child through several gait cycles pay attention to each limb and joint.
  o Running may help uncover subtle gait abnormalities.
  o To minimize the affected limb’s pain, the amount of time spent in the stance phase decreases and that spent in the swing phase increases (Barkin, Barkin & Barkin, 2000; Herring, 2007; Laine, Kaiser & Diab, 2010; Leet & Skaggs, 2000; Renshaw, 1995; Wyndam, 2007).
• Examine deep tendon reflexes, tone, clonus, sensation, straight leg raise, muscle wasting, evaluation of the feet and toes for clawing or deformity (Herring, 2007; Leet & Skaggs, 2000; Morrissy & Weinstein, 2006; Wenger & Rang, 1993).
  o A positive exam finding from above is suggestive of an etiology from either the spinal cord or a nerve root.
Causes

The etiology of musculoskeletal pain, with or without a limp, is broad. Below are commonly seen etiologies for musculoskeletal pain. The diagnoses can be grouped into the following categories:

- **Trauma**: (i.e. strains/sprains, fractures, dislocations)
- **Infection**: septic arthritis, osteomyelitis, brodies abscess
- **Immune-mediated**: toxic synovitis, juvenile rheumatoid arthritis, Lyme disease, Strep reactive arthritis, osteoid osteoma
- **Acquired**: slipped capital femoral epiphysis (SCFE), Legg-Calve-Perthes disease
- **Neoplastic**: leukemia/lymphoma, Ewing’s sarcoma, osteosarcoma
- **Referred**: discitis, psoas abscess, spine or hip pathology
- **Benign musculoskeletal**: Growing pains, tendonitis/apophysitis

Additional non-painful etiologies that can cause a limp to consider include:

- **Congenital**: developmental dysplasia of the hip
- **Non-painful limp**: leg length discrepancy, scoliosis
- **Neurologic**: cerebral palsy, myelomeningocele, or underlying neuromuscular pathology

**Risk Factors** The vast majority of parents/care takers will identify a history of trauma for any source of musculoskeletal pain, especially in the young and non-verbal. Most often the etiology of musculoskeletal pain is related to accidental injury. However, it is important for a provider to always remember the vast number of other causes of musculoskeletal pain.

**Complications** While most musculoskeletal pain can be traced to a benign condition, one must remember infection and neoplastic processes can mimic many other diseases. The purpose of these guidelines is to provide the provider with the tools to work up patients with lower extremity pain in a timely manner, which in result will prevent further morbidity and medical complications.
Recommendations for Providers considering referral to Pediatric Orthopaedic specialist

- Pre Work up

**Work-up Algorithm**

1. **History of Trauma**
   - Yes → Perform Radiographs
   - No → Abnormal Exam with or without constitutional symptoms

2. **Abnormal Exam with or without constitutional symptoms**
   - Perform Radiographs

3. **Abnormal**
   - Perform Labs (Please refer to lab section for correct labs to...
   - Normal

4. **Normal**
   - Perform Labs (Please refer to lab section for correct labs to...

5. **Differential**
   - Fracture/dislocation
   - Soft Tissue
   - Overuse Apophysitis
   - Sprain

6. **Treatment options**
   - Treat and/or refer as appropriate
   - Consider further work up as needed,
   - Treat as fracture if pt has physeal tenderness

7. **Bone or Musculoskeletal Pain**
   - Osteomyelitis,
   - Neoplasm
   - Sacroiliitis
   - Abscess
   - Discitis

8. **Bone or Musculoskeletal Pain**
   - Joint Pain +/- effusion
     - Transient synovitis
     - Septic joint
     - Reactive
     - Inflammatory
     - Arthritis

9. **Bone or Musculoskeletal Pain**
   - Accessory Navicular
   - Tarsal coalition
   - Legg Calve Perthes
   - Slipped Capital Femoral Epiphysis
   - Kohlers
   - Foreign body
   - Rickets (+/- pain)
   - Scoliosis (+/- pain)
   - Spondylolysis/isthesis (+/- pain)
   - Nonpainful +/- limp
     - Developmental Dysplasia of the Hip
     - Leg length discrepancy

10. **Joint Pain**
    - Legg Calve Perthes
    - Slipped Capital Femoral Epiphysis
    - Osteochondritis dissecans

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### Imaging

<table>
<thead>
<tr>
<th>Location of Pain</th>
<th>Radiographs</th>
<th>Views to Obtain</th>
<th>Other Imaging Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip</td>
<td>Pelvis</td>
<td>AP, frog, lateral</td>
<td>-MRI: Soft tissue and joints, large amounts of effusion; ex: stress fractures; infection; abscess; neoplasm; ligament injury; cartilage evaluation</td>
</tr>
<tr>
<td>Femur</td>
<td>Femur</td>
<td>AP, lateral</td>
<td>-CT: Bony abnormalities suspected but not definitive by x-ray, ex: intra-articular fracture</td>
</tr>
<tr>
<td>Knee</td>
<td>Knee</td>
<td>AP, lateral, sunrise, notch</td>
<td>-Ultrasound: Effusion of joints, vascular injuries suspected; ex: septic hip, infant DDH</td>
</tr>
<tr>
<td>Ankle</td>
<td>Tibia</td>
<td>AP, lateral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ankle</td>
<td>AP, lateral, mortise</td>
<td></td>
</tr>
<tr>
<td>Foot</td>
<td>Foot</td>
<td>AP, lateral, oblique</td>
<td></td>
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</tbody>
</table>

### Laboratory Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Condition</th>
<th>Expected Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC</td>
<td>Infection</td>
<td>Elevated WBC &amp; Platelets</td>
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<tr>
<td></td>
<td>Inflammation</td>
<td>Elevated WBC &amp; Platelets</td>
</tr>
<tr>
<td></td>
<td>Malignancy</td>
<td>Cytopenia</td>
</tr>
<tr>
<td>CRP</td>
<td>Infection</td>
<td>Elevated</td>
</tr>
<tr>
<td></td>
<td>Inflammation</td>
<td>Elevated</td>
</tr>
<tr>
<td></td>
<td>Malignancy</td>
<td>Elevated</td>
</tr>
<tr>
<td>ESR</td>
<td>Infection</td>
<td>Elevated</td>
</tr>
<tr>
<td></td>
<td>Inflammation</td>
<td>Elevated</td>
</tr>
<tr>
<td></td>
<td>Malignancy</td>
<td>Elevated</td>
</tr>
<tr>
<td>ASO</td>
<td>Acute rheumatic fever</td>
<td>Markedly increased &amp; usually very ill child</td>
</tr>
<tr>
<td></td>
<td>Unresolved/undetected Group A hemolytic strep</td>
<td>Increased ASO, sore throat</td>
</tr>
<tr>
<td>AntiDNAse B</td>
<td>Acute rheumatic fever</td>
<td>Positive &amp; usually very ill child</td>
</tr>
<tr>
<td></td>
<td>Unresolved/undetected Group A hemolytic strep</td>
<td>Positive</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Test</th>
<th>Condition</th>
<th>Expected Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANA</td>
<td>SLE</td>
<td>Markedly positive</td>
</tr>
<tr>
<td></td>
<td>False positive</td>
<td>Mildly positive</td>
</tr>
<tr>
<td>Lyme</td>
<td>Lyme disease</td>
<td>Titer positive and Western Blot positive</td>
</tr>
<tr>
<td></td>
<td>False positive titer (exposed but no disease)</td>
<td></td>
</tr>
<tr>
<td>Synovial Cell Count</td>
<td>Septic arthritis</td>
<td>Turbid fluid; WBC &gt;50,000 to over 100K, PMNs &gt;75%</td>
</tr>
<tr>
<td></td>
<td>Transient synovitis</td>
<td>Clear yellow synovial fluid; WBC 5,000-15K, PMNs &lt;25%</td>
</tr>
<tr>
<td></td>
<td>JIA</td>
<td>25,000-100,000K</td>
</tr>
<tr>
<td>Blood Cx</td>
<td>Infection</td>
<td>+/- positive</td>
</tr>
<tr>
<td>Joint/Bone Cx</td>
<td>Infection</td>
<td>+/- positive</td>
</tr>
<tr>
<td>Stool Cx</td>
<td>Reactive arthritis with diarrhea</td>
<td><em>Salmonella</em>, <em>Shigella</em>, <em>Yersinia</em>, <em>Campylocbacter</em></td>
</tr>
<tr>
<td>Urine Cx</td>
<td>Reactive arthritis</td>
<td><em>Neisseria gonorrhoeae</em> or <em>Chlamydia</em></td>
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<tr>
<td>Serum ferritin</td>
<td>Restless Leg Syndrome</td>
<td>Meet NIH RLS criteria</td>
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<tr>
<td></td>
<td></td>
<td>Serum Ferritin &lt; 50mcg</td>
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Adapted from Junnila & Cartwright, 2006a; Junnila & Cartwright, 2006b; Sawyer, J.R. & Kapoor, M. 2009, p. 220
Treatment and Referral of Pediatric Lower Extremity Pain

Musculoskeletal complaints most commonly are from diagnoses treated by orthopedic and sports medicine providers. Occasionally, the underlying etiology causing musculoskeletal pain is from a problem not usually treated by orthopedic sub-specialists. Below are common conditions that present with lower extremity pain and/or limp. Included are initial interventions orthopedic providers implement.

Clinics at the CHW Orthopedic Center & Sports Medicine Program include:

- Cerebral Palsy Clinic
- Concussion
- Fracture
- General Orthopaedic
- Scoliosis
- Sports Medicine
- Trauma
- Well child lower extremity screening clinic

Clinic locations: Children’s Hospital of Wisconsin-Main campus; CHW-Greenway; CHW-New Berlin (concussion only)

To schedule an appointment: Central Scheduling 414.607.5280 or toll free 877.607.5280

Orthopedic nurse line: 414.266.2513

Sports line 414.604.6512

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>History, Physical and Test findings</th>
<th>Treatment and Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessory navicular</td>
<td>Medial foot pain + x-ray findings</td>
<td>• conservative treatment with Non-steroidal anti-inflammatory drugs (NSAIDS)</td>
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<td>• activity modification</td>
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<td></td>
<td>• possible immobilization or orthosis</td>
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<td></td>
<td></td>
<td>• referral to CHW Orthopedics or Sports Medicine with no improvement</td>
</tr>
<tr>
<td>Apophysitis/musculoskeletal conditions:</td>
<td>Tender to palpation over apophysis</td>
<td>• NSAIDS or Naproxen twice a day</td>
</tr>
<tr>
<td>- Osgood-Schlatter</td>
<td>+/- x-ray findings</td>
<td>• may consider short one to two week immobilization or bracing</td>
</tr>
<tr>
<td>- Patella femoral pain</td>
<td></td>
<td>• physical therapy (PT) 1-2 times per week for 6-8 weeks to include range of motion of</td>
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<tr>
<td>- Sindig-Larsen-Johansen Syndrome</td>
<td></td>
<td>affected joint(s), strengthening of lower extremities including</td>
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<tr>
<td>- Severs</td>
<td></td>
<td>hamstring/quadriceps/gluteus/calf muscles, with a return to sports program</td>
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<td></td>
<td>• follow up in 6 weeks, consider referral to CHW Sports Medicine with no</td>
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<tr>
<td></td>
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<td>improvement of symptoms</td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
<td>Recommendations</td>
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</tr>
<tr>
<td><strong>Cerebral Palsy</strong></td>
<td>Neurology deficits with motor impairment</td>
<td>• Referral to CHW Multi Disciplinary Cerebral Palsy Clinic or CHW Physical Medicine and Rehabilitation</td>
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<tr>
<td></td>
<td>Hypertonia</td>
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<td></td>
<td>Non painful limp</td>
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</table>
| **Complex Regional Pain Syndrome**| Pain after an injury, lower limb most common; pain to light touch that is disproportionate to mechanism of injury; evaluate for autonomic symptoms (skin temp different; color changes, absence of sweating) | • NSAIDS or Naproxen twice a day  
• begin PT for desensitization  
• discontinuation of any bracing  
• refer to CHW Pain & Palliative Care |
| **Developmental Dysplasia of Hip**| Check history for female, first born, breech, and family history.  
+ Ortolani and Barlow, asymmetric thigh fold,  
+ Galeazzi, + Klisic | • refer to CHW Pediatric Orthopedics with positive exam findings or imaging studies (ultrasound or x-ray) |
| **Discitis**                     | Back pain, +/-fever, decreased spinal motion, often systemic symptoms and systemically ill       | • Referral to CHW emergency room  
• treat with IV antibiotic therapy with inpatient admission.  
• involvement of CHW orthopedics  
• consider LSO immobilization for pain control |
| **Foreign Body**                 | Possible history of foreign body, red, swollen, +/- x-ray findings                              | • remove of foreign body  
• antibiotic prophylaxis as needed  
• if surgical excision required referral to CHW general surgery or orthopedics if bone involvement |
| **Fracture**                     | Swelling/pain with motion/palpation: + x-ray findings: If tender over physis assume fracture     | • splint and refer to CHW orthopaedics if non-displaced and closed fracture  
• urgent care or emergency department if open fracture, displacement, or angulation present |
<table>
<thead>
<tr>
<th>Illness</th>
<th>Description</th>
<th>Management</th>
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</table>
| Gonococcal/Chlamydial arthritis | + Sexual activity; arthritis of one or more joints; sometimes accompanying dermatitis and systemic signs and symptoms; +/- positive nucleic acid amplification (NAAT) tests of synovial fluid, urine, vagina/cervix | • involvement of local subspecialists as needed, (i.e. infectious disease and/or rheumatology), orthopaedics if septic joint  
• I&D and antibiotic treatment if septic joint  
• antibiotic treatment if aseptic joint and chlamydia likely plus pain management |
| Growing Pains           | Late evening or night time lower extremity pains, usually bilateral, resolve with pain reliever/massage, not typically during day. X-rays negative/Labs negative | • conservative management using symptomatic NSAIDS, massage, warmth, and other supportive measures until the syndrome resolves with time  
• may try a course of PT with muscle stretching and exercise  
• Restless Leg Syndrome may present as growing pains. Consider referral to CHW |
| Juvenile inflammatory arthritis | Morning pain, often multiple joint involvement, chronic, younger than sixteen, +/-CBC, ESR, ANA, AntiDNAse B, ASO | • symptomatic relief can be obtained with NSAIDS  
• referral to a CHW Pediatric Rheumatology |
| Kohler’s disease        | Pain/swelling mid foot, limp, + x-ray findings navicular bone | • restrict weight bearing and splint (ie prowalker  
• consider refer to CHW orthopedics |
| Legg-Calve-Perthes disease | White males 4-10yo, hip and groin pain, decreased internal hip rotation, x-ray findings: flattening and fragmentation of femoral head | • restrict activities and refer to CHW Orthopedics |
| Limb length discrepancy  | +/-limp, not painful, + galeazzi, + AP leg length films | • refer to CHW Orthopedics |
| Lyme Arthritis          | Exposure to endemic area, +/-target rash, swelling/pain joints, +Lyme titer with +western blot, | • refer to cdc.gov for most recent treatment guidelines OR  
• refer to Red Book: Report of the Committee on Infectious Disease (most recent edition)  
• involvement of local subspecialists as needed (i.e. infectious disease and/or rheumatology) |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
<th>Actions</th>
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</thead>
<tbody>
<tr>
<td><strong>Neoplasm</strong></td>
<td>Progressive or intermittent, deep seated, gnawing pain, often worse at night, +/- constitutional symptoms, +/- elevated labs, +/- x-ray findings</td>
<td>• expedited referral to CHW/Froedert pediatric musculoskeletal tumor specialist or pediatric oncologist</td>
</tr>
<tr>
<td><strong>Non accidental Trauma</strong></td>
<td>Injury doesn’t match story, child non-ambulatory with high suspicion fractures, + x-ray findings of affected area</td>
<td>• treat injuries and begin further workup to evaluate for non accidental trauma based upon CHW facility guidelines • admit to hospital for safety of patient and further workup</td>
</tr>
<tr>
<td><strong>Osteochondritis dissecans</strong></td>
<td>Pain +/- swelling affected joint, increase with activity, +/- catch/locking, + x-ray findings or older child/teen</td>
<td>• treat initially with activity restrictions, immobilization, and non weight bearing to affected limb • NSAIDS • refer to CHW Sports Medicine</td>
</tr>
<tr>
<td><strong>Osteomyelitis</strong></td>
<td>Local tenderness/swelling bone, limp, +/- fever, elevated CBC, ESR, and CRP</td>
<td>• refer to emergency room • emergent</td>
</tr>
<tr>
<td><strong>Restless Leg Syndrome</strong></td>
<td>Sleep disturbance, normal physical exam, no systemic symptoms, meet NIH RLS guidelines criteria</td>
<td>• Referral to pediatric sleep center</td>
</tr>
<tr>
<td><strong>Rickets</strong></td>
<td>No supplemental vitamin d, darker skin, genu varum and x-rays findings: widening/cupping of the metaphysis; abnormal labs</td>
<td>• treatment of rickets by primary care provider with involvement of CHW endocrine team as needed • refer to CHW Orthopedics for treatment of genu varum</td>
</tr>
<tr>
<td><strong>Scoliosis</strong></td>
<td>Thoracic/lumbar prominence on Adams forward bend test/ asymmetric shoulders/pelvis; Rarely painful; x-ray PA/lateral scoliosis shows scoliosis</td>
<td>• refer to CHW Orthopedics-scoliosis/spine conditions clinic</td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
<td>Recommendations</td>
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<td>-----------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Septic joint</td>
<td>Pain with joint motion, redness, swelling, warmth, restricted joint motion,</td>
<td>• emergent</td>
</tr>
<tr>
<td></td>
<td>non-weight bearing or limp, fever, elevated CBC, CRP, ESR +/- blood cultures</td>
<td>• ultrasound hip joints to evaluate for septic hip</td>
</tr>
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<td></td>
<td></td>
<td>• refer CHW Emergency room septic joint work up protocol</td>
</tr>
<tr>
<td>Slipped Capital femoral</td>
<td>Often seen 10-14yo teens, M&gt;F, overweight, groin/knee pain, pain internal</td>
<td>• emergent</td>
</tr>
<tr>
<td>epiphysis</td>
<td>hip rotation, limp, + AP/frog lateral Pelvis x-ray</td>
<td>• strict non-weight bearing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• refer to emergency room for surgical stabilization</td>
</tr>
<tr>
<td>Spondylolysis / Spondylolisthesis</td>
<td>Pain with back extension, AP/Lat/Oblique lumbar sacral spine films +/-</td>
<td>• refer to CHW Orthopedics-scoliosis/spine conditions clinic</td>
</tr>
<tr>
<td></td>
<td>findings</td>
<td>• NSAIDS as needed for pain</td>
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<td></td>
<td></td>
<td>• consider activity limitations until seen by subspecialty providers</td>
</tr>
<tr>
<td>Strain/sprain</td>
<td>Tender to palpation over soft tissue, +/- laxity, swelling, no significant</td>
<td>• NSAIDS</td>
</tr>
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<td></td>
<td>pain with weight bearing</td>
<td>• range of motion brace</td>
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<tr>
<td></td>
<td></td>
<td>• begin ambulation as tolerated</td>
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<tr>
<td></td>
<td></td>
<td>• refer to physical therapy if needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• refer to CHW Orthopedics with recurrent sprains</td>
</tr>
<tr>
<td>Tarsal coalition</td>
<td>Pain in foot with activity, often flat foot and restricted subtalar foot</td>
<td>• refer to CHW Orthopedics</td>
</tr>
<tr>
<td></td>
<td>motion, +/- x-ray findings</td>
<td></td>
</tr>
<tr>
<td>Toxic synovitis</td>
<td>Mild pain with hip motion, ambulatory, afebrile, normal CBC, CRP, ESR</td>
<td>If ambulatory, afebrile, no constitutional symptoms, normal CBC, ESR, CRP, provider comfortable</td>
</tr>
<tr>
<td></td>
<td>Labs needs to be evaluated</td>
<td>• NSAIDS</td>
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<tr>
<td></td>
<td></td>
<td>• follow up in 2 to 3 days</td>
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<tr>
<td></td>
<td></td>
<td>• ambulation as tolerated</td>
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<tr>
<td></td>
<td></td>
<td>• limit sports</td>
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<td></td>
<td></td>
<td>If any of following symptoms refer to CHW Emergency for septic joint work up protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nonweightbearing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Febrile or constitutional symptoms</td>
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<tr>
<td></td>
<td></td>
<td>• Moderate-severe pain</td>
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<tr>
<td></td>
<td></td>
<td>• Elevated WBC, CRP or ESR</td>
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</tbody>
</table>


