

# K1 Knee Primary

Patient addressograph

**Important:**

Please tick relevant boxes. All component stickers should be affixed to the accompanying 'Minimum Data Set form component labels sheet'. Please ensure that all sheets are stapled together.

**All fields are mandatory unless otherwise indicated**

**Remember! Make a note of the NJR reference number when you enter the data**

**NJR ref:**

## Patient details

|                                                                                                                        |                                 |                                       |                                                                                                                                                                                                                                                                                  |                                        |
|------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| NJR patient consent obtained                                                                                           | Yes <input type="checkbox"/>    | No <input type="checkbox"/>           | Not recorded <input type="checkbox"/>                                                                                                                                                                                                                                            |                                        |
| If 'Yes' or 'No' was selected for patient consent above, was consent provided by a consultee on behalf of the patient? | Yes <input type="checkbox"/>    | No/Not known <input type="checkbox"/> | This refers to NJR consent being provided by a third party on behalf of the patient, not the 'consent to operate' normally obtained by the consultant. If an 'NJR Patient Consultee Declaration Form' has not been completed, this section should be completed as 'No/Not known' |                                        |
| Has the patient consented to linkage of study data to NJR data?                                                        | Yes <input type="checkbox"/>    | No/Not known <input type="checkbox"/> | Study ID (max 25 characters)                                                                                                                                                                                                                                                     |                                        |
| Body Mass Index (enter either H&W <b>or</b> BMI <b>or</b> tick Not available box)                                      | Height (In M)<br>Weight (In KG) |                                       | BMI                                                                                                                                                                                                                                                                              | Not available <input type="checkbox"/> |

## Patient identifiers

|                                                                 |                               |                                 |                                           |
|-----------------------------------------------------------------|-------------------------------|---------------------------------|-------------------------------------------|
| Forename(s)                                                     |                               |                                 |                                           |
| Surname                                                         |                               |                                 |                                           |
| Sex                                                             | Male <input type="checkbox"/> | Female <input type="checkbox"/> | Indeterminate <input type="checkbox"/>    |
| Date of birth (DD/MM/YYYY)                                      |                               |                                 |                                           |
| Patient postcode                                                |                               |                                 | Overseas address <input type="checkbox"/> |
| NHS number <b>or</b> National Patient Identifier (if available) |                               |                                 |                                           |
| Patient hospital ID                                             |                               |                                 |                                           |
| Patient email address (if provided)                             |                               |                                 |                                           |
| Patient mobile phone number (if provided)                       |                               |                                 |                                           |

## Operation details

|                             |                                  |                                              |                                                 |                                                          |                            |
|-----------------------------|----------------------------------|----------------------------------------------|-------------------------------------------------|----------------------------------------------------------|----------------------------|
| Hospital                    |                                  |                                              |                                                 |                                                          |                            |
| Operation date (DD/MM/YYYY) |                                  |                                              |                                                 |                                                          |                            |
| Anaesthetic types           | General <input type="checkbox"/> | Regional – epidural <input type="checkbox"/> | Regional – nerve block <input type="checkbox"/> | Regional – spinal (intrathecal) <input type="checkbox"/> |                            |
| Patient ASA grade           | 1 <input type="checkbox"/>       | 2 <input type="checkbox"/>                   | 3 <input type="checkbox"/>                      | 4 <input type="checkbox"/>                               | 5 <input type="checkbox"/> |
| Operation funding           | NHS <input type="checkbox"/>     | Independent <input type="checkbox"/>         |                                                 |                                                          |                            |

| Surgeon details                                                |                                                                             |                                    |                                                                 |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
|----------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------|----------------------------------------|--|--------------------------|--------------------------|--|--|--|--|--|
| Consultant in charge                                           |                                                                             |                                    |                                                                 |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Operating surgeon number one                                   |                                                                             |                                    |                                                                 |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Operating surgeon number one Grade                             | Consultant <input type="checkbox"/>                                         | SPR/ST3-8 <input type="checkbox"/> | Senior Fellow (Post-CCT or equivalent) <input type="checkbox"/> | F1-ST2 <input type="checkbox"/>               | Specialty doctor/SAS <input type="checkbox"/> | Other <input type="checkbox"/>         |  |                          |                          |  |  |  |  |  |
| Dual consultant operation?                                     | Yes <input type="checkbox"/>                                                |                                    | No <input type="checkbox"/>                                     |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Operating consultant number two (if dual consultant operation) |                                                                             |                                    |                                                                 |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| First assistant Grade                                          | Consultant <input type="checkbox"/>                                         |                                    | Other <input type="checkbox"/>                                  |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Knee primary procedure details                                 |                                                                             |                                    |                                                                 |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Side                                                           | Left <input type="checkbox"/>                                               |                                    | Right <input type="checkbox"/>                                  |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Indications for implantation<br>(select all that apply)        | Osteoarthritis                                                              |                                    |                                                                 | <input type="checkbox"/>                      | SONK (Spontaneous Osteonecrosis of the Knee)  |                                        |  | <input type="checkbox"/> |                          |  |  |  |  |  |
|                                                                | Avascular necrosis (AVN)                                                    |                                    |                                                                 | <input type="checkbox"/>                      | Trauma                                        |                                        |  |                          |                          |  |  |  |  |  |
|                                                                | Other inflammatory arthropathy                                              |                                    |                                                                 | <input type="checkbox"/>                      | Trauma acute                                  |                                        |  | <input type="checkbox"/> |                          |  |  |  |  |  |
|                                                                | Infection – previous                                                        |                                    |                                                                 | <input type="checkbox"/>                      | Trauma chronic                                |                                        |  | <input type="checkbox"/> |                          |  |  |  |  |  |
|                                                                | Infection – active                                                          |                                    |                                                                 | <input type="checkbox"/>                      | Metastatic cancer/malignancy                  |                                        |  | <input type="checkbox"/> |                          |  |  |  |  |  |
|                                                                | Rheumatoid arthritis                                                        |                                    |                                                                 | <input type="checkbox"/>                      | Other                                         |                                        |  | <input type="checkbox"/> |                          |  |  |  |  |  |
|                                                                | Focal chondral and osteochondral defects                                    |                                    |                                                                 | <input type="checkbox"/>                      |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Pre-operative range of movement                                |                                                                             |                                    |                                                                 |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Fixed flexion deformity (degrees)                              | Less than 10 <input type="checkbox"/>                                       |                                    | 10 to 30 <input type="checkbox"/>                               | Greater than 30 <input type="checkbox"/>      |                                               | Not available <input type="checkbox"/> |  |                          |                          |  |  |  |  |  |
| Flexion (degrees)                                              | Less than 70 <input type="checkbox"/>                                       |                                    | 70 to 90 <input type="checkbox"/>                               | 91 to 110 <input type="checkbox"/>            | Greater than 110 <input type="checkbox"/>     | Not available <input type="checkbox"/> |  |                          |                          |  |  |  |  |  |
| Surgical approach                                              |                                                                             |                                    |                                                                 |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Patient procedure                                              | Primary total prosthetic replacement using cement                           |                                    |                                                                 |                                               |                                               |                                        |  |                          | <input type="checkbox"/> |  |  |  |  |  |
|                                                                | Primary total prosthetic replacement not using cement                       |                                    |                                                                 |                                               |                                               |                                        |  |                          | <input type="checkbox"/> |  |  |  |  |  |
|                                                                | Primary total prosthetic replacement not classified elsewhere (e.g. hybrid) |                                    |                                                                 |                                               |                                               |                                        |  |                          | <input type="checkbox"/> |  |  |  |  |  |
|                                                                | <b>Unicompartmental knee replacement (select all that apply)</b>            |                                    |                                                                 |                                               |                                               |                                        |  |                          | <input type="checkbox"/> |  |  |  |  |  |
|                                                                | Medial                                                                      | <input type="checkbox"/>           | Lateral                                                         | <input type="checkbox"/>                      | Patello-Femoral                               | <input type="checkbox"/>               |  |                          |                          |  |  |  |  |  |
|                                                                | <b>Focal knee resurfacing (select all that apply)</b>                       |                                    |                                                                 |                                               |                                               |                                        |  |                          | <input type="checkbox"/> |  |  |  |  |  |
|                                                                | Medial femoral condyle                                                      |                                    |                                                                 | <input type="checkbox"/>                      | Lateral tibial plateau                        |                                        |  | <input type="checkbox"/> |                          |  |  |  |  |  |
|                                                                | Lateral femoral condyle                                                     |                                    |                                                                 | <input type="checkbox"/>                      | Trochlea                                      |                                        |  | <input type="checkbox"/> |                          |  |  |  |  |  |
|                                                                | Medial tibial plateau                                                       |                                    |                                                                 | <input type="checkbox"/>                      | Patella                                       |                                        |  | <input type="checkbox"/> |                          |  |  |  |  |  |
|                                                                | Planned incomplete primary procedure                                        |                                    |                                                                 |                                               |                                               |                                        |  |                          | <input type="checkbox"/> |  |  |  |  |  |
| Approach                                                       | Medial parapatellar                                                         | <input type="checkbox"/>           | Mid-vastus                                                      | <input type="checkbox"/>                      |                                               |                                        |  |                          |                          |  |  |  |  |  |
|                                                                | Lateral parapatellar                                                        | <input type="checkbox"/>           | Other                                                           | <input type="checkbox"/>                      |                                               |                                        |  |                          |                          |  |  |  |  |  |
|                                                                | Sub-vastus                                                                  | <input type="checkbox"/>           |                                                                 |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Associated procedures at the time of surgery                   | Synchronous ACL reconstruction <input type="checkbox"/>                     |                                    |                                                                 | Other <input type="checkbox"/>                | None <input type="checkbox"/>                 |                                        |  |                          |                          |  |  |  |  |  |
| Minimally invasive technique used?                             | Yes <input type="checkbox"/>                                                |                                    | No <input type="checkbox"/>                                     |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Computer guided surgery used?                                  | Yes <input type="checkbox"/>                                                |                                    | No <input type="checkbox"/>                                     |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Robotic surgery used?                                          | Yes <input type="checkbox"/>                                                |                                    | No <input type="checkbox"/>                                     |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| If Yes, name of robot                                          |                                                                             |                                    |                                                                 |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Patient specific instruments?                                  | Yes <input type="checkbox"/>                                                |                                    | No <input type="checkbox"/>                                     |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| Use of tourniquet                                              | Yes <input type="checkbox"/>                                                |                                    | No <input type="checkbox"/>                                     |                                               |                                               |                                        |  |                          |                          |  |  |  |  |  |
| How long was it used for?                                      | 0-15 minutes <input type="checkbox"/>                                       |                                    | 15-30 minutes <input type="checkbox"/>                          | More than 30 minutes <input type="checkbox"/> |                                               |                                        |  |                          |                          |  |  |  |  |  |

| Thromboprophylaxis regime (intention to treat)                                      |                                                 |                          |                   |                          |                          |                          |       |                          |  |
|-------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------|-------------------|--------------------------|--------------------------|--------------------------|-------|--------------------------|--|
| Chemical                                                                            |                                                 |                          |                   |                          | In hospital              | At home                  |       |                          |  |
|                                                                                     | Aspirin                                         |                          |                   |                          | <input type="checkbox"/> | <input type="checkbox"/> |       |                          |  |
|                                                                                     | LMWH                                            |                          |                   |                          | <input type="checkbox"/> | <input type="checkbox"/> |       |                          |  |
|                                                                                     | Pentasaccharide (e.g. Fondaparinux)             |                          |                   |                          | <input type="checkbox"/> | <input type="checkbox"/> |       |                          |  |
|                                                                                     | Warfarin                                        |                          |                   |                          | <input type="checkbox"/> | <input type="checkbox"/> |       |                          |  |
|                                                                                     | Direct thrombin inhibitor (e.g. Dabigatran)     |                          |                   |                          | <input type="checkbox"/> | <input type="checkbox"/> |       |                          |  |
|                                                                                     | Factor Xa inhibitor (e.g. Rivaroxaban/Apixaban) |                          |                   |                          | <input type="checkbox"/> | <input type="checkbox"/> |       |                          |  |
|                                                                                     | Other                                           |                          |                   |                          | <input type="checkbox"/> | <input type="checkbox"/> |       |                          |  |
|                                                                                     | None                                            |                          |                   |                          | <input type="checkbox"/> | <input type="checkbox"/> |       |                          |  |
| Mechanical                                                                          | Foot pump                                       | <input type="checkbox"/> | Other             |                          | <input type="checkbox"/> |                          |       |                          |  |
|                                                                                     | Intermittent calf compression                   | <input type="checkbox"/> | None              |                          | <input type="checkbox"/> |                          |       |                          |  |
|                                                                                     | TED stockings                                   | <input type="checkbox"/> |                   |                          |                          |                          |       |                          |  |
| Bone graft used                                                                     |                                                 |                          |                   |                          |                          |                          |       |                          |  |
| Was femoral bone graft used?                                                        | Yes                                             | <input type="checkbox"/> | No                | <input type="checkbox"/> |                          |                          |       |                          |  |
| Femoral – form                                                                      | Structural                                      | <input type="checkbox"/> | Morsellised/chips | <input type="checkbox"/> |                          |                          |       |                          |  |
| Femoral – type                                                                      | Autograft                                       | <input type="checkbox"/> | Allograft         | <input type="checkbox"/> | Synthetic                | <input type="checkbox"/> | Other | <input type="checkbox"/> |  |
| Was tibial bone graft used?                                                         | Yes                                             | <input type="checkbox"/> | No                | <input type="checkbox"/> |                          |                          |       |                          |  |
| Tibial – form                                                                       | Structural                                      | <input type="checkbox"/> | Morsellised/chips | <input type="checkbox"/> |                          |                          |       |                          |  |
| Tibial – type                                                                       | Autograft                                       | <input type="checkbox"/> | Allograft         | <input type="checkbox"/> | Synthetic                | <input type="checkbox"/> | Other | <input type="checkbox"/> |  |
| Structural implant or other augment(s) used e.g. stems, wedges, block, cone, sleeve |                                                 |                          |                   |                          |                          |                          |       |                          |  |
| Were femoral structural implant or other augment(s) used?                           | Yes                                             | <input type="checkbox"/> | No                | <input type="checkbox"/> |                          |                          |       |                          |  |
| Were tibial structural implant or other augment(s) used?                            | Yes                                             | <input type="checkbox"/> | No                | <input type="checkbox"/> |                          |                          |       |                          |  |
| If yes, please affix implant labels under “Accessories”                             |                                                 |                          |                   |                          |                          |                          |       |                          |  |
| Surgeon's notes                                                                     |                                                 |                          |                   |                          |                          |                          |       |                          |  |
|                                                                                     |                                                 |                          |                   |                          |                          |                          |       |                          |  |
| Intra-operative event                                                               |                                                 |                          |                   |                          |                          |                          |       |                          |  |
| Untoward intra-operative event                                                      | None                                            | <input type="checkbox"/> | Ligament injury   | <input type="checkbox"/> |                          |                          |       |                          |  |
|                                                                                     | Fracture                                        | <input type="checkbox"/> | Other             | <input type="checkbox"/> |                          |                          |       |                          |  |
|                                                                                     | Patella tendon avulsion                         | <input type="checkbox"/> |                   |                          |                          |                          |       |                          |  |

# Minimum Data Set form – component labels

1. Please affix any component labels to this sheet and ensure any extra component label sheets are attached to the main Minimum Data Set form.
2. Ensure all component details are provided, including cement.
3. The NJR **does not** record the following: wire, mesh, cables or surgical tools.

|                                                            |                                               |
|------------------------------------------------------------|-----------------------------------------------|
| Femoral component (or unicondylar femoral component)       | Tibial tray (or unicondylar tibial component) |
|                                                            |                                               |
| Meniscal component                                         | Cement (if used)                              |
|                                                            |                                               |
| Patella (if used)<br>Needed in Patello-femoral replacement | Accessories                                   |
|                                                            |                                               |