Lisa Stamp Intra-articular injections

Gauze swab and chlorhexadine – no gloves, mark where I go but then don’t touch the area while injecting

Knee – 40 – 80 mg Kennacort (because large joint)

Less in eg shoulder joint

Never more than a 10 ml syringe because of the increased pressure maybe drawing back synovial tissue 🡪 blocking off of the needle

Aspiration – even if only a drop in the needle, this might be enough for crystals and culture.

If can see numbers on opposite side of syringe likely to be no inflammatory cells.  
- if can still see but not clearly, maybe inflammatory white cells in moderately high numbers, whereas if can’t see the numbers then likely frank infection.

Can’t see infection on a plain xray until 10- 14 days, so don’t do

PVNS – malignancy of the synovium – the aspirate will show pigment haemosiderin – like concentrated urine colour. Need Magnetic resonance image.

When send aspirate off to lab, they only do cell count, but not eg cytology. Should ask for crystals as well.

Consistency of synovial fluid is stringy, blood is different so if stringy, either haemarthrosis or PVNS.

Infection risk: this happens in only 1 in 50,000 therefore uncommon.

No real problem injecting an infected joint – certainly not in the first 24 – 48 hours. This has happened many times without any real problems.

Any one joint only two or three times per year

Once every six weeks – no more frequently than that (generally).

Gouty joints, and diabetics more likely to get an infected joint (either before or after an injection)

Don’t forget tuberculous infection (not from “TB” but from the mycobacterium – very difficult to culture - ? up to 18 months sometimes).

What if you inject with steroid in an infected joint? Probably not much of a problem but need quick follow-up. Does the cell count help in deciding if infected or not? Non-inflammatory cell count (white) is < 200 per high power field. If 50,000, then likely to be infected.

NB Vaso-vagal Peter “ shouldn’t let the patient drive for 24 hours after – there is a medico-legal requirement”

Always aspirate before injecting.

Darran: two drops onto a dipstick – if 2 + protein then likely infection.

**INJECT**

I indications

N negative outcomes

J juice (LA + cortisone)

E expected outcomes

C contraindications

T telephone/follow-up

Older people and OA.

There is a role for those people – especially if there is some low grade inflammation. I don’t repeat much if the response is not at least three months. (Though I would do it maybe twice initially).

I won’t inject the same joint more than four times in one year.

Never inject a replaced (prosthetic) joint.