ROBERT PETTIT, MD

Restoring Function. Maximizing Performance.

ORTHOPAEDIC SPORTS MEDICINE · BEACON ORTHOPAEDICS & SPORTS MEDICINE

CINCINNATI, OH · FORT THOMAS, KY

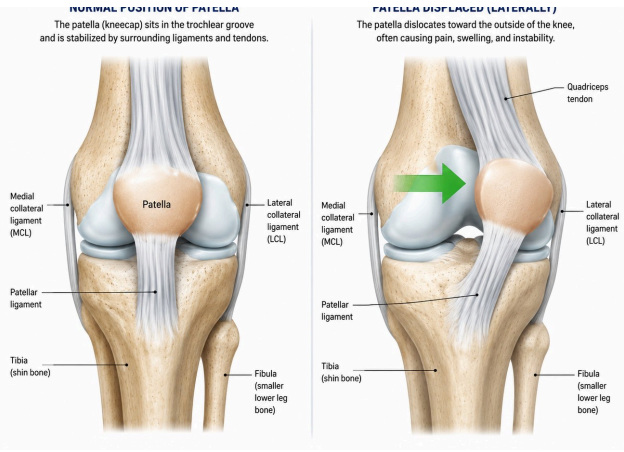
(513) 354-3700

FELLOWSHIP-TRAINED · BOARD CERTIFIED (ABOS) · MAKO ROBOTICS CERTIFIED · CINCINNATI REDS TEAM PHYSICIAN

KNEE CONDITION

Patellofemoral Pain Syndrome

Runner's Knee / Anterior Knee Pain — Patient Condition Guide



The kneecap (patella) and its groove · for education; your anatomy may differ

OVERVIEW

Patellofemoral pain syndrome (PFPS) — often called runner's knee — is pain arising from the joint between the kneecap and the groove it glides in. It is the single most common cause of knee pain in active people, driven by load that exceeds what the joint is currently conditioned for, often with contributions from hip and quad weakness or training errors.

SYMPTOMS

- Aching pain behind or around the kneecap
- Worse with stairs (especially down), squatting, running hills, and prolonged sitting ('theater sign')
- Occasional grinding or a sense of the knee 'giving' with pain
- Usually no significant swelling

DIAGNOSIS

PFPS is a clinical diagnosis: the history and a focused exam of the kneecap, hip strength, and movement patterns usually tell the story. X-rays or MRI are reserved for atypical cases or symptoms that persist despite good rehab.

TREATMENT OPTIONS

The evidence strongly supports exercise-based treatment: temporarily modifying aggravating load, then progressively strengthening the quadriceps and hip abductors and addressing movement mechanics. Taping or a sleeve can calm symptoms during the transition. Injections and surgery have almost no role in true PFPS.

RECOVERY OUTLOOK

Most patients improve substantially over 6–12 weeks of a structured program and return to full running and sport. Keeping the hip-and-quad program going is the best insurance against recurrence.

SCAN FOR THE LATEST VERSION ONLINE

robertpettitmd.com/handouts/patellofemoral-pain.pdf

This handout is for general patient education and does not replace personalized medical advice. Always follow the specific instructions given by Dr. Pettit and your care team.

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HOME EXERCISE PROGRAM

Patellofemoral Pain Syndrome: Exercises & Strengthening

The hips and quads control how the kneecap tracks. Build from the basics to the slow step-downs — the eccentric step-down is the key exercise.

Why eccentric strengthening? Tendons heal and get stronger when they are loaded slowly while lengthening — the "eccentric" (lowering) phase of an exercise. Take 3–4 seconds on every lowering movement. A mild ache (up to 3–4/10) during eccentric work is acceptable and even expected; sharp pain, or pain that worsens into the next day, means reduce the load. Tendon programs work over 6–12 weeks of consistency — stick with it.

Stop and call the office at (513) 354-3700 if any exercise causes sharp pain, swelling, numbness, or symptoms that worsen into the next day. This general program does not replace an individualized plan from Dr. Pettit or your physical therapist.

Quad Set

10-second holds × 10, 2 sets daily

Sitting or lying with the leg straight, tighten the muscle on top of the thigh, pressing the back of the knee toward the floor. Hold, then relax.

Straight Leg Raise

2 sets of 10, daily

Tighten the thigh, lock the knee straight, and lift the entire leg about 12 inches. Lower slowly with control.

Clamshells

3 sets of 15 per side, daily

Side-lying with knees bent and feet together, lift the top knee like a clamshell opening while keeping the pelvis still.

Side-Lying Leg Raise

3 sets of 12, daily

Side-lying with the top leg straight and in line with your body, lift it toward the ceiling, then lower slowly.

Wall Sit (Isometric)

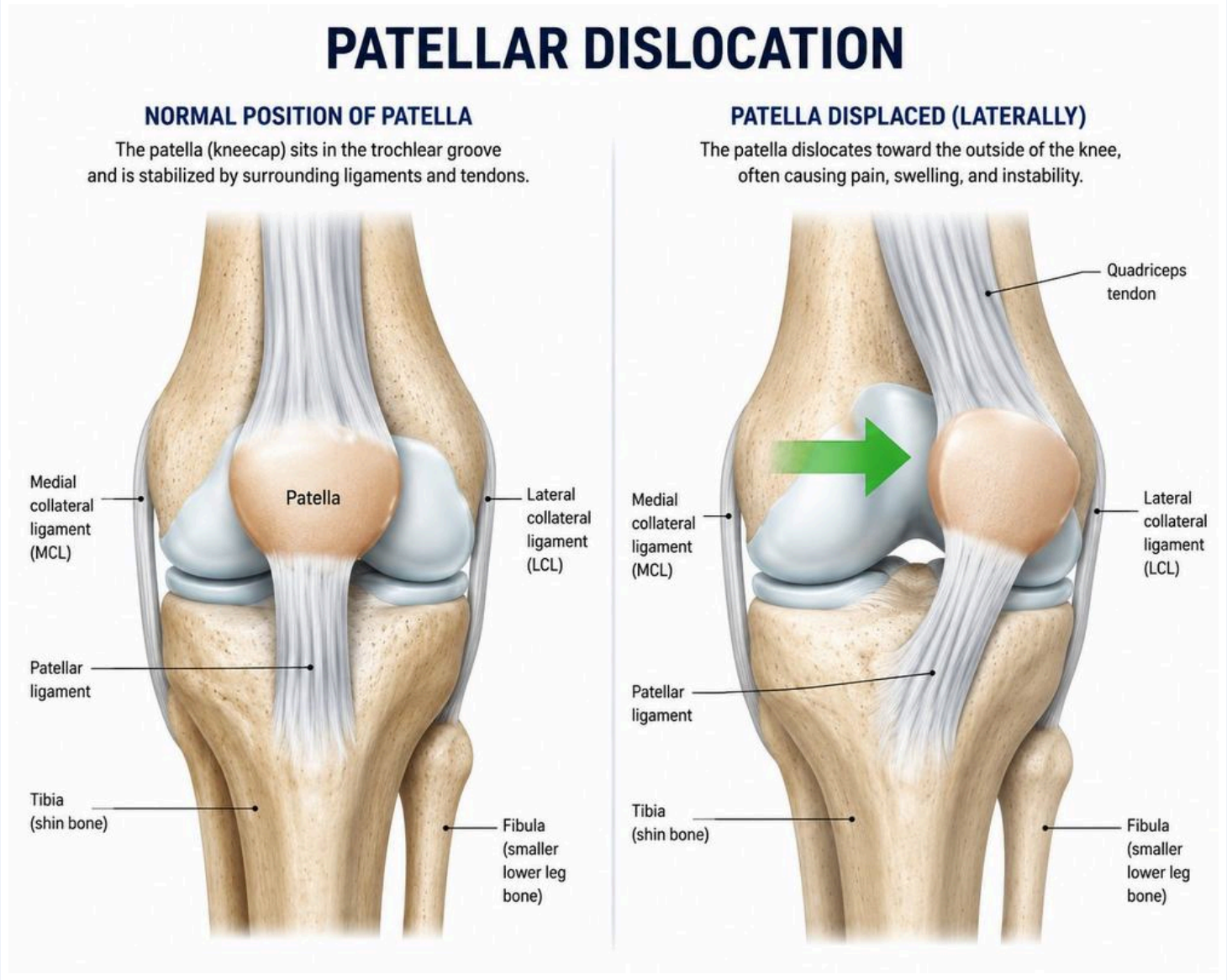
3 × 30–45-second holds, daily

Back flat against the wall, slide down to a partial squat (well short of pain) and hold. Isometric holds are excellent for calming irritable tendons.

Slow Step-Downs ECCENTRIC

3 sets of 10 per leg, every other day

Standing on a low step, slowly lower the other heel toward the floor over 3–4 seconds, keeping the kneecap tracking over the toes, then step back up.



For patient education; your anatomy may differ.