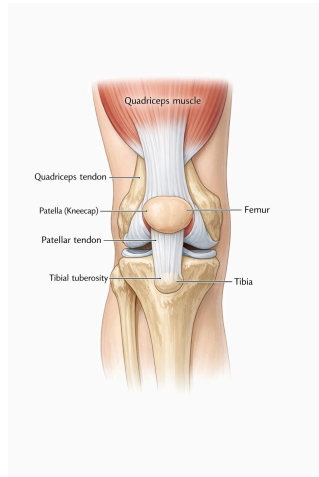


ONE-PAGE PATIENT SUMMARY

Patellar Tendonitis

Jumper's knee: a loading-related tendon condition



Anatomy of the patellar tendon and knee extensor mechanism.

Pain below the kneecap

Patellar tendonitis, more accurately patellar tendinopathy or jumper's knee, is pain and dysfunction in the tendon below the kneecap. It commonly affects people exposed to repeated jumping and landing, but may also follow repetitive loading or a sudden rise in activity.

What to look for

- Pain is usually localised at the lower tip of the kneecap.
- It often follows repetitive jumping, landing, running or sudden activity increases.
- Morning stiffness, stair pain and pain after sitting can occur.
- Diagnosis is clinical; ultrasound commonly assesses tendon changes and can guide injections.
- This is usually tendon degeneration, not simply inflammation.

Treatment pathway

1 Assessment and plan

Your clinician examines the knee and may use ultrasound; MRI may be used for complex cases or surgical planning.

2 Modify, do not stop

Reduce jumping, sprinting and rapid direction changes initially. Continue suitable low-impact activity and a structured loading programme rather than complete rest.

3 Progressive loading

Build from isometric holds to strengthening, then jumping and sport-specific work. Progress by goals and symptoms, with your clinician or physiotherapist.

4 Consider adjuncts or surgery

If rehabilitation alone is insufficient, ultrasound-guided PRP or high-volume injection may be discussed. Arthroscopic debridement is reserved after at least six months of appropriate conservative treatment.

Recovery and aftercare

1 Settle and establish load

Begin controlled isometric loading and reduce aggravating high-energy activity. Aim for pain no more than 3/10 during and 24 hours afterwards.

2 Strength and prepare

Progress to heavy slow strengthening, then energy-storage work such as jumping, only when technique, strength and symptoms allow.

3 Return and maintain

Return to training and sport gradually when criteria are met; retain maintenance strength work to help reduce recurrence risk.

Protect the tendon

Use the 24-hour pain-monitoring rule, including the single-leg decline squat as a daily pain test. Pain up to 3/10 during rehabilitation may be acceptable if it returns to your baseline within 24 hours. If it is worse the next day, reduce the load.

Get urgent help

Attend A&E immediately for sudden severe pain with a pop or snap, inability to straighten the knee or lift the leg, or a visible gap below the kneecap. Contact the clinic urgently for marked swelling, redness or warmth, or fever after an injection. Seek urgent clinic review for worsening night pain unrelated to activity.

Important limitations and choices

Response and recovery vary. Mr Dehne uses real-time ultrasound guidance for injections; high-volume injection targets the patellar tendon–Hoffa's fat pad interface. Corticosteroid injections are generally not recommended, as short-term relief may weaken the tendon and increase rupture risk. His preferred surgical option is arthroscopic debridement, only after at least six months of appropriate conservative care, including loading rehabilitation and injection therapy.

Need advice tailored to you? This poster supports, but does not replace, individual assessment or consent.

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