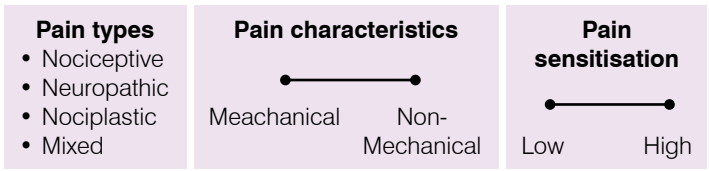

Figure 1: Pain features within the Musculoskeletal Clinical Translation Framework.

Table 1: Framework for considering assessment findings.

Interpretation of the pain sensitivity assessment		
The big picture		
• Is the presence of pain sensitivity expected or unexpected? - For the stage of the disorder? - For the diagnosis? • Is the presence of pain sensitivity helpful (protecting injured or unhealthy tissues) or unhelpful (contributing to the person's presentation in a negative manner)? • What is the relationship between pain sensitivity and other biopsychosocial factors in the person's presentation? - Are other factors driving pain sensitivity (such as sleep or mood)? - Will addressing other factors alter the pain sensitivity or does pain sensitivity itself need to be a primary consideration of management?		
Categorisation of the sensitivity		
Helpful/protective	**Incidental**	
Sensitivity is reasonable in relation to the stage of the disorder. With usual management of the disorder and time, the sensitivity should resolve.	Sensitivity, though present, can essentially be ignored because it is not a driving factor. It may be part of the person's normal sensory profile or might be expected to resolve as the disorder improves.	
Minor contribution	**Significant contribution**	**Main barrier**
Sensitivity potentially needs monitoring, but on its own will not influence management.	Understanding and addressing pain sensitivity will form part of management planning.	Understanding and addressing pain sensitivity will form an integral and major part of management planning.

Table 2: Examples for the categorisation of pain sensitivity.

Medial collateral ligament injury		
Scenario 1: One day ago: Range of motion is limited to 50 per cent expected range by pain. Single-leg stance is limited due to pain. Valgus stress test is highly provocative with mild pressure. There is sharp hyperalgesia over the medial knee and blunt pressure allodynia in the same area.	**Scenario 2: Eight weeks ago:** Pain increases with dynamic direction-changing activities and settles rapidly with rest. Range is full, with end range pain in extension with moderate overpressure. Single leg-stance is pain-free. Valgus stress test is mildly painful. There is minor increased sensation with sharp and with cold over the medial knee compared to the lateral knee and compared to the other side.	**Scenario 3: Eight weeks ago:** There is constant 5/10 medial knee pain, escalated by weight-bearing for more than five minutes, which then takes 40 minutes to settle. Pain spreads down the anteromedial shin. There is tingling down the anterior shin into the great toe. Knee range is limited to 75 per cent by pain. Valgus stress test is painful with mild pressure. There is allodynia to light touch in the medial knee and in the anteromedial shin. There is sharp, cold and blunt pressure hyperalgesia in the same areas.
Categorisation		
Helpful/protective: This level of pain sensitivity is expected for this injury at this time.	**Minor contribution:** Mild tactile pain sensitivity is present, but is not overly influencing function.	**Significant contribution:** There is significant tactile pain sensitivity and the sensitivity is related to significant functional limitations and does not correlate with the degree of tissue injury.
Management		
Nil specific. Manage the injury and the sensitivity should settle as it heals.	Nil specific. Educate the patient—explain that this is an indicator that the tissues are still healing.	Possibly investigate to exclude other specific knee pathology. Screen specific lower limb peripheral nerves. If clear, educate regarding sensitivity; consider centrally acting medication (**tinyurl.com/QO72F1**) or a topical Lignocaine patch with GP; consider other contributing factors; consider a graded desensitising program including graded activity.